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NOTES

THE DOCTOR'S DILEMMA WITH THE OKLAHOMA ABORTION LAW ULTRASOUND REQUIREMENT

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I. INTRODUCTION

Oklahoma's abortion law[1] is unique among the United States.

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1. OKLA. STAT. tit. 63, §§ 1-730 to -741.12 (OSCN through 2011 Leg. Sess.). After this Note was written, Oklahoma County District Court permanently enjoined enforcement of the Ultrasound Act, 2010 Okla. Sess. Laws 173, finding violation of the Oklahoma Constitution article V, section 46 (prohibiting special laws that authorize limitations of civil actions) and section 59 (requiring a general law, rather than a special law, when a general law could be applied). Nova Health Sys. v. Pruitt, No. CV-2010-533 (Dist. Ct., Okla. Cnty., Okla. Mar. 28, 2012) (motion to reconsider *denied* May 23, 2012). Although this decision invalidates Oklahoma Statute title 63, sections 1-738.1A, 1-738.3d, and 1-738.3e, which are discussed in this Note, the Oklahoma Attorney General has recently appealed. Petition in Error (SC#110813) *Nova*, No. CV-2010-533 (June 22, 2012). The court's decision did not address the issues discussed in this Note.

Oklahoma Statute title 63, section 1-738.3d requires that a physician perform an ultrasound examination prior to performing an elective abortion of a pregnant woman. The ultrasound must be completed using either an abdominal or vaginal transducer, whichever will produce a clearer image of the embryo or fetus.[2] If the physician fails to perform the ultrasound, the physician may be charged with a felony, among other crimes.[3] However, when the statutorily required procedure is not medically necessary, the physician cannot perform the ultrasound procedure without violating either the standards of medical professional conduct or other Oklahoma criminal statutes.[4] This Note will examine the impact of Oklahoma's unique sonography requirement from the perspective of a physician who cares for women seeking an abortion during their first trimester.

Part II describes the relevant Oklahoma statutes. Part III explains relevant medical principles. Part IV provides the physician's view of the statutes' intersection with medical care. Part V presents the attorney's analysis of the physician's dilemma and his risk of liability. Part VI provides arguments against the statute based on these concerns.

II. THE LAW

When a woman seeks an abortion in Oklahoma, state law requires that "the physician who is to perform or induce the abortion, or the certified technician working in conjunction with the physician, shall: 1. Perform an obstetric ultrasound on the pregnant woman, using either a vaginal transducer or an abdominal transducer, whichever would display the embryo or fetus more clearly."[5] No other state has such a requirement. Alabama, Louisiana, Mississippi, North Carolina, and Texas require that a woman have a sonogram prior to an abortion, but do not specify the type of transducer that must be used.[6] Arizona and Florida

2. OKLA. STAT. tit. 63, § 1-738.3d(A)–(B)(1).
3. *Id.* § 1-738.5.
4. *See infra* Parts II–VI.
5. OKLA. STAT. tit. 63, § 1-738.3d(B). Although the law allows a certified technician to perform the ultrasound, the technician would be acting under the direction of the physician. *Id.* Whether a physician or technician performs the exam is not relevant to the issue presented in this Note, so the text will refer to the sonographer as a physician simply to streamline the discussion. Masculine pronouns will refer to the physician simply to distinguish the physician from the pregnant patient, to whom the feminine pronouns will refer.
6. ALA. CODE § 26-23A-4(b)(4)–(6) (2009); LA. REV. STAT. ANN.

require a sonogram only after the first trimester, but do not specify the type of transducer.[7] Only Oklahoma requires sonography using a vaginal transducer when it will create a clearer picture.[8]

In Oklahoma, a physician must show the patient her ultrasound and explain the images to her *during* the sonogram while she is lying on the examination table.[9] The physician does not have the option to acquire the images, allow the woman to get dressed and sit up, and then explain the images. Alabama, Louisiana, Mississippi, and North Carolina give the woman the option to see the images but do not require the display and explanation of the images simultaneously with the ultrasound examination.[10]

In Oklahoma, the woman must certify that the physician has complied with the specific provisions of the abortion law regarding the conduct and showing of the ultrasound.[11] If a physician fails to obtain this certification from the woman, the physician has violated the statute and has committed a felony.[12] However, the woman is not penalized.[13]

In the case of a medical emergency, the sonography requirements do not apply if the physician certifies, in writing, the nature of the medical emergency.[14] The statute defines a medical emergency as one involving only the physical condition of the woman and specifically excludes psychological conditions.[15] There are no other exceptions to the ultrasound requirement.[16]

Oklahoma law provides that a knowing or reckless violation of the abortion statute is a felony,[17] punishable by up to two years in prison and a $1,000 fine.[18] Additionally, the Oklahoma State Board of Medical

§ 40:1299.35.2(C)–(D) (Supp. 2012); MISS. CODE ANN. § 41-41-34(1)(a) (2011); N.C. GEN. STAT. §§ 90-21.81(4), -21.85(a)(1) (2012); TEX. HEALTH & SAFETY CODE ANN. § 171.012(4)(A) (TCAS through Sept. 2011).

7. ARIZ. REV. STAT. ANN. §§ 36-449.03, -2301.02(A) (AZ LEG through 2012 Reg. Sess.); FLA. STAT. § 390.0111(a)(1)(b) (FL LEG through Jan. 2012).

8. OKLA. STAT. tit. 63, § 1-738.3d(B)(2).

9. *Id.* § 1-738.3d(B)–(B)(2).

10. ALA. CODE § 26-23A-4(b)(4); LA. REV. STAT. ANN. § 40:1299.35.2(C)–(D); MISS. CODE ANN. § 41-41-34(1)(b); N.C. GEN. STAT. §§ 90-21.81, -21.85(a)(2)-(b).

11. OKLA. STAT. tit. 63, § 1-738.3d(B)(5).

12. *Id.* § 1-738.5(D).

13. *Id.* § 1-738.5(B).

14. *Id.* § 1-738.3d(D).

15. *Id.* § 1-738.1A(5).

16. *See id.* §§ 1-730 to -741.12.

17. *Id.* § 1-738.5(D).

18. OKLA. STAT. tit. 21, § 9 (OSCN through 2011 Leg. Sess.).

Licensure and Supervision may suspend or revoke the license of a physician who violates the Oklahoma abortion statute.[19] If a physician is enjoined from performing abortions due to a violation of the abortion statute, and he knowingly violates the injunction, the physician may be fined for each violation of the injunction in escalating amounts from $10,000 for the first violation to over $100,000 for the fourth and subsequent violations.[20] The Oklahoma abortion statute also creates a private cause of action against the abortion-providing physician for "any knowing or reckless violation of this act."[21] The patient may sue for actual and punitive damages.[22] A woman undergoing a legal abortion may not be penalized under any provisions of the Oklahoma abortion statute.[23]

III. THE MEDICINE

When a woman requests an elective abortion, the doctor must confirm that the woman is pregnant, determine whether the pregnancy is intrauterine, and estimate the gestational age of the embryo or fetus.[24] A positive urine or serum test of human chorionic gonadotropin (HCG) confirms an early pregnancy.[25] A physician determines whether a pregnancy is intrauterine or ectopic and determines the gestational age by evaluating the result of the HCG test, physical examination, sonography, or some combination of these.

Sonography uses very high frequency sound waves that reflect off the tissues of interest, just as ships use much lower frequency SONAR to identify underwater structures. To transmit the sound waves into the patient, the ultrasound unit has transducers of different frequencies and physical shapes. A transducer converts an electrical signal into sound

19. OKLA. STAT. tit. 63, § 1-738.3e(E). In Oklahoma, the State Board of Medical Licensure may discipline allopathic (M.D.) physicians. OKLA. STAT. tit. 59, § 503 (OSCN through 2011 Leg. Sess.). The State Board of Osteopathic Examiners may discipline osteopathic (D.O.) physicians. *Id.* § 637. For simplicity, this Note refers to only the M.D. licensing board. All references to the M.D. licensing board also apply to the D.O. licensing board.

20. OKLA. STAT. tit. 63, § 1-738.3e(C).

21. *Id.* § 1-738.3e(D).

22. *Id.*

23. *Id.* § 1-738.5(B).

24. RONALD S. GIBBS ET AL., DANFORTH'S OBSTETRICS AND GYNECOLOGY 588 (10th ed. 2008).

25. *Id.*

that is transmitted into the patient; it then converts the bounced-back sound wave into another electrical signal that is sent to the ultrasound unit. The ultrasound unit uses software to process the signal derived from the reflected sound waves and then to display the images on a screen. The frequency of the sound wave produced by the transducer is a function of the wavelength of the sound waves produced. The lower the frequency, the longer the wavelength, and the further the sound waves will travel. The operator of the ultrasound unit selects the appropriate transducer based upon the location of the tissue being examined and what is best for that individual patient.

For obstetric ultrasound studies, the physician uses either an abdominal transducer or a vaginal transducer.[26] For a transabdominal sonogram, the woman drinks extra water and comes to the examination with a full bladder. The liquid-filled bladder helps transmit the sound waves from the surface of the abdomen to produce a better ultrasound image of the uterus, located behind the bladder. The woman lies face-up on the examination table and slides her clothing out of the way to expose her entire belly. The physician applies warm gel to the surface of the abdomen, moves the abdominal transducer across the abdomen, and then the tissues of interest are displayed on the ultrasound unit's screen. The gel helps conduct the sound waves efficiently between the transducer and the patient.

In contrast, the transvaginal sonogram creates a very different experience for the patient.[27] For a transvaginal sonogram, the patient empties her bladder prior to the study. The patient takes off her clothing below the waist and lies face-up on the examination table with her buttocks elevated. She exposes her vagina by bending her knees, placing her feet up in stirrups or on the table near her hips, and spreading her legs apart. The physician applies gel to the wand-like probe, places a condom-type protective cover over the gel-covered probe and applies more gel on the outside of the cover. The tip of the vaginal probe is approximately two to two and a half centimeters in diameter.[28] The physician uses one hand to open the labia while the other hand holds the probe. The physician inserts the probe into the patient's vagina until the tip of the probe is near the cervix, then moves the probe in and out,

26. 2 SANDRA L. HAGEN-ANSERT, TEXTBOOK OF DIAGNOSTIC ULTRASOUND, 953–59 (5th ed. 2001).

27. *Id.* at 957–58.

28. One centimeter is slightly less than one-half inch.

angles the probe up and down, and rotates the probe as needed to see the uterus and nearby structures.[29]

A basic sonogram, to determine only the gestational age of the embryo or fetus, lasts a few minutes, while a complete first trimester sonogram generally lasts fifteen to twenty minutes. When the physician must describe the details of the examination while simultaneously performing the ultrasound, the procedure usually lasts much longer.

The quality of the images produced during the ultrasound examination depends upon a number of factors: the manufacturer and age of the ultrasound equipment, the maintenance of the equipment, the software that processes the images, the frequency of the transducer, the type of transducer (abdominal vs. vaginal), the size of the patient, and the location of the area of interest. In general, to obtain the best ultrasound images of small structures, the physician uses a higher frequency transducer placed as closely as possible to the structure of interest.

A transabdominal obstetric sonogram typically uses a three-and-a-half- to five-megahertz transducer,[30] while a transvaginal sonogram uses a five- to ten-megahertz transducer.[31] The vaginal transducer can image structures up to about six centimeters from the transducer.[32] The lower frequency abdominal transducer can image much further, especially when the procedure uses the full bladder to aid in sound transmission.[33] During early pregnancy, the contents of the uterus are closer to the vagina than to the surface of the abdomen; thus, a transvaginal sonogram provides a better image than a transabdominal sonogram.[34] However, in many cases the transabdominal sonogram provides images that are quite adequate for the purpose of medical diagnosis. The ultrasound procedure generally begins using the abdominal transducer. If needed, a vaginal transducer is used later in the examination.[35] A defined time of gestation does not exist at which a transabdominal sonogram produces "more clear" images than a transvaginal sonogram.

The first day of the woman's last menstrual period prior to becoming

29. HAGEN-ANSERT, *supra* note 26, at 958–59.

30. *Id.* at 955. "Megahertz" is a measure of frequency. One megahertz is one million cycles per second.

31. *Id.*

32. *Id.* at 957. Six centimeters is slightly less than two and one-half inches.

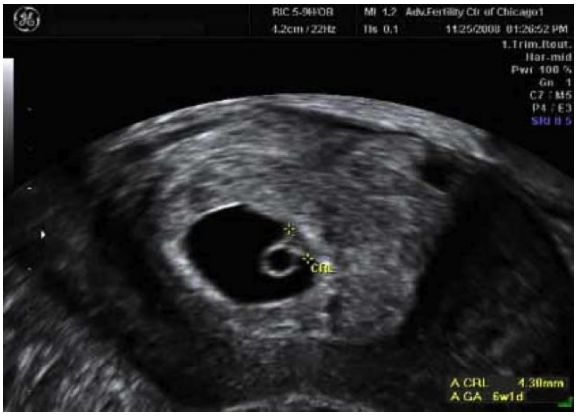
33. *See id.* at 954–56.

34. *Id.* at 597; Clifford S. Levi et al., *Early Diagnosis of Nonviable Pregnancy with Endovaginal US*, 167 RADIOLOGY 383, 383 (1988).

35. HAGEN-ANSERT, *supra* note 26, at 954.

pregnant is the starting point for determining gestational age.[36] Pregnancy usually begins at the midpoint of the menstrual cycle when ovulation typically occurs. Thus, pregnancy begins at two weeks' gestational age. Although the terminology might seem to indicate otherwise, there is actually no pregnancy until two weeks' gestational age. In other words, there is no such thing as a one-week gestational age embryo.

A trans*vaginal* sonogram may show the three-millimeter[37] gestational sac in the uterus at about four weeks' gestation, when the woman first misses her normal menstrual period.[38] The early gestational sac contains the new embryo and the yolk sac, which supplies the nutrients for the developing embryo as well as providing the initial blood cells and the early parts of the gastrointestinal system.[39] The new embryo is located between the yolk sac and the wall of the uterus.[40] One to two weeks later, at about six weeks' gestation, a trans*abdominal* sonogram may be used to show these structures.[41] A transvaginal ultrasound of a six-week-and-one-day gestation pregnancy is shown in the figure below.



[Transvaginal u]ltrasound picture at 6 weeks and 1 day of gestation[.] Yolk sac is seen to the left of the fetal pole (fetus)[.] Fetus has CRL, crown-rump length, of 4.3 mm (between cursors)[.] A fetal heartbeat was seen during this scan[.][42]

36. WILLIAM D. MIDDLETON ET AL., ULTRASOUND: THE REQUISITES 307 (2d ed. 2004).
37. Three millimeters is approximately one-eighth of an inch.
38. Levi, *supra* note 34, at 383.
39. HAGEN-ANSERT, *supra* note 26, at 599.
40. *Id.* at 598–600.
41. ROGER C. SANDERS & TOM WINTER, CLINICAL SONOGRAPHY: A PRACTICAL GUIDE 390 (4th ed. 2007).
42. Used with permission of the Advanced Fertility Center of Chicago. Image

During the embryonic stage, from about six to twelve weeks' gestational age, organs develop as the embryo grows from four to fifty-five millimeters[43] in crown-rump length, a growth rate of about one millimeter per day.[44] The terms "embryo" and "fetus" are often used interchangeably during this phase of development. At approximately ten to twelve weeks' gestation, the internal organs are recognizable, the embryonic stage is complete, and the fetal stage begins.[45] The first trimester ends after the twelfth week of gestation.[46] The fetus is not considered potentially viable until well after twenty weeks' gestation.[47]

In the United States, approximately 34% of legal abortions are performed at six weeks' gestation or earlier, and 63% are performed at eight weeks' gestation or earlier.[48] Therefore, nearly one-third of abortions are performed when the embryo is about four millimeters in length or less, as shown in the figure above. Nearly two-thirds of all abortions are performed when the embryo is less than two centimeters.[49] In addition, over 90% of all legal abortions performed in the United States are performed when the embryo is thirteen weeks' gestational age or less.[50]

When a woman presents for a first-trimester elective abortion, the standard of care requires the physician to perform a pre-procedure assessment that includes a bi-manual pelvic examination.[51] This routine pelvic exam lasts a minute or two. If the pregnancy is far enough along

available at http://www.advancedfertility.com/ultraso3.htm (last visited June 17, 2012).

43. Four millimeters is just over one-eighth of an inch, while fifty-five millimeters is about two inches.

44. HAGEN-ANSERT, *supra* note 26, at 599–601. The crown-rump length is measured from the top of the head to the base of the tail/buttocks. *Id.* at 605. One millimeter is just over one thirty-second of an inch.

45. *Id.* at 600–04.

46. *Id.* at 624.

47. Louis P. Halamek, *Prenatal Consultation at the Limits of Viability*, 4 NEOREVIEWS 153, 154 (2003). *See also* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 860 (1992).

48. Karen Pazol et al., *Abortion Surveillance - United States, 2008*, SS-15, 60 CDC MMWR Surveillance Summaries 6 (Nov. 25, 2011), *available at* http://www.cdc.gov/mmwr/pdf/ss/ss6015.pdf.

49. Four millimeters is just over one-eighth of an inch. Two centimeters (twenty millimeters) is approximately three-quarters of an inch.

50. Pazol et al., *supra* note 48, at 6.

51. GIBBS ET AL., *supra* note 24, at 588. During a bi-manual pelvic examination, the physician places one hand on the surface of the lower abdomen and two fingers of the other hand in the vagina. The physician can feel the uterus and other structures between his hands.

and the patient knows her menstrual dates well, an experienced physician can determine the gestational age and confirm that the pregnancy is intrauterine via the physical examination.[52] Clinics in the United States commonly use a sonogram to verify the gestational age,[53] although a sonogram is not medically required for all women.[54]

Except in very early or problematic pregnancies, a physician can verify the gestational age and confirm that a pregnancy is intrauterine by performing a transabdominal sonogram.[55] In very early pregnancy, before transabdominal sonography can produce an image of the embryo, the physician may offer to perform a transvaginal sonogram or may give the patient the alternative to return in one to two weeks for a transabdominal sonogram.[56] For a routine first-trimester pre-abortion evaluation, a transvaginal sonogram is not clinically required by the medical standard of care.[57]

IV. THE PHYSICIAN

"It cannot be disputed that . . . physicians owe a duty of care to their patients. The standard of care required for those engaged in the practice of the healing arts in Oklahoma is measured by national standards."[58] "[T]he standard of care generally applied to physicians requires that the physician exercise the care, skill, and learning ordinarily exercised by other physicians under similar circumstances."[59] Deviation from the standard of care without clear justification could demonstrate negligence and be grounds for civil action.[60] The physician could be disciplined by

52. *Id.*

53. Petition at 13 Nova Health Sys. v. Edmondson, No. CJ-2008-9119 (Dist. Ct., Okla. Cnty., Okla. Aug. 17, 2009), *aff'd*, 2010 OK 21, 233 P.3d 380.

54. GIBBS ET AL., *supra* note 24, at 588; American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin: Medical Management of Abortion*, 106 OBSTETRICS & GYNECOLOGY 871, 877 (2005).

55. GIBBS ET AL., *supra* note 24, at 588.

56. *Id.*; American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin: Ultrasonography in Pregnancy*, 113 OBSTETRICS & GYNECOLOGY 451, 452–53 (2009); AMERICAN COLLEGE OF RADIOLOGY, PRACTICE GUIDELINE FOR THE PERFORMANCE OF OBSTETRICAL ULTRASOUND 3 (2007).

57. GIBBS ET AL., *supra* note 24, at 588.

58. Grayson v. State, 1992 OK CIV APP 116, 838 P.2d 546, 550; *see also* OKLA. STAT. tit. 76, § 20.1 (OSCN through 2011 Leg. Sess.); American Medical Association, AMA Code of Medical Ethics, Opinion 9.14 (2009).

59. Sisson v. Elkins, 1990 OK 123, 801 P.2d 722, 727.

60. *See* Robinson v. Okla. Nephrology Assoc., 2007 OK 2, ¶ 9, 154 P.3d 1250, 1253–54.

the state medical board,[61] sued for professional negligence,[62] and reported to the National Practitioner Data Bank.[63]

When providing imaging services, the physician must determine what type of procedure is appropriate and perform the imaging study so that he can accurately answer the question posed by the clinical situation. The imaging provider is not required to use the "best" equipment or technique for every imaging procedure. To require the provider to use the best equipment and technique for every study would mean that every time a manufacturer produced a new model device with slightly improved technology, the imaging provider would have to buy the new device. Such a standard would create an expensive and never-ending requirement for the newest technology. The standard of care requires only that the imaging study be adequate to answer the clinical question, given all relevant clinical circumstances present.

The imaging physician may tailor the imaging study to the clinical circumstance rather than having to acquire the clearest image and still practice within the standard of care. For example, if a referring provider requests a chest x-ray to determine whether an adult patient has pneumonia, the radiologist will usually obtain two x-rays—a posterior-anterior view and a lateral view of the chest[64]—taken with the appropriate technique to visualize the fine details of the lungs. On the other hand, if the referring provider requests an x-ray of a small toddler to determine whether the child swallowed a nickel, the radiologist might obtain a single anterior-posterior view[65] that shows the neck, chest, and abdomen. If the adult pneumonia patient moved at all during the examination, the radiologist would require repeat x-rays, without the blurring caused by motion, so that the radiologist could see the fine detail

61. OKLA. ADMIN. CODE § 435:10-7-4(15), (18) (2012).

62. *See Robinson*, 2007 OK 2, ¶ 9.

63. 45 C.F.R. §§ 60.1–60.11 (2012). The National Practitioner Data Bank (NPDB) is a federal repository for information concerning health care providers who have been the subject of adverse actions by licensing boards, privileging entities, or peer-review organizations. *Id.* Additionally, a provider on whose behalf a medical malpractice judgment or settlement is paid must be reported to the NPDB. *Id.* § 60.7.

64. A posterior-anterior view is obtained with the x-ray beam transmitted from behind the patient, to the front, and then onto the x-ray film. A lateral view is obtained with the x-ray beam transmitted from one side of the patient to the other side, usually from right to left, then onto the x-ray film. When possible, the patient is standing while the radiographs are obtained.

65. An anterior-posterior view is obtained with the x-ray beam transmitted from the front of the patient, through the back, and onto the x-ray film.

of the lungs and answer the clinical question accurately. Conversely, the child's x-ray could have some blurring due to the child's movement and the radiologist might still be able to answer the clinical question. When the radiologist can answer the clinical question despite the blurring, the radiologist would not order repeat x-rays because the added radiation and trauma to the child would not be justified simply to have clearer images. Standard-of-care practice requires that the physician consider the *totality* of the clinical circumstances to recommend what is best for each patient.

When a physician provides abortion services to women in their first trimester, the medical standard of care does not require the physician to perform an ultrasound examination,[66] although at least one Oklahoma abortion clinic chooses to perform an ultrasound on every woman.[67] When a sonogram is needed, the physician's clinical judgment determines the type of transducer used.[68]

A transvaginal ultrasound study is an intrusive procedure because of the need to introduce the probe into the vagina. Such a vaginal intrusion may be unpleasant or disturbing to some women. As one woman described her experience:

> I recently underwent a vaginal ultrasound to check for kidney tumors. It was the best way to get the pictures, and I did the procedure willingly. The device was larger than expected. The kind voice and apologies of the caring technician were no comfort to the amount of prodding that was necessary. Intellectually, I knew it had to be done. Emotionally and physically, I felt like something bad and of a sexual nature was occurring.
>
> At the end, I was so shaken and holding back tears so I would not make the technician feel bad. I had pain from the procedure for a few days afterward.
>
> It is without a doubt against the oath of all doctors to "first, do no harm" to force them to do this to women who are seeking legal medical attention and who have no medical need whatsoever for such an incredibly invasive procedure.[69]

66. GIBBS ET AL., *supra* note 24, at 588.

67. Petition at 13 Nova Health Sys. v. Edmondson, No. CJ-2008-9119 (Dist. Ct., Okla. Cnty., Okla. Aug. 17, 2009), *aff'd*, 2010 OK 21, 233 P.3d 380.

68. *Id.*; *see also* HAGEN-ANSERT, *supra* note 26, at 953–59.

69. Jamie Levescy, Letter, OKLA. GAZETTE, July 14, 2010, at 8.

Due to the physically intrusive nature of the transvaginal examination, no physician would recommend the procedure unless the procedure were clearly necessary. Additionally, the patient might reasonably refuse to undergo such a procedure, even when that procedure is medically preferable. If a procedure is not medically necessary or the patient does not consent to the procedure, performance of the procedure would violate the standard of care.

The Oklahoma abortion statute requires that the ultrasound transducer used for the sonogram shall be the transducer that "would display the embryo or fetus more clearly."[70] Based upon the current science of ultrasound imaging, this statutory requirement forces the abortion-providing physician to perform early pregnancy sonograms using the vaginal transducer, even when the abdominal transducer would medically suffice, be less invasive for the woman, and still comply with the medical standard of care.[71] While the transvaginal sonogram provides a better image very early in pregnancy, at some time during each woman's pregnancy the transabdominal sonogram would provide an image of the embryo or fetus that is as clear or clearer than the transvaginal sonogram would provide. However, the specific time when this change occurs cannot be pre-determined with precision for any woman.

To comply fully with the Oklahoma statute, the physician would have to perform *both* a transabdominal sonogram and a transvaginal sonogram in some women, and then select the clearer image. As written, the statute does not allow the physician to use medical judgment to select the transducer that is most appropriate for the individual patient's best interest.[72] Neither does the statute permit the woman to refuse a transvaginal ultrasound, no matter how painful or disturbing this invasion may be to her.[73] As written, the plain language of the statute forces all women early in their first trimester to have a transvaginal ultrasound prior to undergoing a legal abortion.

70. OKLA. STAT. tit. 63, § 1-738.3d(A)–(B)(1) (OSCN through 2011 Leg. Sess.).

71. *See supra* text accompanying notes 51–57. The issue of statutorily mandated pre-abortion ultrasound, even without the type of transducer specified, is the subject of other articles. *See also* Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351 (2008); Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. REV. 939, 1001–09 (2009).

72. OKLA. STAT. tit. 63, § 1-738.3d(B)(1).

73. *Id.* § 1-738.3d.

To reiterate, an Oklahoma physician is subject to being charged with a felony if he fails to comply with *any* of the Oklahoma abortion statute's provisions.[74] For the physician to comply with the abortion statute, he must perform a transvaginal sonogram even when the physician would not normally perform such a scan or the woman does not want the scan, all to satisfy a non-medically based statute.[75]

Although written consent is not required prior to a routine imaging procedure, the physician must still explain the nature of the procedure and obtain the patient's express verbal or implied consent prior to performing the procedure. "A patient has an absolute right to meaningful treatment and a contrary right to refuse treatment . . . ."[76] Because the Oklahoma legislature statutorily requires voluntary and informed consent prior to performance of an abortion,[77] the legislature has shown its intention that physicians are expected to obtain such consent when providing medical care.

When the patient undergoes a transvaginal sonogram only to meet the statutory requirement, the physician must explain the requirement to the woman to obtain her full consent. "Consent is willingness in fact for conduct to occur."[78] Performance of a procedure without the patient's consent violates standards of medical professional conduct.[79] However, once the patient knows that she *must* consent to the procedure in order to have the abortion, *her consent is no longer voluntary*. Because the physician cannot perform the procedure without *voluntary* consent, the physician cannot perform the transvaginal sonogram even if the patient agrees once she knows that she is required to have the study. Thus, in this contorted, legislatively created situation, consent cannot be voluntary.

When the transvaginal sonogram is not necessary, a physician who elects to ignore the standard of care by not informing the woman of the true reason for the procedure and her option to refuse it then performs the procedure without informed consent. Physicians know that such subversion is wrong, but most are unaware of the potential legal liabilities.

74. *Id.* § 1-738.5.
75. *See supra* text accompanying notes 51–57.
76. *In re* K.K.B., 1980 OK 7, 609 P.2d 747, 749.
77. OKLA. STAT. tit. 63, § 1-738.2.
78. RESTATEMENT (SECOND) OF TORTS § 892 (1979).
79. American Medical Association, AMA Code of Medical Ethics, Opinion 8.08 (2006); Scott v. Bradford, 1979 OK 165, 606 P.2d 554, 556–57.

When the physician finds that he is required to perform a transvaginal sonogram that the patient neither needs nor wants, the patient cannot truly consent to the sonogram; however, the physician cannot perform the sonogram without the patient's voluntary, informed consent. From the physician's viewpoint, the Oklahoma legislature has created a Catch-22.[80]

V. THE ATTORNEY

If a frustrated physician contacts an attorney for advice, the attorney would first have to understand the medical issues.[81] Without this medical information, most attorneys would not recognize the dilemma that the Oklahoma abortion statute creates.[82] Once the physician explains his concerns, the lawyer begins by reviewing the Oklahoma abortion statute.[83]

A. Oklahoma Statutes

A thorough reading of the Oklahoma statutes reveals several inconsistencies. Title 63, section 1-738.2, a section not amended by the law establishing the ultrasound requirement, requires that the abortion-requesting woman give voluntary and informed consent, but then goes on to require the provision of inaccurate information.[84] This section requires that the physician or his agent tell the woman "that ultrasound imaging and heart tone monitoring that enable the pregnant woman to view her unborn child or listen to the heartbeat of the unborn child are *available* to the pregnant woman."[85] Notice that this specific information is mandated but is not correct. This portion of the statute notifies the woman of the *availability* of the sonogram, but then section 1-738.3d *mandates* the sonogram, even if she neither wants nor needs it.[86] Section 1-738.3d states that the sonogram is required "[i]n order for the woman to make an informed decision,"[87] excluding the term "voluntary" perhaps in

80. JOSEPH HELLER, CATCH-22 46–47 (1955). A Catch-22 is an illogical situation such that the solution to the problem is made impossible by the circumstances.

81. *See supra* Part III.

82. OKLA. STAT. tit. 63, § 1-738.3d(A)–(B)(1).

83. *Id.* §§ 1-730 to -741.12.

84. *Id.* § 1-738.2.

85. *Id.* § 1-738.2(B)(1)(a)(5) (emphasis added).

86. *Id.* § 1-738.3d(B).

87. *Id.*

recognition of the legislature's abrogation of her right to determine her own medical care.[88]

Section 1-738.2 also requires that the Oklahoma State Board of Medical Licensure and Supervision "promulgate rules to ensure that physicians who perform abortions and referring physicians or agents of either physician comply with all the requirements of this section."[89] The Board Rules implementing this law state that "[a]ny physician performing an abortion in violation of Title 63, O.S., § 1-738.2 shall be subject to disciplinary action by the Board."[90] However, there is no mention that the same penalty applies to a violation of other parts of section 1-738. Under this rule, the Oklahoma Medical Board will subject a physician to disciplinary action for violating a statute, even if that physician used sound medical judgment, practiced quality medicine, and acted in the best interest of the patient.

Section 1-738.5 states that "[a]ny person who knowingly or recklessly performs or attempts to perform an abortion in violation of this act shall be guilty of a felony."[91] Although a felony is a much more severe penalty than Board discipline, the legislature does not require the Board to inform physicians about the potential for felony charges, much less any other requirements or penalties in the abortion statute outside of those listed in section 1-738.2.[92] Thus, the legislature leaves the physician at risk of being blindsided.

The attorney would focus on the wording of the ultrasound requirement in section 1-738.3d to determine the plain meaning of the statute. On the surface, the statute's meaning seems clear: The physician must use the transducer that would produce the clearer image of the embryo or fetus.[93] Although the meaning of the statement about the transducer choice appears simple, it is not.

As described in Part III, the clarity of the ultrasound images depends upon the transducer and technique, as well as time of gestation, equipment available, and size of the patient.[94] The physician cannot always pre-determine which transducer will provide better images. Thus, to comply fully with the statute, the physician would have to perform

88. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269–80 (1990).
89. OKLA. STAT. tit. 63, § 1-738.2(C).
90. OKLA. ADMIN. CODE § 435:10-21-1(c) (2012).
91. OKLA. STAT. tit. 63, § 1-738.5(D).
92. *Id.* §§ 1-730 to -741.12.
93. *Id.* § 1-738.3d(B)(1).
94. *See supra* Part III.

both a transabdominal *and* a transvaginal sonogram on some patients to determine which images show the embryo or fetus more clearly. For virtually all early first-trimester patients, the physician would have to perform a transvaginal sonogram, even though a sonogram may be medically unnecessary or only a transabdominal sonogram would be sufficient.

Looking for statutory exceptions to the sonography requirement, the attorney would find one only in case of medical emergency.[95] The statute provides no exception for the physician's judgment that the procedure is unnecessary or to allow the physician to choose the transducer and examination method best for the patient.[96] The statute provides the patient no right to refuse the ultrasound procedure and also have an abortion, even when the ultrasound procedure disturbs the patient, such as after rape or incest.[97] The legislature has categorically taken away the woman's right to refuse a medical procedure.

Only one option allows the physician to avoid performing an unnecessary or undesired transvaginal sonogram and still comply with the law: The physician can use the vaginal transducer outside the vagina. Literally, the statute requires that the physician use a vaginal or abdominal transducer, but does not state *how* the physician must use the transducer.[98] Although the vaginal transducer was designed and approved for intravaginal use, nothing prevents the physician from holding the vaginal transducer inverted against the surface of the abdomen. The transducer will still produce images, though the images are unlikely to show the embryo very well. The physician could use both the abdominal and vaginal transducers trans*abdominally* and then select the images that "display the embryo or fetus more clearly."[99] Using the vaginal transducer in the described manner would be medically inappropriate and likely useless, but would enable the physician to protect the woman from the trauma and discomfort of the vaginal probe. While this technique might be a legal way to avoid an unnecessary transvaginal procedure, this approach would force the physician to practice outside the accepted standard of care. The dilemma continues.

The attorney might next determine whether the abortion statute is

95. OKLA. STAT. tit. 63, § 1-738.3d(D).
96. *See id.* §§ 1-730 to -741.12.
97. *Id.*
98. *Id.* § 1-738.3d(B)(1).
99. *Id.*

consistent with other laws that affect medical care. Title 63, the Oklahoma Public Health Code, enumerates public health and safety laws.[100] A review of the statutes under this title reveals only one instance, other than in the abortion statute, in which the legislature has directly *mandated* a specific medical procedure or course of treatment regardless of the medical judgment of the attending physician, the State Commissioner of Health, or the State Board of Health.[101] A provider who cares for any pregnant woman must assure that the patient's blood is tested for syphilis unless the woman or her health care provider relies on prayer or spiritual means for the treatment or cure of disease.[102] This mandated procedure affects only pregnant women.[103]

To comply with the syphilis mandate, a physician must subject a woman to only a quick, simple needle stick while she is fully clothed. The physician is not required to prolong the procedure by explaining details of the procedure while the needle is in the woman's arm. The simple blood test contrasts sharply with the disturbing requirement of section 1-738.3d that forces a woman to endure a probe in her vagina while waiting through the description of "the dimensions of the embryo or fetus, the presence of cardiac activity, if present and viewable, and the presence of external members and internal organs, if present and viewable."[104] All of these could be described to the woman *after* the procedure is completed using still and video images made during the procedure. There is no medical reason why the procedure-prolonging description must be provided during the sonogram. Further, the medically unnecessary prolongation of the procedure could be considered outside the medical standard of care.

Rather than mandating a specific treatment, one Oklahoma statute *forbids* requiring a procedure: pre-placement or replacement of blood.[105] This statute further requires that any health care worker dealing with the patient or family members concerning blood donations must not cause "a

100. *See* OKLA. STAT. tit. 63.

101. *Id.* §§ 1-515, -516.1 (requiring all pregnant women to have a blood test for syphilis except when the health care provider or patient relies on prayer or spiritual means for treatment or cure of diseases).

102. *Id.*

103. *Id.*

104. *Id.* § 1-738.3d(B)(4).

105. *Id.* § 2153. "Pre-placement" of blood means to donate blood, for oneself or another, prior to a planned procedure for which blood loss is a significant concern. "Replacement" of blood means to infuse blood into a patient—a transfusion.

marked increase in anxiety or emotional disturbance."[106] Unlike the abortion statute ultrasound requirement, here the legislature has shown concern for a patient's stress.

Several Oklahoma Public Health and Safety statutes demonstrate that the legislature has previously deferred to the judgment of the health care community or considered the patient's desire to use prayer or spiritual healing.[107] Because the legislature has not extended these exceptions to pregnant women who seek abortions, the absence appears intentional. The absence of legislative concern for an abortion-seeking pregnant woman's stress contrasts with its concern for citizens' potential "marked increase in anxiety or emotional disturbance" due to blood donation issues.[108] This shift implies that the legislature intends either to discourage a woman from having an abortion or to punish her for seeking an abortion. The attorney can now warn the physician that the legislature may have intentionally created the conditions that cause the dilemma in which the physician is trapped.

Section 1-738.3d is the only Oklahoma statute that requires a medical procedure with the intrusiveness of a transvaginal sonogram, even when the procedure may not be medically necessary or is not court-ordered.[109] Within the Oklahoma abortion statutes, section 1-738.3d is the only one that mandates a legislatively chosen, specific medical procedure.[110] Even section 1-738.2 mandates only the provision of

106. *Id.*

107. *Id.* §§ 1-402, -405 (regulating tuberculosis examinations and treatment under the direction of the Commissioner of Health and allowing refusal of examination or treatment when the individual uses prayer or spiritual means for healing); *id.* § 1-502 (designating the State Board of Health as the authority for rules and regulations regarding communicable diseases); *id.* §§ 1-511, -514 (requiring antiseptic treatment of the eyes of all newborns as approved by the Center for Disease Control and allowing an exception for the best interest of the child as determined by the attending physician or the child's parent and for contrary religious beliefs); *id.* §§ 1-515, -515.1, -516.1 (requiring all pregnant women to have a blood test for syphilis except when the health care provider or patient relies on prayer or spiritual means for treatment or cure of diseases); *id.* § 1-526 (requiring the State Board of Health to make rules and regulations regarding the prevention and cure of venereal diseases); *id.* § 1-533 (requiring the State Board of Health to provide a program for screening newborns for congenital metabolic disorders); *id.* § 1-543 (requiring the State Board of Health to make rules regarding the screening of newborns for hearing loss); *id.* § 488.1 (authorizing the State Department of Public Health to make rules and regulations regarding immunizations against infantile paralysis).

108. *Id.* § 2153.

109. *See supra* text accompanying notes 100–08.

110. OKLA. STAT. tit. 63, § 1-738.3d(B). *See generally id.* §§ 1-730 to -741.11.

information, rather than the performance of a specific procedure.[111] The physician who must comply with section 1-738.3d faces a uniquely directive and profession-threatening statute.

B. Statute Interpretation

The attorney must now determine how to interpret section 1-738.3d(B)(1), which requires that the physician "[p]erform an obstetric ultrasound on the pregnant woman, using either a vaginal transducer or an abdominal transducer, whichever would display the embryo or fetus more clearly."[112] The Oklahoma Attorney General has stated that the statute "requires that the person performing the ultrasound use his or her experience and clinical judgment to select the instrument that will produce the most easily visible and detailed image of the fetus."[113]

Interestingly, the Attorney General's interpretation is inconsistent with the plain wording of the statute. No language permits the physician to choose the method that most "easily" produces an image of the fetus, nor does the statute require that the image must be the most "detailed." The statute, as written, *requires* the use of the transducer that will produce the "clearer" image, without regard to their ease of acquisition.[114] Further, "most easily visible" is as vague as "more clearly." The degree of "ease" could be based on what is easy for the patient or what is easy for the physician. The statute is not easy to understand, and "men of common intelligence" must be able to understand the statute's meaning and apply it to a real-world situation or the statute may not be enforceable.[115] The Attorney General's interpretation confuses rather than clarifies.

Had the legislature agreed with the Attorney General, it could have changed the statute to read as the Attorney General suggested. The court enjoined the original version of the statute because it violated the Oklahoma single-subject rule.[116] Subsequently, the legislature re-passed

111. *Id.* § 1-738.2.

112. *Id.* § 1-738.3d(B)(1).

113. Defendants' Memorandum of Law in Support of Defendants' Motion to Dismiss at 13–14 Nova Health Sys. v. Edmondson, No. CJ-2008-9119 (Dist. Ct., Okla. Cnty., Okla. Aug. 17, 2009), *aff'd*, 2010 OK 21, 233 P.3d 380.

114. OKLA. STAT. tit. 63, §§ 1-738.2, 1-738.3d.

115. Pratt v. State, 1982 OK CR 31, 642 P.2d 268, 269–70 ("A criminal statute is void only when it is so vague that men of common intelligence must necessarily guess at its meaning."); *see infra* Part VI.A.

116. *Nova*, 2010 OK 21, ¶ 1.

the ultrasound requirement section without changes that could have reflected the Attorney General's interpretation.[117]

In contrast, the legislature made changes to a separate section of the abortion law, replacing section 1-729 with section 1-729a, seemingly in direct response to issues raised at trial in *Nova v. Edmondson*.[118] Had the legislature wanted the physician's judgment to determine which method was easier for the woman and provided more detail, the legislature could have so provided. It did not.

C. Criminal Liability

If the physician finds that to perform the sonogram as mandated by law is unconscionable, but he still performs an abortion, he risks criminal prosecution. The greatest concern is that the prosecutor would follow section 1-738.5(D) and charge the physician with a felony[119] punishable by imprisonment in the state penitentiary for up to two years.[120] For example, when a woman is only six weeks pregnant, a trans*vaginal* sonogram would be expected to produce "clearer" images of the embryo.[121] A physician risks criminal charges if he performed only a trans*abdominal* sonogram and then performed an abortion for this woman.[122]

To convict the physician for failing to comply with section 1-738.3d, the prosecutor must prove beyond a reasonable doubt that the physician failed to produce ultrasound images that "would display the embryo or fetus more clearly."[123] Because "more clearly" is not a medical term of art, the jury should be able to determine compliance for itself. The statute does not provide a definition for the phrase. To find beyond a reasonable doubt that the transvaginal ultrasound images are clearer, a jury might reasonably want to see those images and compare them with the transabdominal images that the physician acquired. To be truly comparable, the images would need to be from the woman for whom the

117. 2010 Okla. Sess. Laws 598–99.
118. *Compare* OKLA. STAT. tit. 63, § 1-729(B)–(C) (repealed Apr. 2, 2010), *and* § 1-729a(B)–(C) (effective Apr. 2, 2010), *with* Petition at 13 *Nova*, No. CJ-2008-9119, *and* Defendants' Memorandum of Law in Support of Defendants' Motion to Dismiss at 5 *Nova*, No. CJ-2008-9119.
119. OKLA. STAT. tit. 63, § 1-738.5(D).
120. OKLA. STAT. tit. 21, § 9 (2012).
121. *See supra* Part III.
122. OKLA. STAT. tit. 63, §§ 1-738.3d(B)(1), -738.5(D).
123. *Id.* § 1-738.3d(B)(1).

physician performed the abortion for which he is being prosecuted. But no such images could exist because there would be no violation of the statute if the transvaginal images had been acquired. Now the prosecutor is caught in the legislative Catch-22[124] that also ensnares the physician.

The prosecutor's only alternative would be to show demonstrative images from another woman. The physician's attorney would object to the admission of such evidence as irrelevant,[125] misleading,[126] and prejudicial.[127] The prosecutor could also seek clinical experts to testify about what the transvaginal images *might* have shown,[128] but a jury is unlikely to be certain beyond reasonable doubt that images the physician *should* have obtained would have been "clearer."

His lawyer should also evaluate the physician's risk for criminal liability if the physician performs the sonogram without obtaining voluntary consent. If the patient "consents" simply because she is told that she can only have an abortion if she allows the physician to perform an unnecessary medical procedure, the physician has coerced the patient's consent and the consent is void.[129] Further, "[i]f treatment is completely unauthorized and performed without any consent at all, there has been a battery."[130] Oklahoma defines simple criminal battery as "any willful and unlawful use of force or violence upon the person of another."[131] Because "force" may mean "[t]hreats and intimidation,"[132] a physician uses force if he coerces a patient to have a transvaginal ultrasound by saying that he cannot perform her desired abortion unless she agrees to the procedure. The statute provides no exception for use of force by a physician who acts in compliance with law.[133] Therefore, a physician is at risk for a criminal charge of battery for which he has no affirmative defense.

124. *See supra* note 80.
125. OKLA. STAT. tit. 12, §§ 2401–2402 (OSCN through 2011 Leg. Sess.).
126. *Id.* § 2403.
127. *Id.*
128. *Id.* §§ 2702–2703.
129. *See* Schneckloth v. Bustamonte, 412 U.S. 218, 233 (1973) ("[I]f under all the circumstances it has appeared that the consent was not given voluntarily—that it was coerced by threats or force, or granted only in submission to a claim of lawful authority—then we have found the consent invalid and the search unreasonable.").
130. Scott v. Bradford, 1979 OK 165, 606 P.2d 554, 557.
131. OKLA. STAT. tit. 21, § 642 (OSCN through 2011 Leg. Sess.).
132. BLACK'S LAW DICTIONARY 717 (9th ed. 2009).
133. OKLA. STAT. tit. 21, § 643.

In Oklahoma, a felony *medical* battery conviction would require that the defendant practiced medicine without a license[134] and that the victim suffered permanent physical injury.[135] Therefore, felony medical battery should not be a potential charge against the physician who performs an unconsented transvaginal ultrasound. The physician is still at risk, though, for charges of misdemeanor medical battery and also rape by instrumentation.

Rape by instrumentation occurs when an inanimate object penetrates the vagina of another person without her consent where force "is used or threatened, accompanied by apparent power of execution to the victim or to another person."[136] Because the physician has the power to deny the patient her requested abortion if she refuses the transvaginal ultrasound, such "threat" could fulfill the force element of this offense. The offense does not require intent, and it offers no exceptions or affirmative defenses.[137]

An aggressive prosecutor could charge a physician with battery, medical battery, or rape by instrumentation if the physician performs an "unconsented" transvaginal ultrasound to comply with the Oklahoma abortion law.[138] Although the likelihood of a physician being so charged is extremely low, the maximum penalty for rape by instrumentation—confinement for life without parole—is exceptionally high.[139] Few physicians are likely to take that risk.

D. Civil Liability

When a transvaginal ultrasound is clinically necessary and the patient consents prior to any awareness that the transvaginal ultrasound is required for an abortion, the physician will *not* violate any statute or ethical standard. However, when a transvaginal sonogram is required by section 1-738.3d, but is not medically necessary, the physician puts himself at risk of *criminal* and *civil* liability if he performs the ultrasound procedure without informing the patient that she has a choice. A patient tends to trust her physician and generally does not question what the physician tells her to do, so there is a strong likelihood that a woman

134. *Id.* § 650.11(B)(1).
135. *Id.* § 650.11(B)(2).
136. *Id.* §§ 1111–1111.1.
137. *Id.*
138. *See supra* text accompanying notes 129–37.
139. OKLA. STAT. tit. 21, § 1111.1.

would never know that the procedure was unnecessary. However, if the patient becomes aware that the ultrasound procedure was not necessary, she could sue for medical negligence. Similarly, if the physician tells the patient that the law requires the procedure and obtains her "consent" that is not truly voluntary, the patient could state a claim for malpractice because the physician coerced her into having a non-medically necessary procedure.

Unlike Oklahoma statutes that protect medical personnel from liability when they are required to draw blood for intoxication evaluation[140] or for HIV testing,[141] the abortion statute does not protect the physician from civil litigation when acting to comply with section 1-738.3d. Because the legislature has proven its ability to create such protection, the lack of protection as part of the abortion statutes is presumptively intended to put the physician at risk and therefore discourage his performance of an otherwise legal procedure.

This lack of legislated protection leaves the physician vulnerable to the woman filing a civil action for failure to obtain voluntary and informed consent. Anglo-American law's "premise of thoroughgoing self-determination" forms the basis of the doctrine of informed consent.[142] "[E]ach [wo]man [is] considered to be [her] own master. . . . [A] physician [may not] substitute his judgment for that of the patient . . . ."[143] The Oklahoma Supreme Court has explained:

> Consent to medical treatment, to be effective, should stem from an understanding decision based on adequate information about the treatment, the available alternatives, and the collateral risks. This requirement, labeled "informed consent," is, legally speaking, as essential as a physician's care and skill in the *performance* of the therapy. The doctrine imposes a duty on a physician or surgeon to inform a patient of his options and their attendant risks. If a physician breaches this duty, patient's

140. OKLA. STAT. tit. 47, § 752(C) (OSCN through 2011 Leg. Sess.) (protecting the medical personnel from civil liability when properly drawing blood, as directed by law enforcement, for confirming the presence of alcohol or other intoxicants under the motor vehicle statutes).

141. OKLA. STAT. tit. 63, § 1-502.3 (OSCN through 2011 Leg. Sess.) (protecting medical personnel from civil liability when drawing blood for human immunodeficiency virus testing under the statute).

142. Scott v. Bradford, 1979 OK 165, 606 P.2d 554, 556.

143. *Id.*

> consent is defective, and [the] physician is responsible for the consequences.[144]

The court has later held that "the scope of a physician's communications must be measured by his patient's need to know enough to enable [the patient] to make an intelligent choice."[145] "A patient has an absolute right to meaningful treatment and a contrary right to refuse treatment . . . ."[146]

Based on these tenets, the physician who fails to fully inform his patient or who does not enable the patient to make a voluntary choice could be subject to civil suit. To prevail, the patient need only establish that the physician failed to disclose the information necessary for the patient to make an informed choice, that the patient would have made a different choice had all the information been presented, and that the physician's lack of full disclosure caused the patient harm.[147]

The final element of harm would be the most difficult for the abortion-seeking woman to prove. Given the nature of the transvaginal sonogram, significant physical injury is highly unlikely. Even if physical injury occurred, there might be no documentation because the woman might try to avoid further medical invasion that further care would necessitate. If there were no documented physical injury, the woman would then have the burden to prove psychological harm directly attributable to the transvaginal sonogram. That a patient would discover that she might have a cause of action, have actual harm from the transvaginal sonogram, and then file a civil petition for medical malpractice based on a failure to provide informed consent is very unlikely.

In *Applegate v. Saint Francis Hospital, Inc.*, the Oklahoma Court of Appeals discussed civil liability for battery and declined to "extend[] 'medical battery' beyond surgical cases to include medication treatment."[148] Although *Applegate* did not discuss criminal liability based upon a physician's failure to obtain voluntary consent,[149] the lawyer advising the abortion-providing Oklahoma physician should consider the

144. *Id.* at 556–57.
145. *Id.* at 558.
146. *In re* K.K.B., 1980 OK 7, 609 P.2d 747, 749.
147. *Scott*, 606 P.2d at 558–59.
148. Applegate v. Saint Francis Hosp., Inc., 2005 OK CIV APP 28, ¶ 16, 112 P.3d 316, 319.
149. *Id.* ¶ 7.

risk of criminal liability based on this failure,[150] as well as the abortion statute's criminal liability provisions, as discussed in Part V.C, above.

The physician still has the option of using the vaginal transducer to perform a medically useless transabdominal sonogram.[151] This use of the transducer is not medically appropriate under normal circumstances, but neither is performing a transvaginal sonogram that is not in the patient's best interest. If the physician fully explains to the woman the medical and legal issues, the woman is likely to agree that the unorthodox procedure is her best option for dealing with the statutory requirements and to avoid the undesired transvaginal sonogram. But again, because an ultrasound procedure is statutorily required,[152] her consent could not be truly voluntary, and the physician remains at risk of liability.

E. Summary

Physicians have a low likelihood of criminal or civil liability due to the Oklahoma law ultrasound requirement, but possibilities exist. Potential penalties are so high that any reasonable physician would avoid even a very low risk of criminal liability. The physician who performs abortions is left again with the Catch-22[153]: whether to violate his professional duty to practice within the standard of care, commit criminal battery, commit rape by instrumentation, violate the Oklahoma abortion statutes, or some combination of these acts. Because a statutory violation is inevitable, the physician needs to know that he has several arguments in his defense if he is prosecuted.

VI. THE ARGUMENTS

A. Vagueness

The physician who challenges section 1-738.3d could first argue that the statute is void for vagueness. A vague law violates federal and state due process clauses because enforcement of the law could deprive a person of liberty or property without adequate notice of an action's illegality.[154]

150. OKLA. STAT. tit. 63, § 1-738.5(D) (OSCN through 2011 Leg. Sess.).
151. *See supra* Part V.A.
152. OKLA. STAT. tit. 63, § 1-738.3d.
153. *See supra* note 80.
154. U.S. CONST. amend. XIV § 1; OKLA. CONST. art. 2 § 7.

"[L]aws [must] give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning."[155] "The dividing line between what is lawful and unlawful cannot be left to conjecture. The citizen cannot be held to answer charges based upon penal statutes whose mandates are so uncertain that they will reasonably admit of different constructions. A criminal statute cannot rest upon an uncertain foundation."[156] However:

> A criminal statute is void only when it is so vague that men of common intelligence must necessarily guess at its meaning. Further, a criminal statute requires only reasonable certainty and the prohibited act may be characterized by a general term without the aid of definition, if that term has a settled and commonly understood meaning which doesn't leave a person of ordinary intelligence in doubt. This is true even though the definition of the term contains an element of degree whereby reasonable men may differ.[157]

Thus, the distinction may be slight about a term over which "reasonable men may differ,"[158] yet the interpretation "cannot be left to conjecture."[159]

The level of scrutiny the court will apply in a vagueness challenge depends on the type of statute.[160] Courts hold criminal statutes to a higher standard of clarity because, unlike civil penalties, criminal penalties may lead to deprivation of liberty.[161] Due process "requires legislatures to set reasonably clear guidelines for law enforcement officials and triers of fact in order to prevent 'arbitrary and discriminatory enforcement.'"[162]

155. Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc., 455 U.S. 489, 498 (1982) (citing Grayned v. City of Rockford, 408 U.S. 104, 108–09 (1972)). *See also* Pratt v. State, 1982 OK CR 31, 642 P.2d 268, 269–70.

156. Connally v. Gen. Constr. Co. 269 U.S. 385, 393 (1926) (quoting United States v. Capitol Traction Co., 34 App. D.C. 592, 598 (1910)).

157. *Pratt*, 642 P.2d at 269–70 (citations omitted).

158. *Id.* at 270.

159. *Connally*, 269 U.S. at 393 (quoting *Capitol Traction Co.*, 34 App. D.C. at 598).

160. *Hoffman Estates*, 455 U.S. at 498.

161. *Id.* at 498–99.

162. Smith v. Goguen, 415 U.S. 566, 573–74 (1974) (quoting Grayned v. City of Rockford, 408 U.S. 104, 108 (1972)).

Because violation of the Oklahoma abortion law is a felony, the court should require that the statute have a clear meaning that enables the physician to know in advance precisely what conduct is unlawful.[163] Oklahoma's Attorney General has stated that the meaning of section 1-738.3d is apparent and that the law "requires that the person performing the ultrasound use his or her experience and clinical judgment to select the instrument that will produce the most easily visible and detailed image of the fetus."[164] Based on this interpretation, the physician could understand a critical element of compliance with the law—the need to select the transducer that will provide the clearer images. But when even the physician cannot always pre-determine which transducer will best comply with the law,[165] law enforcement certainly cannot provide "reasonably clear guidelines" as the court requires.

The State would likely argue that some degree of uncertainty is tolerable because most citizens can understand the general concept of seeing something "more clearly." However, the evaluation of ultrasound images is more complex than looking at routine photographs familiar to ordinary citizens. No objective criteria are included to enable an untrained observer to evaluate the clarity of the image. Interpretation of ultrasound studies requires extensive medical training well beyond medical school. Law enforcement personnel cannot acquire this knowledge in the course of their training, and jurors certainly do not have this training.

Characteristics that determine medical diagnostic clarity of ultrasound images are different from features that determine the clarity of a photograph of a person or a landscape. The term "clear" may have a "settled and commonly understood meaning"[166] in the context of routine photographs of familiar objects. However, when a statute uses that term in the setting of complex medical images, "men of common intelligence must necessarily guess"[167] at which ultrasound images "display the embryo or fetus more clearly."[168] Because neither common citizens nor law enforcement personnel can interpret the ultrasound images,

163. *Connally*, 269 U.S. at 393–94.

164. Defendants' Memorandum of Law in Support of Defendants' Motion to Dismiss at 13–14 Nova Health Sys. v. Edmondson, No. CJ-2008-9119 (Dist. Ct., Okla. Cnty., Okla. Aug. 17, 2009), *aff'd*, 2010 OK 21, 233 P.3d 380.

165. *See supra* Part IV.

166. Pratt v. State, 1982 OK CR 31, 642 P.2d 268, 270.

167. *Id.* at 269–70.

168. OKLA. STAT. tit. 63, § 1-738.3d(B)(1) (OSCN through 2011 Leg. Sess.).

section 1-738.3d lacks guidelines sufficiently definitive for enforcement. Because of this uncertainty and the risk that physicians could be subject to "arbitrary and discriminatory enforcement,"[169] the law should be stricken as void for vagueness.

To further convince the court to strike the law as void for vagueness, the physician should also remind the court that "the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights."[170] Since this law affects a woman's access to a legal abortion during the first trimester, a protected right,[171] the court has a critical reason to require that the law provide clear guidance for those who could potentially violate it and for those responsible for its enforcement. A physician cannot always comply with section 1-738.3d without sometimes violating other criminal statutes.[172] This conflict results in no physician being able to lawfully provide abortion services for many women who desire early first trimester abortions, "inhibit[s] the exercise of constitutionally protected rights,"[173] and therefore provides additional grounds to declare the law void for vagueness.

In defense of a vagueness challenge to section 1-738.3d, the prosecutor might point to *Doe v. Bolton* in which the Court found that a Georgia abortion statute was *not* unconstitutionally vague when the statute allows a physician's medical judgment to determine that an abortion is "necessary" before the physician performs an abortion.[174] Because the physician's judgment is based upon all factors relating to the pregnant woman's health, including psychological and emotional factors, the Court found that the requirement for the physician to find the abortion necessary *was* a reasonable requirement rather than having more specific criteria.[175] The Oklahoma prosecutor might argue that, as the Attorney General interpreted the statute,[176] the physician's judgment

169. Kolender v. Lawson, 461 U.S. 352, 357 (1983).

170. Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc., 455 U.S. 489, 499 (1982).

171. Gonzales v. Carhart, 550 U.S. 124, 182–83 (2007).

172. *See supra* Part V.C.

173. *Hoffman Estates*, 455 U.S. at 499.

174. Doe v. Bolton, 410 U.S. 179, 191–92 (1973). The Court decided *Doe* the same day as *Roe v. Wade*, 410 U.S. 208 (1973).

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

176. Defendants' Memorandum of Law in Support of Defendants' Motion to Dismiss at 12 Nova Health Sys. v. Edmondson, No. CJ-2008-9119 (Dist. Ct., Okla. Cnty., Okla. Aug. 17, 2009), *aff'd*, 2010 OK 21, 233 P.3d 380.

determines the appropriate transducer selection under the Oklahoma statute, just as under the constitutional Georgia statute the physician's judgment determines that a woman's health is in danger and an abortion may be necessary.

If the prosecutor does raise this argument, the physician should emphasize that, unlike Oklahoma's ultrasound requirement, the Georgia statute *explicitly* states that the abortion necessity decision is "based upon [the physician's] best clinical judgment,"[177] which, as the *Bolton* Court interpreted, includes "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient."[178]

In contrast, the Oklahoma abortion statute's ultrasound requirement does *not* explicitly allow the physician to use his best judgment to determine the woman's treatment.[179] Instead, the Oklahoma legislature requires a specific medical procedure with no provision for the physician to exercise his clinical judgment.[180] Further, the Oklahoma abortion statute specifically *excludes* "emotional, psychological, or mental" health factors from consideration when determining whether a medical emergency exists and would allow deviation from the statutory requirements.[181]

In fact, *nowhere* in the Oklahoma abortion statute is the physician's full medical judgment allowed to determine the care of the patient. The Oklahoma statute's limitations stand in stark contrast to the *Bolton* Court's finding that "[a]ll these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman."[182] An Oklahoma prosecutor would have a steep hill to climb to convince the court that the Oklahoma abortion statute, as written, allows the physician the same freedom to use his judgment for the benefit of the pregnant woman.

The physician also should remind the court of *Colautti*, where a Pennsylvania abortion statute *was* held void for vagueness.[183] The

177. GA. CODE ANN. § 16-12-141(a) (OCGA through 2012 Reg. Sess.). At the time of *Doe v. Bolton*, this statute was codified in Georgia statutes as section 26-1202.
178. *Doe*, 410 U.S. at 192.
179. OKLA. STAT. tit. 63, §§ 1-730 to -741.12 (OSCN through 2011 Leg. Sess.).
180. *Id.* § 1-738.3d.
181. *Id.* §§ 1-738.1A(5), -738.3d(D).
182. *Doe*, 410 U.S. at 192.
183. Colautti v. Franklin, 439 U.S. 379, 401 (1979).

Pennsylvania statute, like the Oklahoma statute, included criminal liability for violations, and it required the physician to determine whether a fetus may or may not be viable based upon the physician's medical judgment.[184] The Court found that the statute had a confusing interplay of the terms "is viable" versus "may be viable" and that the medical determination of viability is uncertain.[185]

Because a medical determination of the likelihood of viability is a complex decision based upon many factors, viability cannot be determined with precision in any given patient.[186] Even experts can disagree about this determination.[187] "[S]uch [potential] disagreement, in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment."[188]

The problems with the Pennsylvania statute are markedly similar to those with Oklahoma's section 1-738.3d. Both include criminal liability for violation of abortion statutes that lack clear guidance about what conduct is prohibited. Both statutes involve medical determinations for which expert medical professionals may have different answers. Both statutes create concerns that physicians may be unwilling to perform constitutional abortions for fear of violating the statutes. Just as the Pennsylvania statute was found void for vagueness, so should Oklahoma's section 1-738.3d be found.

B. Right to Work

The physician might also challenge section 1-738.3d on the grounds that the statute interferes with his right to practice medicine. Although the right to work is not a fundamental right, "the right to continue [to work] is often of great value to the possessors, and cannot be arbitrarily taken from them, any more than their real or personal property can be thus taken."[189]

184. *Id.* at 400–01.
185. *Id.* at 391–96.
186. *Id.* at 395–96.
187. *Id.* at 396.
188. *Id.*
189. Dent v. West Virginia, 129 U.S. 114, 121–22 (1889).

If the physician challenges the statute as a simple interference of his right to work, the court would probably evaluate the interference on a rational basis standard.[190] The physician would have a better chance of success if he could convince the court that the statute interferes with a fundamental right. He might argue that section 1-738.3d is unconstitutional because the statute interferes with a woman's fundamental right to an abortion. The "State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability"[191] and may not create regulations that place an undue burden on the woman seeking an abortion before viability.[192]

The prosecutor would likely argue that the physician does not have standing to bring this claim because the right to an abortion is the patient's and not the physician's right. However, the physician's ability to provide an abortion is inextricably linked to a woman's right to have a first-trimester abortion because Oklahoma law allows only a licensed physician to perform an abortion.[193] Therefore, if the State interferes with the physician's ability to perform an abortion, the State has essentially interfered with the pregnant woman's right to an abortion.

With this argument, the physician would steer the court to use heightened scrutiny to review the statute's constitutionality.[194] "Not all burdens on the right to decide whether to terminate a pregnancy will be undue. In [the Court's] view, the undue burden standard is the appropriate means of reconciling the State's interest [in potential life] with the woman's constitutionally protected liberty."[195] "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[196]

The physician would have to convince a court that the Oklahoma abortion statute's ultrasound requirement places a substantial obstacle in the path of his provision of abortion services, and, thus, in the path of the woman seeking an abortion. As discussed in Parts IV and V above, section 1-738.3d creates a clinical scenario in which no physician can

190. *See* Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 712 (D.C. Cir. 2007) (en banc).
191. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 879 (1992).
192. *Id.* at 876–78.
193. OKLA. STAT. tit. 63, § 1-731(A) (OSCN through 2011 Leg. Sess.).
194. *Casey*, 505 U.S. at 896.
195. *Id.* at 876.
196. *Id.* at 877.

always act in the best interest of the patient.[197] For many women seeking a first-trimester abortion, the physician must choose between committing a felony by failing to obtain the ultrasound that "would display the embryo or fetus more clearly"[198] or forcing the pregnant woman to have an unnecessary and undesired transvaginal ultrasound.[199] Due to justifiable fears of violating section 1-738.3d or other statutes, the physician might not risk providing abortion services for women in the first trimester. If the physician will not provide first-trimester abortions, women would be forced to delay having an abortion until later in pregnancy, an outcome that the courts could decide is a substantial obstacle.

The prosecutor would argue that the legislature's intent is not to interfere with the woman's access to an abortion, but only to assure that she is fully informed. "The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it."[200] The court would have to determine whether a substantial obstacle is created by chilling the willingness of physicians to provide abortion services during the first trimester and potentially causing women to delay having an abortion until a transabdominal ultrasound is "clearly" sufficient, such as in the second trimester.

If the physician cannot convince the court to use heightened scrutiny, he will have to challenge the statute under rational basis scrutiny,[201] which "requires that the [challenger] prove that the government's restrictions bear no rational relationship to a legitimate state interest."[202] However, "the law need not be in every respect logically consistent with its aims to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it."[203]

The prosecutor would argue that the State has a legitimate concern that a woman must be fully informed before having an abortion and that

197. *See supra* Parts IV–V.
198. OKLA. STAT. tit. 63, § 1-738.3d(B)(1).
199. *See supra* Parts IV–V.
200. *Casey*, 505 U.S. at 874.
201. *See* Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 712 (D.C. Cir. 2007).
202. *Id.*
203. Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487–88 (1955).

she is freely choosing to have an abortion. The legislature believes that a fully informed woman is one who has seen and heard described a clear image of her developing embryo or fetus. The ultrasound requirement is simply part of assuring that a woman has a clear picture of her embryo or fetus—a rational part of assuring that a woman is fully informed and gives voluntary consent. The legislature also has emphasized that voluntary consent is critical by having a statutory requirement that every abortion facility display signage stating, in part, that "[b]y law, we cannot perform . . . an abortion unless we have your freely given and voluntary consent. It is against the law to perform . . . an abortion against your will."[204] The government would argue that this requirement shows that the State believes that consent for a procedure must be both informed and voluntary.

Under rational basis scrutiny, the court is highly deferential to the State and would generally accept the government's declared purpose of assuring the pregnant woman's voluntary and informed consent to any abortion procedure.[205] However, the physician could show that the legislature is neither accurate nor forthcoming when it claims that its purpose is to assure that women are "fully informed." The physician can point to section 1-741.12, which was enacted the *same day* as the ultrasound requirement and provides that a physician cannot be sued for wrongful life or wrongful birth for failing to inform a woman about any birth defects for which she claims she would have decided to have an abortion.[206] In other words, the legislature has abrogated the woman's right to a remedy for a doctor's failure to fully inform her about birth defects about which the doctor was aware.[207] This statute directly contradicts the government's claim that the legislature truly wants women to be fully informed.

The physician could also argue that the statute is irrational. By showing that the law unnecessarily abrogates the woman's ability to voluntarily consent to a procedure that is a prerequisite to an abortion, the physician could show that the statute defeats the legislature's stated purpose "for the woman to make an informed decision."[208]

204. OKLA. STAT. tit. 63, § 1-737.4(A) (OSCN through 2011 Leg. Sess.).
205. *See id.* § 1-738.2(A).
206. *Id.* §§ 1-741.12, -738.3d. The Governor vetoed the bills, but the legislature overrode both on April 27, 2010. 2010 Okla. Sess. Laws 594–602.
207. OKLA. STAT. tit. 63, § 1-741.12.
208. *Id.* § 1-738.3d(B).

A physician has a fiduciary duty to the patient to provide healthcare within the standard of care and in the patient's best interest.[209] To practice standard-of-care medicine, a physician must fully inform the patient prior to any medical procedure and obtain the patient's voluntary and informed consent.[210] The patient has a right to refuse any medical procedure.[211] If a patient does not consent to a procedure, the physician cannot ethically or legally perform the procedure.[212]

When a state statutorily makes a specific medical procedure a prerequisite for a different, requested procedure, that state coerces the patient's "consent." The patient has lost her free will, and her consent is no longer valid.[213] When her consent is not valid, the physician cannot perform the prerequisite procedure. Because the woman has not had the prerequisite procedure, the physician may not perform the other requested procedure without violating the statute. The state's statute interferes with the patient's access to the desired procedure by interfering with the physician's ability to practice standard-of-care medicine. The patient and physician are now hopelessly stuck in a circle of unsound logic created by the legislature.

This reasoning applies directly to the situation created by the Oklahoma abortion statute. The practical effect of section 1-738.3d is that essentially all women seeking an abortion during their first trimester are required to undergo a transvaginal ultrasound.[214] For the vast majority of women, this procedure is not medically essential when she does not desire it.[215] Once the physician tells a woman that she *must* have a transvaginal ultrasound prior to being allowed to have an abortion, she can no longer freely consent to the procedure.[216] Therefore, the physician cannot perform the transvaginal ultrasound because the patient cannot

209. *See* Tracy v. Merrell Dow Pharm., Inc., 569 N.E.2d 875, 879 (Ohio 1991); West Virginia *ex rel.* Kitzmiller, 437 S.E.2d 452, 454 (W. Va. 1993); Mattingly v. Sisler, 1946 OK 321, 175 P.2d 796, 799.

210. Scott v. Bradford, 1979 OK 165, 606 P.2d 554, 556–57; American Medical Association, AMA Code of Medical Ethics, Opinion 8.08 (2006).

211. *In re* K.K.B., 1980 OK 7, 609 P.2d 747, 749.

212. *Scott*, 606 P.2d at 556–57. There are exceptions to the consent requirement, such as when a medical emergency requires immediate treatment to save the patient's life but the patient is unable to consent. A detailed discussion of medical consent is beyond the scope of this Note.

213. *See* Schneckloth v. Bustamonte, 412 U.S. 218, 233 (1973).

214. *See supra* text accompanying notes 70–73.

215. *See supra* text accompanying notes 51–57.

216. *See supra* text accompanying notes 76–80.

truly consent.[217] Without the statutorily required ultrasound, the woman cannot have the abortion.[218] For these women, the state's statute prevents the physician from performing the abortion while still practicing standard-of-care medicine, and, thus, limits a woman's access to a first-trimester abortion. Again, the patient and physician are stranded without a solution.

Because "[t]he State . . . has an interest in protecting the integrity and ethics of the medical profession,"[219] the physician should be allowed to choose to maintain his professional ethics and to practice standard-of-care medicine rather than to compromise those standards in compliance with the vague and irrational Oklahoma abortion statute that creates a substantial obstacle to a woman who seeks a constitutional first-trimester abortion.

VII. CONCLUSION

By specifying the type of transducer the physician must use when performing a pre-abortion ultrasound, the Oklahoma legislature has created an untenable situation for physicians and patients alike. Under this law, the physician who wishes to provide abortion services to women in their first trimester must choose to commit a felony or compromise professional standards, rather than choosing care that is in the best interest of the woman who has made the constitutional choice to seek a first-trimester abortion. The legislature must write laws that assure a woman's opportunity to give truly informed consent and a physician's ability to practice standard-of-care medicine. The Oklahoma abortion law ultrasound requirement[220] assures neither.

217. *See supra* text accompanying notes 76–80.
218. OKLA. STAT. tit. 63, § 1-738.3d(B) (OSCN through 2011 Leg. Sess.).
219. Washington v. Glucksberg, 521 U.S. 702, 731 (1997).
220. OKLA. STAT. tit. 63, § 1-738.3d(B).