BAD MEDICINE

How a Political Agenda is Undermining Women's Health Care

SECOND EDITION

national partnership for women & families

Contents

About the National Partnership for Women & Families

At the National Partnership for Women & Families, we believe that actions speak louder than words, and for four decades we have fought for every major policy advance that has helped women and families.

Today, we promote reproductive health and rights, access to quality, affordable health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. Our goal is to create a society that is free, fair and just, where nobody has to experience discrimination, all workplaces are family friendly and no family is without quality, affordable health care and real economic security.

Founded in 1971 as the Women's Legal Defense Fund, the National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C.

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The findings and conclusions presented here are those of the authors alone.

Introduction

Across the country, politicians are increasingly enacting laws that mandate how health care providers must practice medicine, regardless of the provider's professional judgment, ethical obligations or the needs of his or her patients. As this report explains, these laws undermine the high-quality, patient- and family-centered care that health care providers and advocates strive to achieve. They are political interference with the provision of health care — they are **bad medicine**.

The government has an important role to play in regulating the medical profession,[1] but when those regulations do not comport with medical standards or when they directly interfere in the relationship between patients and their health care providers, lawmakers have abused their authority.

Examples of laws or regulations that undermine health care include:

- Requiring a health care provider to give — and a patient to receive — tests or procedures that are not supported by evidence, the provider's medical judgment or the patient's wishes.
- Dictating the information that a health care provider must or must not give to a patient, including requirements to provide biased or medically inaccurate information.
- Forcing a health care provider to delay time-sensitive care regardless of the provider's medical judgment or the patient's needs.
- Prohibiting a health care provider from prescribing medication using the best and most current evidence, medical protocols and methods.
- Requiring a health care provider and/or medical facility to conform to burdensome licensing restrictions that are not based on scientific evidence and are contrary to modern medical practice.

"[L]awmakers increasingly intrude into the realm of medical practice, often to satisfy political agendas without regard to established, evidence-based guidelines for care."

— Leaders of the American College of Physicians, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and American College of Surgeons, *New England Journal of Medicine*, Oct. 2012

This report focuses on women's health and, specifically, on the provision of abortion care. However, the growing trend of imposing politics on medical care has much broader implications. Similar restrictions impair health care providers' ability to counsel patients on gun safety and environmental risk factors, among other health and safety concerns.[2] Major medical organizations from the American Medical Association (AMA)[3] to the American College of Physicians (ACP)[4] and the American College of Obstetricians and Gynecologists (ACOG)[5] have all recognized that this trend of political interference in medical decision-making is detrimental to patient care.

All patients deserve accurate information, high-quality care and the treatment options that best meet their needs. Health care providers should not be stymied by medically unnecessary restrictions enacted in pursuit of a political agenda.

The abortion restrictions covered in this report include:[i]

- Ultrasound Requirements
- Biased Counseling Laws
- Mandatory Delays
- Medication Abortion Restrictions
- Targeted Regulation of Abortion Providers (TRAP Laws)

What Is Quality Health Care?

Improving the quality of care is a central goal of a cross-sector national effort to transform our nation's health care system. According to the Institute of Medicine — an independent, nonprofit organization that serves as the health arm of the National Academies of Sciences, Engineering, and Medicine — quality care is care that meets the patient's needs and is based on the best scientific knowledge.[6] It is the *right care* at the *right time* in the *right setting* for the individual patient.[7] It is care that aligns with the patient's values, preferences and needs. It should be accessible and affordable.

"Prior to the passage of these onerous legislative restrictions, our only focus was to treat patients with dignity and respect, with the first priority being a focus on providing the highest quality medical services with compassion and attention to patient needs. Unfortunately the passage of these laws means that our focus has had to be distracted. While we continue to strive for patient-centered experiences, we struggle to do this while at the same time abiding by the laws in our state."

— Brooke Bailey, Clinic Counselor, Florida

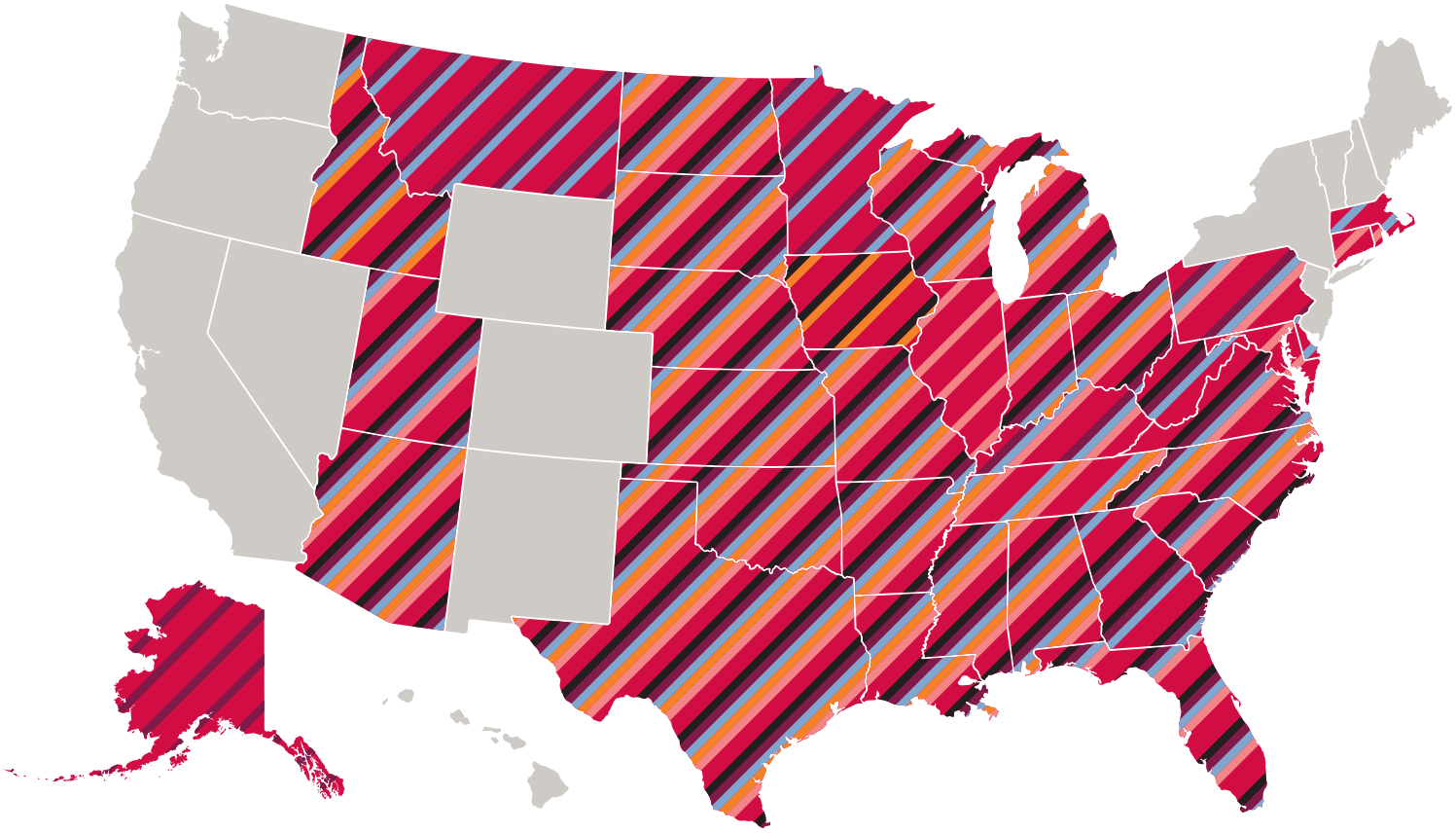
The path to a high-quality, patient- and family-centered health care system is best reflected by the Institute for Healthcare Improvement's Triple Aim: improving patients' experience of care, improving health outcomes, and reducing costs.[8] Health care providers; policymakers at the national, state and local levels; and patient advocates across the country are all investing significant resources in promoting these values and transforming our health care system.[9]

While the nation works to achieve the Triple Aim with health care that meets patient needs and is evidence-based, politicians are pushing the regulation of abortion care in the opposite direction. The laws discussed in this report force health care providers to deliver outmoded care that is not in line with patient interests and not based on the best medical knowledge. They force providers to bypass research and patient preferences in order to comply with laws that require counseling with irrelevant, biased and sometimes patently false information. These laws make care more onerous to provide and difficult to access — driving up costs for both providers and patients without improving patient experience or health. Ultimately, these laws undermine patient- and family-centered quality care; subvert the goals of better care, better outcomes, and reduced costs; and harm women's health.

[i] This list is not meant to be comprehensive, but instead demonstrates how abortion restrictions can interfere in the patient-provider relationship and undermine health care providers' ability to provide the best quality care. These laws are part of a larger trend of abortion restrictions that disregard evidence and medical need to the detriment of women's health.

Bad Medicine Overview

Thirty-seven states have passed restrictions that fit into at least one of these categories; 17 states have all five types.[10ii] Courts have enjoined several of these laws, either permanently after they were successfully challenged, or temporarily while litigation is pending. Thirty-four states have at least one restriction in force, and in 16 states all five types of restrictions are in force.



Ultrasound requirements | **Biased counseling** | **Mandatory delays** | **Medication abortion restrictions** | **TRAP laws**

All applicable restrictions are permanently enjoined in Del., Mass. and Mont.

All or a portion of at least one restriction is permanently enjoined in Iowa, N.C. and Okla.

All or a portion of at least one restriction is enjoined in pending litigation in Ala., Ariz., Ark., Fla., Kan., La., Miss., Okla., Texas and Wis.

In Ill., the restrictions are governed by a consent decree.

[ii] As of December 31, 2015. The specific requirements of each law vary from state to state, and some restrictions may be modified in limited circumstances. All applicable restrictions are permanently enjoined in Delaware, Massachusetts and Montana. All or a portion of at least one restriction is permanently enjoined in Iowa, North Carolina and Oklahoma. All or a portion of at least one restriction is enjoined in pending litigation in Alabama, Arizona, Arkansas, Florida, Kansas, Louisiana, Mississippi, Oklahoma, Texas and Wisconsin. In Illinois, the restrictions are governed by a consent decree. As used in this report, the term "permanent" indicates that a law has been enjoined and the litigation has concluded.

Ultrasound Requirements

Bad medicine is requiring a health care provider to give — and a patient to receive — diagnostic tests and medical interventions that are not based on evidence or the provider's professional judgment, or are against the patient's wishes.

"Mandated care may also interfere with the patient-physician relationship and divert clinical time from more immediate clinical concerns."

— American College of Physicians, Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship, July 2012

While ultrasound is a standard part of abortion care, best practices and medical ethics dictate that it should be administered only when it is necessary for medical purposes or the patient requests it.[11] Laws requiring a provider to administer an ultrasound, along with other state-directed mandates such as forcing a provider to display the image and describe it, even when a woman objects, undermine quality health care. These mandates flout foundational principles of medical ethics, which make clear that a patient's decision to decline information is "itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy."[12] It is a violation of medical standards to use a procedure to influence, shame or demean a patient.[13]

Quality care is based on evidence and medical need in the context of each patient's individual circumstances. Yet some states force providers to place the ultrasound image in the patient's view and then give a detailed, pre-scripted description of that image. The only way for the woman to avoid this intrusion may be to cover her eyes or ears until the procedure and speech are over. This process does not serve a medical need; rather, it serves to impart the state's opposition to abortion.[14] These laws usurp the medical judgment of health care providers and ignore the needs and best interests of women. Additional mandates such as a delay after the ultrasound or a requirement that the ultrasound and the abortion be performed by the same provider cause unnecessary delays, make care inefficient and directly undermine the provider's ability to make health care decisions with the patient based on what is medically appropriate in her particular circumstance.[15]

Mapping Ultrasound Requirements

Twenty-five states regulate the provision of ultrasound by abortion providers.[16] This may include: mandating an ultrasound; requiring the provider to describe and display the ultrasound image; requiring the provider to offer an ultrasound; requiring the provider to give or offer information on accessing ultrasound services prior to having an abortion; or requiring a provider to offer specific information if an ultrasound is already included in the patient's care.[17]

"The hard part is turning the screen toward a woman who doesn't want to look at it. Sometimes I find myself apologizing for what the state requires me to do, saying, 'You may avert your eyes and cover your ears.' This is unconscionable: my patient has asked me not to do something, and moreover it's something that serves no medical value – and I, as a physician, am being forced to shame my patient."

— Anonymous Physician, Texas

Of the 25 states regulating ultrasound by abortion providers, 13 have passed laws mandating an ultrasound before an abortion[18] and of those, five include a requirement that the provider display and describe the image.[19][iii] This forces the provider to give, and the patient to receive, information she may not want or need. Most other states that mandate an ultrasound

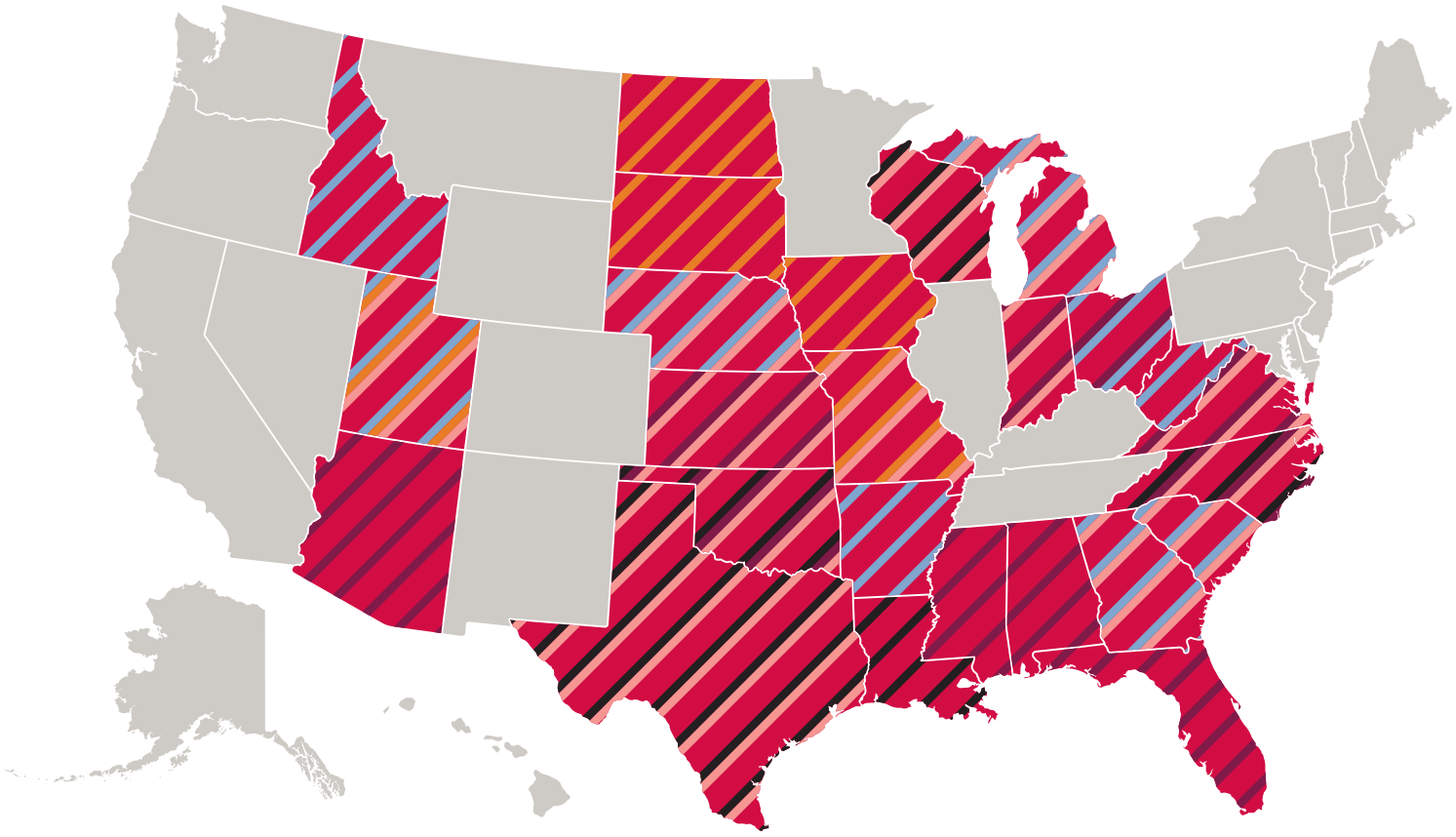
[iii] Enforcement is permanently enjoined in North Carolina and Oklahoma. In addition to the enjoined describe and display law, North Carolina regulations mandate an ultrasound and require that the provider offer the patient the opportunity to see the image; this regulation remains in place and enforceable. In Oklahoma, the 2010 describe and display law is permanently enjoined; in May 2014, the governor signed a law directing the state Board of Health to implement additional abortion regulations, including ultrasound for all abortion patients. This law went into effect on November 1, 2014.

require that the provider offer the patient the opportunity to see the image. Early in pregnancy, transvaginal ultrasound may be necessary to meet the requirements of many of these laws.[20]

In addition to the laws mandating ultrasound, 20 states have laws regulating pre-abortion ultrasound in other ways. In five states, the provider is required to offer an ultrasound.[21] In nine states, a patient must be explicitly offered the opportunity to view the ultrasound image if the provider performs one.[22] Thirteen states require that the woman be given or offered information on how to access ultrasound services.[23]

In five states, the ultrasound must take place 24 hours before the abortion procedure for most women,[24] thus creating a mandatory delay of a time-sensitive procedure without regard to the wishes of the patient and without any medical rationale. (See section on mandatory delays for more information.)

Ultrasound Requirements



Provider must perform ultrasound, display image and describe fetal characteristics

Provider must perform ultrasound and in some states offer opportunity to view image

Provider must offer opportunity to view ultrasound image if performing ultrasound procedure

Provider must offer ultrasound procedure

Provider must offer or give patient information about obtaining an ultrasound

Laws requiring providers to perform ultrasound, display image and describe fetal characteristics are permanently enjoined in N.C. and Okla. In addition to the enjoined law, N.C. regulations mandate an ultrasound and require that providers offer patients the opportunity to see the image – this regulation remains in place and enforceable. In Okla., the 2010 describe and display law is permanently enjoined; in May 2014, the governor signed a law directing the state Board of Health to implement additional abortion regulations, including ultrasound for all abortion patients. This law went into effect on November 1, 2014.

Biased Counseling Laws

Bad medicine is dictating the content of a health care provider's counsel to his or her patient and mandating that a provider share biased information that is not supported by medical evidence.

Informed consent is a fundamental requirement for medical practice in every state, and is foundational to patient-centered care and the patient-provider relationship.[25] Laws mandating the provision of information that is inaccurate, biased, irrelevant or otherwise outside the medical profession's evidence-based standards of care undermine true informed consent.[26]

"Seeking informed consent expresses respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity."

— American College of Obstetricians and Gynecologists, Committee Opinion Number 439, Aug. 2009 (reaffirmed 2012)

The medical community has well-established standards for informed consent for an abortion that health care providers have a professional and ethical obligation to follow.[27] Informed consent must be based on an open and honest conversation between a patient and her health care provider. It allows a patient to engage in her own care and make her own decisions and judgments. Quality patient-centered care requires providing medically accurate information that is tailored to the patient's individual circumstances.

According to ACOG, a pregnant woman "should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. The professional should make every effort to avoid introducing personal bias."[28] In addition to ensuring that patients receive only scientifically accurate and up-to-date information, medical standards dictate that "[t]he quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients."[29]

Patients rely on their health care providers to give them accurate information based on medical evidence, not on politicians' ideology. When laws require a health care provider to give information that is not based on scientific evidence or the interests of the patient, the patient can no longer trust that she is receiving the best possible care. That, in turn, undermines the trust that is essential to the patient-provider relationship. The AMA explains in its Code of Medical Ethics that "[t]he relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."[30]

Mapping Biased Counseling Laws

Twenty-nine states have measures that require health care providers to give or offer patients abortion-specific, state-developed written materials.[31][iv] These requirements apply a one-size-fits-all approach and force women seeking abortion to receive information unrelated to their individual circumstances.

Nineteen states require providers to give or offer verbal or written statements that are medically inaccurate, biased or false.[32] These include:

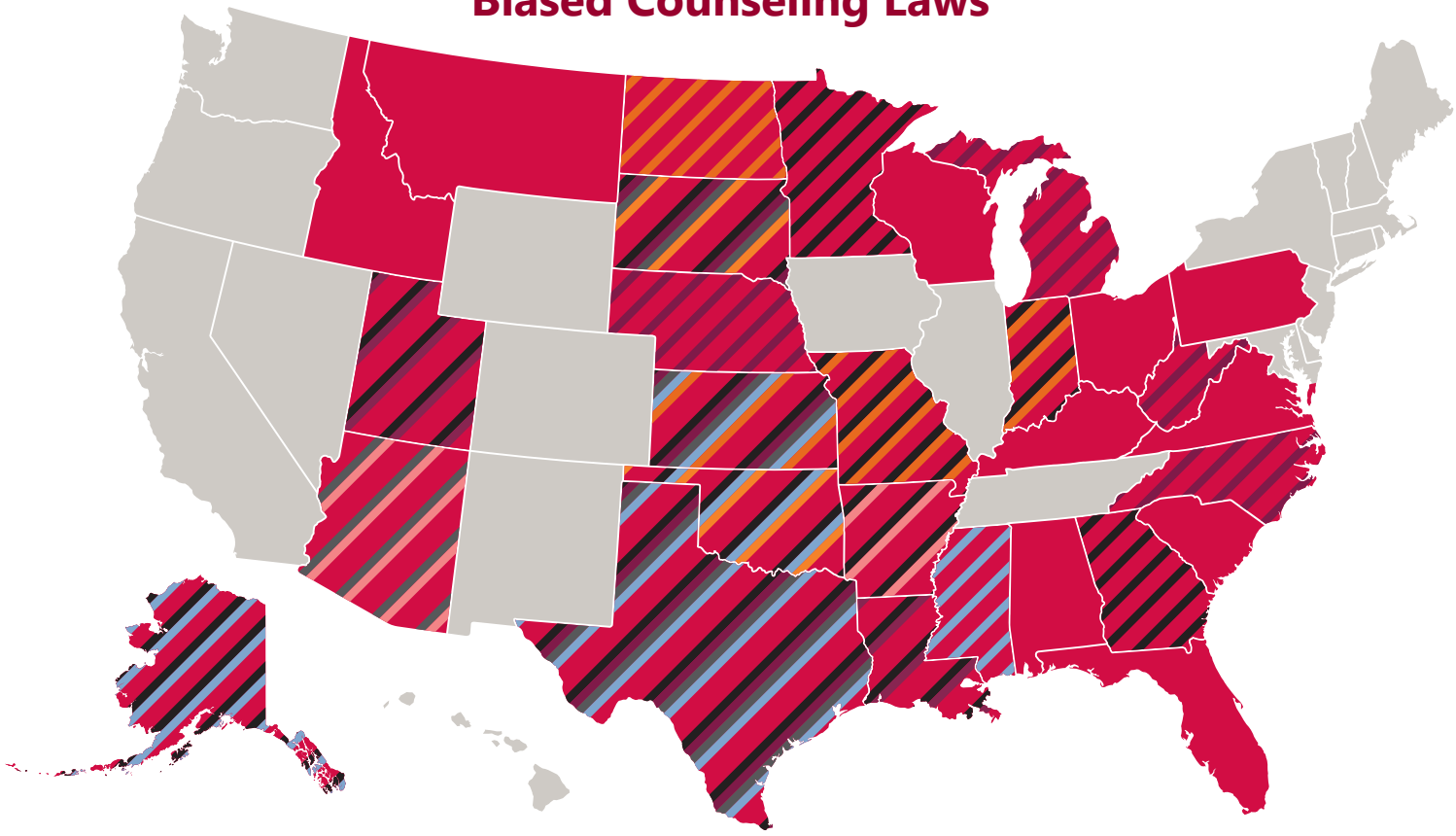
- In 12 states,[33] an unfounded assertion that fetuses can feel pain, despite the lack of scientific evidence.[34]
- In nine states,[35] content emphasizing only negative emotional responses to abortion, including suicidal thoughts, depression or emotional distress — even though these claims have been debunked by the American Psychological Association and the "overwhelming majority" of women feel relief after, and do not regret having, an abortion.[36]

[iv] Enforcement is permanently enjoined in Montana.

- In four states,[37] erroneous statements about the impact of abortion on future fertility.[38]
- In five states,[39] false links between abortion and breast cancer.[40]
- In six states,[41] ideological assertions that personhood begins at conception.
- In two states,[42v] the claim that medication abortion may be "reversible," which medical experts have deemed unsubstantiated, inappropriate and non-scientific.[43]

Twenty-four states require providers to give or offer patients descriptions of all common abortion procedures.[44vi] As procedures vary greatly depending on the stage of gestation, the information presented may be entirely inapplicable to the patient. In 29 states, abortion providers must give or offer patients descriptions of fetal development throughout pregnancy, rather than information about the gestational age relevant to the woman's pregnancy.[45vii]

Biased Counseling Laws



Provider must give or offer specific state-mandated information, regardless of whether it is medically appropriate

Provider must give or offer medically inaccurate or biased information:

- **Unfounded assertion regarding fetal pain**
- **Description of only negative emotional responses to abortion**
- **Erroneous statement about impact of abortion on future fertility**
- **False link between abortion and breast cancer**
- **Assertion that personhood begins at conception**
- **Unsubstantiated claim that medication abortion may be reversible**

Law requiring providers to offer state-mandated materials to patients is permanently enjoined in Mont. Law requiring providers to make the unsubstantiated and unscientific assertion that medication abortion may be reversible is enjoined in pending litigation in Ariz.

v Enforcement is enjoined in pending litigation in Arizona.

vi Enforcement is permanently enjoined in Montana.

vii Enforcement is permanently enjoined in Montana.

Mandatory Delays

Bad medicine is forcing a health care provider to withhold time-sensitive care regardless of his or her medical judgment or the patient's needs and wishes.

Mandatory delays require patients to wait a specified number of days before being able to obtain abortion care, despite the fact that such delays serve no medical purpose and actually undermine the provision of care. Such laws take decision-making away from the health care provider and patient, and disregard a fundamental principle of quality care articulated by the Institute of Medicine: Care should be timely, and according to medical need and the patient's best interests.[46] Mandatory delay laws force providers to withhold care, even if doing so contradicts their medical judgment.

Mandatory delays are often linked to other state interference in health care, such as requiring that women receive specific information or an ultrasound before a delay period begins. In many states, this necessitates at least one extra trip to the clinic for no medical reason.[47] By contrast, quality health care reduces duplicative, unnecessary medical visits for the patient.[48]

According to the World Health Organization (WHO):

> "Information, counseling and abortion procedures should be provided as promptly as possible without undue delay. . . . The woman should be given as much time as she needs to make her decision, even if it means returning to the clinic later. However, the advantage of abortion at earlier gestational ages in terms of their greater safety over abortion at later ages should be explained. Once the decision is made by the woman, abortion should be provided as soon as is possible to do so."[49]

In other words, it is the patient, in consultation with her health care provider, who must make decisions about timing — not the state.

"[M]andatory delays create obstacles for women, including family problems, increased expense, and travel difficulties. These restrictions may disproportionately affect low-income women, particularly those in rural settings."

— American College of Obstetricians and Gynecologists, Committee Opinion Number 424, Jan. 2009

The impact of mandatory delays is exacerbated by the national shortage of abortion providers and can result in waits of greater duration than the state-mandated period. Eighty-nine percent of counties in the United States do not have a single abortion clinic.[50] Even for those counties that do have one or more clinics, abortion services might be available only on certain days. Several states have only one clinic that offers abortion care,[51] and some clinics rely on physicians to fly in from out of state.

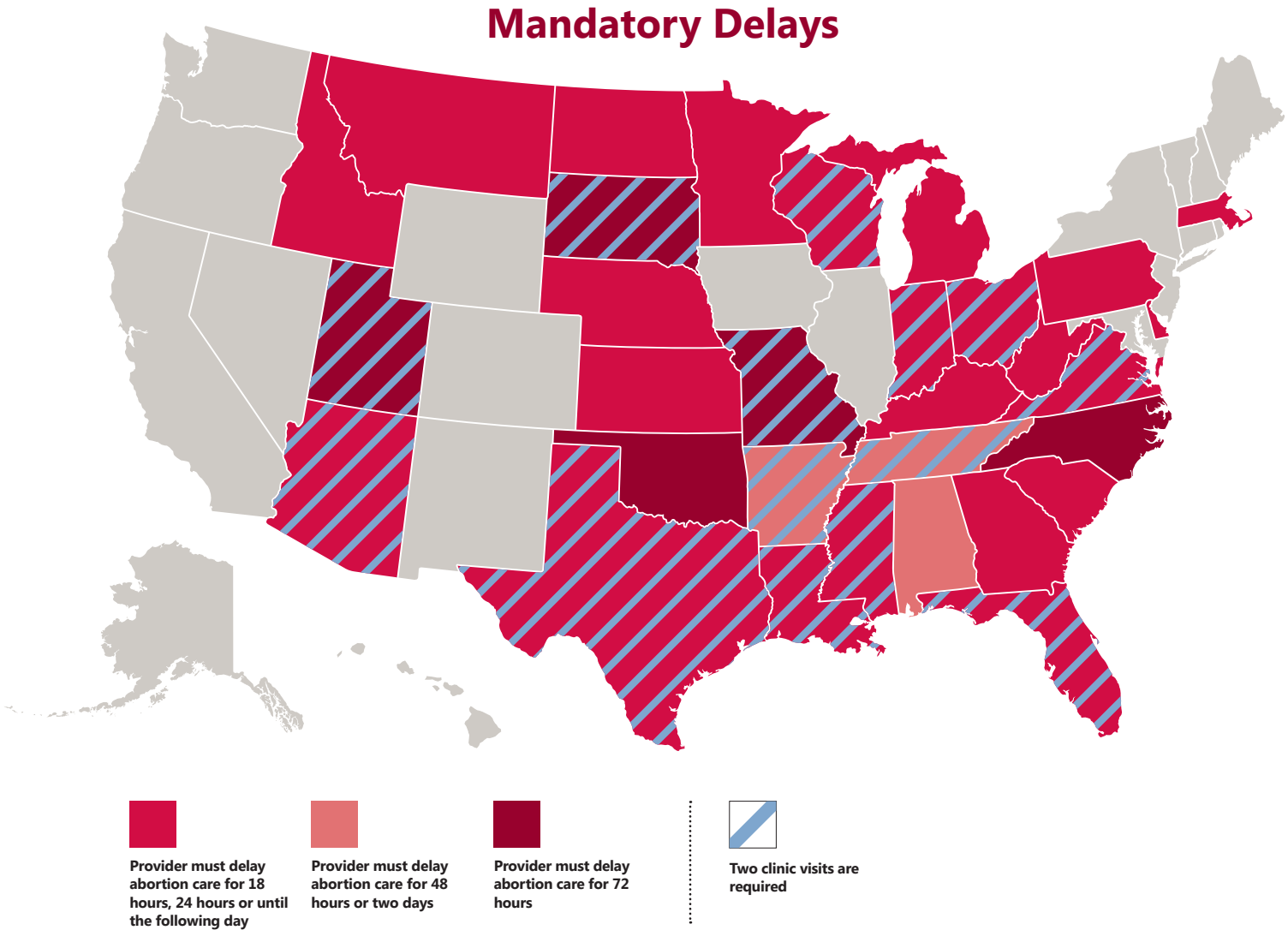
"I recently had a patient who was diagnosed with an aggressive form of breast cancer. She needed to terminate the pregnancy immediately to start chemotherapy. Due to a mandatory waiting period, she was forced to wait before I could perform her abortion. It's cruel that our state law forced her to wait to start life-saving treatment, especially since every day with her family is precious."

— Dr. Elizabeth Schmidt, Missouri

Given the shortage, many women must travel long distances to reach an abortion provider. Most women seeking abortion already have children[52] and thus need to secure child care, as well as transportation and time off work. In states that require two trips to the clinic, women may have to do each of those things twice. As a result, unnecessary delay requirements place the heaviest burden on rural, young and low-income women, exacerbating health disparities.[53] Access to quality care should not vary depending on where a patient lives or how much money she makes.

Mapping Mandatory Delays

Thirty-one states have passed laws imposing a mandatory delay before a woman can have an abortion.[54viii] Fourteen of these states also require that a woman receive state-mandated counseling in person, necessitating at least two trips to the clinic.[55ix] In most states the waiting period is 24 hours; under the Missouri, North Carolina, Oklahoma, South Dakota and Utah laws, a patient must wait 72 hours before obtaining an abortion. South Dakota excludes weekends and state holidays from the 72-hour waiting period,[56] forcing a patient to wait as long as six days if a long weekend follows her first appointment.



Laws requiring providers to delay abortion care are permanently enjoined in Del., Mass. and Mont. Law requiring providers to delay abortion care and patients to make two trips to the clinic is enjoined in pending litigation in Fla.

viii Enforcement is permanently enjoined in Delaware, Massachusetts and Montana. Enforcement is enjoined in pending litigation in Florida.

ix Enforcement is enjoined in pending litigation in Florida.

Medication Abortion Restrictions

Bad medicine is prohibiting a health care provider from using evidence-based standards to administer medication, or banning the use of technology to provide the most appropriate care.

A growing number of states have passed laws that prohibit providers from administering medication abortion according to the most current medical standards, or prevent them from using advances in medical technology. These laws restrict a patient's ability to access appropriate, effective care that fits her needs in a timely manner and in the most appropriate setting, undermining quality care.

Medication abortion is a safe abortion method in which medications are used to end a pregnancy.[57] The medications are dispensed by a trained health care provider, and the patient takes two types of drugs, one or more days apart, according to her provider's written and verbal guidelines.[58] This method is medically indicated for certain women, and others may choose it because it provides more control and privacy. This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure.

Two restrictions on medication abortion are:

- Prohibiting providers from administering medication abortion according to the most current standards; and
- Banning medication abortion via telemedicine.

Prohibitions on the Use of Evidence-Based Standards

Several states have prohibited the use of evidence-based prescribing when it comes to medication abortion. These states require providers to adhere to an outdated protocol that is found on the label for the medication abortion drug, as initially approved by the U.S. Food and Drug Administration (FDA) in 2000, rather than allowing providers to administer it according to current research and evidence-based protocols.

The way a drug is administered often evolves after the FDA has approved its use. Years of use in the field, as well as additional research and clinical studies, allow physicians to learn much more about a drug and adjust the standard of practice based on the most current scientific evidence.[59] The best practices for care constantly improve as new evidence is collected, while an FDA label will typically not be updated unless the manufacturer wants to advertise the drug for a new purpose and, even then, only when the manufacturer has gone through a complicated and expensive updating process.[60] As ACOG has explained, "The purpose [of an FDA-approved label] is not to restrict physicians in their practice of medicine, but rather to inform physicians about information gathered during the approval process, so as to enable physicians to practice medicine using all available scientific and medical evidence."[61] It is common practice — and often representative of the best quality care — for providers to follow the medical community's current evidence-based regimen in lieu of the protocol found on a medication's label.

The 2000 FDA protocol limited medication abortion to the first seven weeks of pregnancy, included specific dosages of the medication and required the second medication to be taken in the presence of a health care provider. Since then, clinical studies and research have shown that medication abortion is safe and effective through at least 10 weeks of pregnancy, that the first pill can be taken at a much lower dosage and that the second pill can be taken in the privacy of one's home.[62]

The AMA has voiced its "strong support for the autonomous clinical decision-making authority of a physician" and noted "that a physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion."[63] Nonetheless, laws restricting medication abortion make it illegal for a health care provider to follow the most up-to-date standard of care.

"Not only is it costly, because the patient must take three mifepristone pills instead of one, but it also requires patients to come to the clinic for four appointments. This law does nothing to make abortion safer – all it does is limit access."

— Dr. Lisa Perriera, Ohio

When providers are forced to follow an outdated label, they are prevented from employing best practices and delivering evidence-based care to their patients. Major medical organizations across the United States and the world have endorsed the more recently developed, evidence-based regimen for medication abortion.[64] As ACOG and the AMA have explained, "[E]vidence-based regimens have emerged that make medic[ation] abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA [over 15] years ago."[65] They note these evidence-based regimens are "superior"[66] to the FDA protocol because they reflect "the most current, well-researched, safe, evidence-based and proven protocols."[67] Importantly, unlike the FDA protocol, the evidence-based regimen eliminates the need for a medically unnecessary trip to a clinic, as it permits taking the second dose of medication at home.[68]

Quality care requires that health services are based on the best scientific knowledge. These laws not only undermine women's access to a safe option for abortion care, but also threaten this central tenet of the practice of medicine — that evidence and research inform improvements in treatment and regimens for patients.

Prohibitions Against Telemedicine

Telemedicine is a safe way to make health care more accessible, especially to individuals in underserved areas — yet states continue their efforts to prohibit providers from using it to administer medication abortion.

Telemedicine is the delivery of any health care service or the transmission of health information using telecommunications technology in order to improve a patient's health.[69] Consultation through video conferencing, where a patient interacts with a remote provider, is a common and growing method of providing care.[70] When medication abortion is administered via telemedicine, a woman meets in-person with a trained medical professional at a health care clinic. She then meets via a video conference system with a physician who has reviewed her medical records and the results of her in-person examination. Once the medical visit is completed, the medication is dispensed to the patient.[71]

"In rural areas in the United States, women may have to travel for hours to see a physician, and this can be an insurmountable barrier to care. Being able to meet with a doctor using telemedicine could help address disparities in access to health care and improve women's health and well-being."

— Dr. Daniel Grossman in "New research finds providing medical abortion using telemedicine is effective, safe, and acceptable to women," July 2011

Telemedicine can improve the quality, safety and efficiency of health care. For example, telemedicine is regularly used to expand access to mammography, chronic disease management, stroke diagnosis and treatment, high-risk pregnancy management and primary care.[72] It can be particularly important for rural women, who experience a significant shortage of reproductive health providers.[73]

Studies and practice have shown that care delivered via telemedicine is not only safe and effective, but can actually increase the safety and effectiveness of care. For example, a study by the University of Missouri found that telemedicine allowed for earlier detection of key warning signs in patients and more timely interventions by providers.[74] According to the same study, telemedicine patients also experienced fewer hospital readmissions.[75] Another study comparing patients with chronic illnesses receiving care through in-person visits and telemedicine found no significant differences between quality of care indicators such as patients' self-management and medication use, or patient satisfaction.[76] Importantly, telemedicine can increase the timeliness of care delivered. According to one study, telemedicine reduced the delay between the request for a wound care consultation and its completion, and the telemedicine consultations were "comparable to traditional face-to-face consultations."[77]

The same is true for providing medication abortion via telemedicine — it is safe and effective and improves access and timeliness. ACOG has determined that medication abortion "can be provided safely and effectively via telemedicine with a high level of patient satisfaction," and that laws banning telemedicine are contrary to medical evidence.[78] Studies comparing in-person medication abortion provision with telemedicine medication abortion show equivalent effectiveness and rates of positive patient experience;[79] as ACOG has noted, the two types of visits are "medically identical."[80] Telemedicine patients particularly valued being able to receive abortion care at clinics closer to their homes and high numbers reported that they would recommend telemedicine to their friends.[81] Yet state restrictions interfere with the delivery of quality care by banning this innovative and effective method of providing abortion care.

Mapping Medication Abortion Restrictions

Twenty states have passed medically unnecessary restrictions on how providers can administer medication abortion.[82x] Six of these states have passed laws preventing providers from administering medication abortion in accordance with the standard of care that reflects the most up-to-date evidence.[83xi] Nineteen of these states have passed measures prohibiting providers from administering medication abortion via telemedicine.[84xii] Five states have passed both of these restrictions.[85xiii]

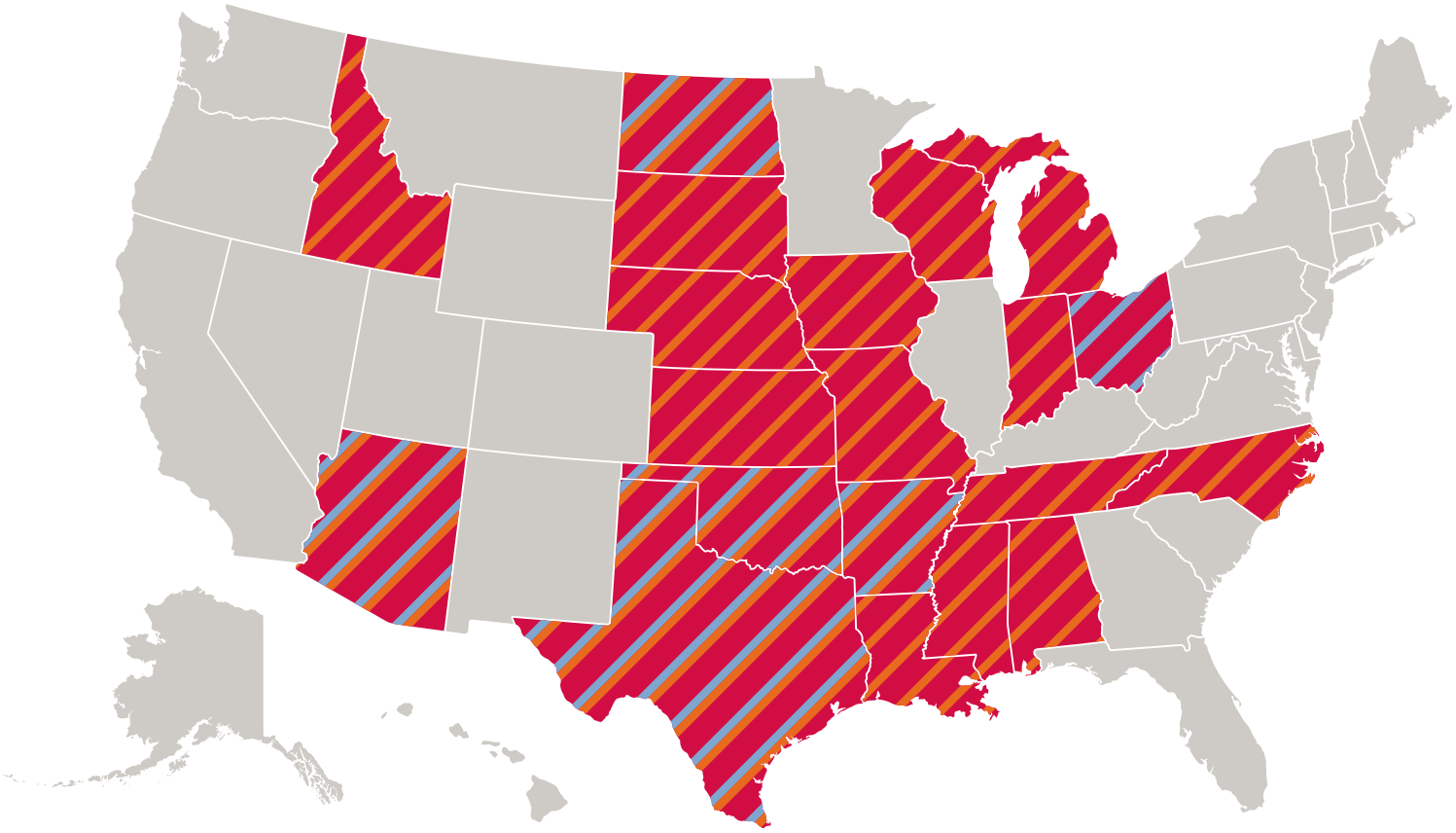
x Enforcement of at least one medication abortion restriction is enjoined permanently in Iowa, and enjoined in pending litigation in Arizona, Arkansas and Oklahoma.

xi Enforcement is enjoined in pending litigation in Arizona and Arkansas. In Oklahoma, the law passed in 2011 is permanently enjoined, but a similar law was passed and signed into law in 2014. This law is enjoined in pending litigation.

xii Enforcement is permanently enjoined in Iowa.

xiii In states that have passed both medication abortion restrictions, enforcement of the FDA protocol restriction is enjoined in pending litigation in Arizona, Arkansas and Oklahoma.

Medication Abortion Restrictions



Provider is prohibited from administering medication abortion according to the most current standards

Provider is banned from administering medication abortion via telemedicine

Laws prohibiting providers from administering medication abortion according to the most current standards are enjoined in pending litigation in Ariz. and Ark. In Okla., the law passed in 2011 is permanently enjoined, but a similar law was passed and signed into law in 2014. This law is enjoined in pending litigation.

Law banning providers from administering medication abortion via telemedicine is permanently enjoined in Iowa.

Targeted Regulation of Abortion Providers (TRAP Laws)

Bad medicine is requiring a clinic or health care provider to comply with burdensome requirements that are contrary to accepted medical practice.

TRAP laws single out abortion clinics and providers for onerous, medically unnecessary requirements that comparable medical facilities and health care providers are not subject to. While these restrictions are often passed under the guise of "patient safety," in truth, they force clinics to close and drive experienced providers out of practice, making it harder for women to access care and undermining women's health.

Abortion is one of the safest medical procedures in the United States.[86] In a study of nearly 6,000 first trimester abortions provided by physicians in outpatient clinics, 99.1 percent of patients experienced no adverse effects. In the rare instances when adverse effects did occur, the majority were so minor that they could be treated at the clinic; only 0.05 percent of patients experienced a complication that required hospitalization.[87] Despite this impressive safety record, state after state has enacted TRAP laws. Two of these restrictions are:

- Requirements that abortion clinics meet standards comparable to those for ambulatory surgical centers (ASCs) or other facility licensing requirements; and
- Requirements that abortion providers obtain admitting privileges at a hospital near their practice.

Leading medical experts — the AMA, ACOG, the American Academy of Family Physicians (AAFP) and the American Osteopathic Association (AOA) — have all recognized that these requirements "are contrary to accepted medical practice and are not based on scientific evidence. They fail to enhance the quality or safety of abortion-related medical care and, in fact, impede women's access to such care by imposing unjustified and medically unnecessary burdens on providers."[88]

While TRAP laws provide no medical benefit, they do force clinics to close, raise the cost of care and increase the distance women must travel and the time they must wait to obtain care.[89] Each of these burdens undermines patient-centered quality care and runs counter to key health care system goals: improving care, including quality and patients' experience; improving health outcomes; and reducing costs.[90]

Ambulatory Surgical Center and Other Onerous Facility Licensing Requirements

Nearly half the states require abortion clinics to meet specifications comparable to those required of ASCs,[91] which are designed to provide complex and invasive surgeries historically provided in hospitals,[92] or impose other unnecessary facility licensing requirements on abortion clinics.[93] While the details of ASC and other facility requirements vary from state to state, none are aligned with the standard of medical care for abortion and they do not enhance women's health.

Office- and clinic-based care is the prevailing practice for many gynecological procedures, including treatment of incomplete miscarriages, which involves the same procedure used for most first trimester abortions.[94] Indeed, many more complex procedures, such as colonoscopies, are routinely provided in office- and clinic-based settings.[95]

A review of 57 studies of complications from first trimester aspiration abortion found that the number of major complications was similar for office-based settings, hospital-based settings and ASCs.[96] Moreover, when complications did occur, they were effectively managed at the clinic — regardless of whether the clinic was subjected to ASC requirements.[97] Nonetheless, a number of states require clinics providing abortion care to meet ASC specifications, even though ASCs are designed for procedures more invasive than abortion and even though there is no evidence that providing abortion care in these "mini-hospitals" provides a benefit to the patient.[98] Indeed, in 19 states, unnecessary facility requirements even apply to clinics that only provide medication abortion, for which a health care provider merely prescribes and dispenses medication.[99]

The American Public Health Association (APHA) has observed that these types of requirements force clinics to "make. . . expensive renovations that have little or nothing to do with the patient services they provide."[100] Similarly, the WHO has cautioned against "excessive requirements for infrastructure, equipment, or staff that are not essential to the provision of safe services"[101] and counseled that facility requirements that are not evidence-based nor tied to safety and efficiency should be eschewed.[102]

"ASC and privileges requirements do nothing to protect the health and safety of women and are incongruous with modern medical practice. Women's access to high-quality, evidence-based abortion care should not be limited by laws enacted under the guise of patient safety but that, in fact, harm women's health."

— American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians and American Osteopathic Association, Amici Curiae Brief Supporting Certiorari in *Whole Woman's Health v. Hellerstedt*, Oct. 2015

TRAP laws do nothing to enhance quality of care. They do, however, increase the cost of care as facilities' operating expenses increase. These laws force care into an unnecessarily high-cost setting for no medical reason, going against the central health care goal of improving patient experience and outcomes while driving down costs.[103]

Facility requirements force clinics to close when they cannot afford to make renovations, when a landlord is unwilling to renovate or when requirements apply not solely to a clinic itself but also to its entire building and other tenants are unwilling or unable to comply.[104] Reducing the number of providers in a state increases wait times for appointments,[105] forces some providers to turn away patients,[106] and increases the distance women must travel to access care.[107] This undermines quality care by reducing access, increasing costs and harming women's health.

Hospital Admitting Privileges and Related Requirements

An increasing number of states require abortion providers to maintain admitting privileges or an alternative formal admitting arrangement with a hospital in a certain geographic range.[108] Admitting privileges are formal arrangements that authorize a physician to admit patients into that hospital and provide care there, effectively becoming a staff member of that hospital. These requirements ignore the way modern medicine is practiced.

In the modern health care system, hospitals rely on hospitalists (physicians focused primarily on "general medical care of hospitalized patients"[109]), not outside physicians, to provide care on-site.[110] Across medical disciplines, continuity of care is achieved through communication across providers and settings, not by a single physician providing care both inside and out of the hospital.[111]

Similarly, admitting privileges are not relevant to whether a patient can access emergency care. The federal Emergency Medical Treatment and Active Labor Act requires that hospital emergency rooms

admit and treat any patient presenting with an emergent condition.[112] Moreover, emergency room admission is unlikely — abortion clinics have the staffing, training and equipment to handle the rare adverse events that occur.[113]

While admitting privileges requirements do nothing to advance quality care, they do prevent qualified physicians who want to provide abortion care from doing so. Admitting privileges can be difficult or impossible to secure for reasons that have nothing to do with a provider's skills.[114] Some hospitals only grant admitting privileges to physicians who accept faculty appointments.[115] Others require physicians to admit a certain number of patients per year but, because abortion is such a safe procedure, abortion providers are unlikely to admit a sufficient number of patients.[116] Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.[117] And hospitals that adhere to religious directives that run counter to established medical standards[118] will often refuse to grant privileges to abortion providers.[119] None of these reasons are related to quality care.

The APHA has observed that physicians applying for admitting privileges must take "time away from their patients to navigate the hospital requirements and to complete the often lengthy application process."[120] Moreover, the AMA, ACOG, AAFP and AOA have all concluded that "[r]equiring that clinicians obtain hospital privileges — when such privileges may be denied for any number of reasons having nothing to do with a clinician's competency or the quality of care that he or she provides — does not promote the wellbeing of . . . women."[121]

Mapping TRAP Laws

Twenty-eight states have passed TRAP laws that impose medically unnecessary requirements on abortion providers and clinics.[122] Such provisions may include ASC and other facility requirements, admitting privileges or transfer agreements with local hospitals.

Of the 28 states with TRAP laws, 25 have passed measures requiring abortion clinics to meet specifications comparable to those required of ASCs.[123xiv] Seventeen states also have unnecessary facility requirements such as corridor width or room size, sometimes on top of their ASC requirements.[124xv]

Twenty-three states have passed laws requiring abortion providers to have a formal arrangement with a hospital, such as admitting privileges or a transfer agreement.[125] Of these states, 11 have laws on the books requiring that abortion providers obtain admitting privileges.[126xvi] Ten states' laws require admitting privileges, but permit providers to enter into an alternative arrangement instead, such as an agreement with a different provider who has admitting privileges, or a transfer agreement.[127xvii] Four states have passed both of these laws.[128xviii] In addition, nine states have measures requiring abortion providers to have transfer agreements with local hospitals.[129] Two of these states' laws require both transfer agreements and admitting privileges.[130]

Twenty-one states have both a facilities requirement and a requirement for a formal arrangement with a hospital on the books.[131xix]

xiv Enforcement is enjoined in pending litigation in Kansas and Texas. In Illinois, the law is governed by a consent decree.

xv Enforcement is enjoined in pending litigation in Texas.

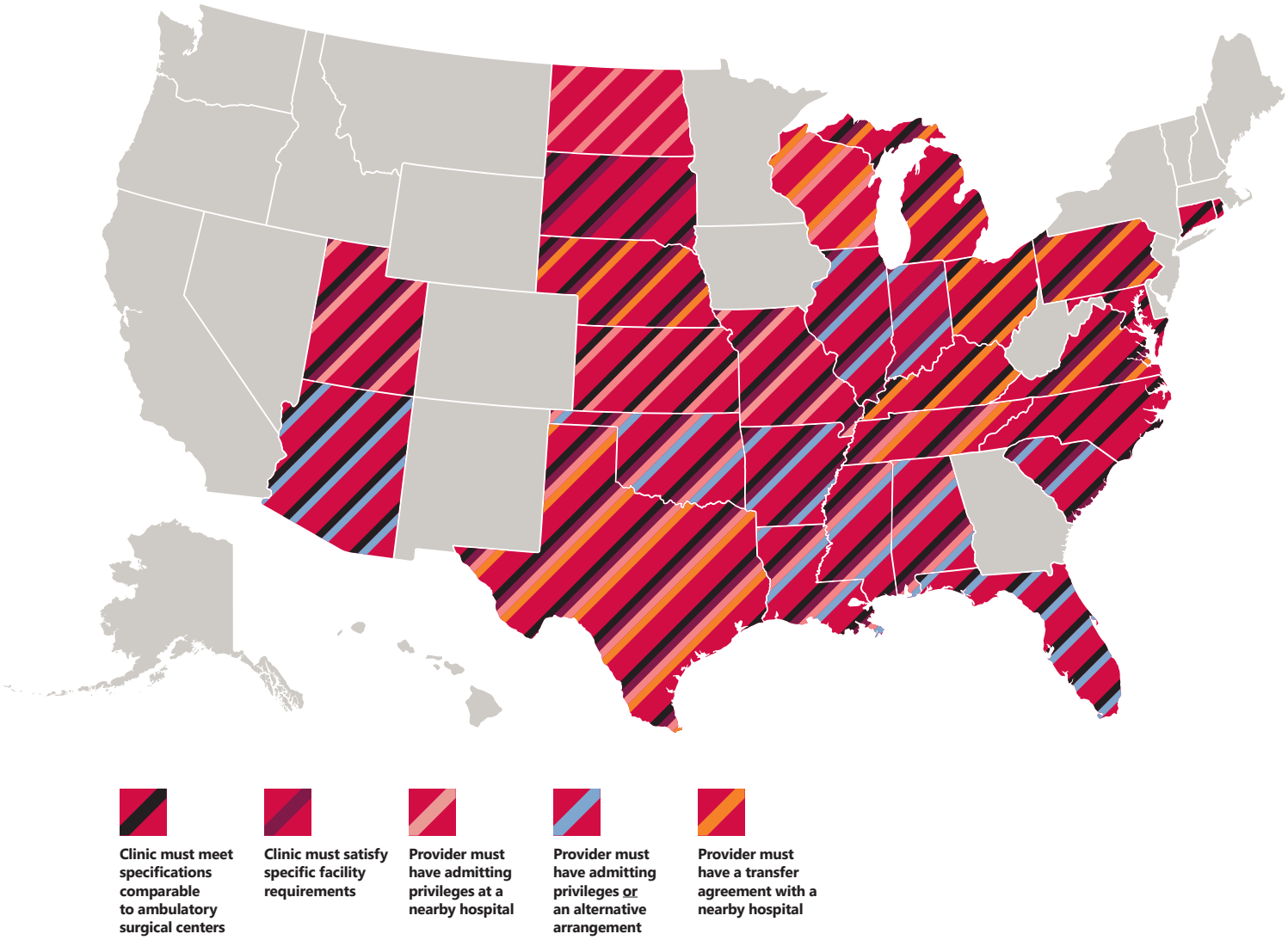
xvi Enforcement is enjoined in pending litigation in Alabama, Kansas, Louisiana, Mississippi, Oklahoma and Wisconsin. In Texas, enforcement is enjoined in pending litigation with respect to two clinics.

xvii In Illinois, the law is governed by a consent decree.

xviii Enforcement of the admitting privileges-only requirement is enjoined in pending litigation in Alabama, Louisiana, Mississippi and Oklahoma. In all four states, the "admitting privileges or alternative agreement" provision remains in place and enforceable.

xix Enforcement of at least one TRAP requirement is enjoined in pending litigation in Alabama, Kansas, Louisiana, Mississippi, Oklahoma and Texas. In Illinois, the law is governed by a consent decree.

TRAP Laws



Laws requiring clinics to meet specifications comparable to ambulatory surgical centers are enjoined in pending litigation in Kan. and Texas.

Law requiring clinics to meet specific facility requirements is enjoined in pending litigation in Texas.

Laws requiring admitting privileges-only are enjoined in pending litigation in Ala., Kan., La., Miss., Okla. and Wis.

In Ill., the law is governed by a consent decree.

Recommendations

States have an appropriate role to play in regulating the medical profession, but stepping into the exam room with an ideological agenda that overrides providers' medical judgment and ignores patients' needs is an unacceptable overreach. Instead, states should acknowledge and support health care providers' ethical and professional obligation to put their patients first, and should strive to improve the quality of care — not undermine it.

- Lawmakers and policymakers should reject legislative and regulatory proposals that interfere in the patient-provider relationship or force providers to violate accepted, evidence-based medical practices and ethical standards.
- The medical community, patients and advocates should speak out against government actions that inappropriately infringe on the relationship between patients and their health care providers, including mandates or restrictions that require providers to violate their professional standards or provide care that does not align with accepted, evidence-based medical practices.
- Laws that are based on politicians' ideology and not sound medical evidence — such as ultrasound requirements, biased counseling laws, mandatory delays, restrictions on medication abortion and TRAP laws — should be repealed.
- Lawmakers should take steps to protect the patient-provider relationship and affirm the importance of individualized care and providers' ability to further the best interests of their patients. This includes advancing legislation that would prohibit interference with licensed health care providers' ability to exercise their professional judgment so that patients can receive care that is based on medical evidence, not politics.

Conclusion

While in many areas there have been advances in making care more accessible and centered on the needs of the patient, state restrictions have moved abortion care in the opposite direction. Women seeking abortion services deserve truthful information, quality care and treatment options that are appropriate for their individual circumstances. They should not face laws that force them to experience unnecessary delays or medical procedures, deny them safe and timely abortion options or force them to receive unnecessary and often inaccurate information. By the same token, health care providers should be able to focus on their obligations to their patients.

It is time to take politics out of the exam room and return abortion care to women and their health care providers. Politicians' personal beliefs about abortion must not be permitted to trump women's health or the weight of medical evidence. States should act to ensure that laws involving women's reproductive health care promote access to quality care without bias, ideology or unnecessary barriers.

"By reducing health care decisions to a series of mandates, lawmakers devalue the patient–physician relationship. Legislators, regrettably, often propose new laws or regulations for political or other reasons unrelated to the scientific evidence and counter to the health care needs of patients."

— Leaders of the American College of Physicians, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and American College of Surgeons, *New England Journal of Medicine*, Oct. 2012

Endnotes

[1] American College of Physicians. (2012, July). *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* (p. 2). Retrieved 20 November 2015, from https://www.acponline.org/advocacy/current_policy_papers/assets/statement_of_principles.pdf ("The many appropriate roles of government include licensing, protecting and improving public health, determining the safety and effectiveness of drugs and medical devices, and supporting medical education, training, and research, among others.")

[2] National Partnership for Women & Families, National Physicians Alliance, Natural Resources Defense Council, & Law Center to Prevent Gun Violence. (2015, October). *Politics in the Exam Room: A Growing Threat*. Retrieved 18 November 2015, from http://www.nationalpartnership.org/research-library/repro/politics-in-the-exam-room-a-growing-threat.pdf

[3] House of Delegates, American Medical Association. (2013). *Resolution 717, Government Interference in the Patient-Physician Relationship*.

[4] See note 1.

[5] Executive Board, American College of Obstetricians and Gynecologists & American Congress of Obstetricians and Gynecologists. (2013). *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*. Retrieved 20 November 2015, from http://www.acog.org/~/media/Statements%20of%20Policy/Public/2013LegislativeInterference.pdf

[6] Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p. 1). Retrieved 16 December 2015, from http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf; Clancy, C. (2009, March 18). *Testimony before the Senate Committee on Finance Subcommittee on Health Care*. Washington, DC. Retrieved 15 December 2015, from http://www.hhs.gov/asl/testify/2009/03/t20090318b.html

[7] Ibid.

[8] Institute for Healthcare Improvement. (n.d.). *The IHI Triple Aim*. Retrieved 15 December 2015, from http://www.ihi.org/engage/initiatives/tripleaim/Pages/default.aspx

[9] National Committee for Quality Assurance. (2007). *The Essential Guide to Health Care Quality* (p. 7). Retrieved 15 December 2015, from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf ("Virtually every part of the health care industry – hospitals, health plans, physicians, nursing homes, home health providers and others – is working to improve health care quality. The federal government, states, employers and consumer advocates are also focused on improving care.")

[10] The 37 states are Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia and Wisconsin. The 17 states are Alabama, Arizona, Arkansas, Indiana, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Texas and Wisconsin.

[11] Minkoff, H. & Ecker, J. (2012, September). When legislators play doctor – The ethics of mandatory preabortion ultrasound examinations. *Obstetrics & Gynecology, 120*(3), 647–649 ("Ultrasonography may be an appropriate element of medical care in many cases, but its timing, context, and the way in which it is used and viewed should be a decision made between the patient and health care provider, not a decision scripted by law."); Committee on Ethics, American College of Obstetricians and Gynecologists. (2007, December; reaffirmed 2013). *Committee Opinion No. 390, Ethical Decision Making in Obstetrics and Gynecology* (p. 6). Retrieved 15 December 2015, from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co390.pdf?dmc=1&ts=20120305T0654106237 [hereinafter ACOG Opinion 390] ("A patient's right to make her own decisions about medical issues extends to the right to refuse . . . medical treatment."); Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2012). *Committee Opinion No. 439, Informed Consent* (p. 7). Retrieved 15 December 2015, from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20130415T1047469933 [hereinafter ACOG Opinion 439] (Advising that refusing information can "be itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy."); National Abortion Federation. (2015). *2015 Clinical Practice Guidelines* (p. 10). Retrieved 3 December 2015, from http://prochoice.org/wp-content/uploads/2015_NAF_CPGs.pdf

[12] Stuart v. Loomis, 992 F. Supp. 2d 585, 591 (M.D.N.C. 2014), quoting Comm. On Ethics, Am. Coll. Of Obstetricians and Gynecologists, Committee Opinion No. 439, Informed Consent 7 (Aug. 2009; reaffirmed 2012).

[13] See note 11, ACOG Opinion 439 (p.3). ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."); American Medical Association. (2001). *AMA Code of Medical Ethics, Principles of Medical Ethics*. Retrieved 15 December 2015, from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."); American Medical Association. (2008). *Model Medical Staff Code of Conduct*. Retrieved 26 January 2016, from http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.page? ("Inappropriate Behavior [includes] . . . Belittling or berating statements . . . Intentionally degrading or demeaning comments regarding patients and their families . . ."); American College of Physicians. (2012). *ACP Ethics Manual* (6th ed.) Retrieved 15 December 2015, from http://www.acponline.org/running_practice/ethics/manual/manual6th.htm ("The physician's primary commitment must always be to the patient's welfare and best interests, whether in preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must respect the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status.") ("The physician must be professionally competent, act responsibly, . . . and treat the patient with compassion and respect . . . .") ("Care and respect should guide the performance of the physical examination.")

[14] See note 11, Minkoff. ("There are no circumstances in which a patient's viewing of the fetus is medically necessary.") ("[Mandatory ultrasound laws] are clearly value-laden in intent and designed in no small measure to relay the opprobrium of those advancing such measures toward the woman's decision to have an abortion."); see note 12, Stuart, 992 F. Supp. 2d at 598 (M.D.N.C. 2014) (Noting the state's acknowledgment that one of the purposes of the ultrasound law in question is to dissuade women from terminating a pregnancy.)

[15] The Texas Policy Evaluation Project. (2013, April). *Research Brief, Impact of Abortion Restrictions in Texas* (p. 1). Retrieved 20 November 2015, from http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf (Finding that almost a third of women "reported that the waiting period had a negative impact on their emotional well-being.")

[16] Guttmacher Institute. (2015, December 10). *State Policies in Brief: Requirements for Ultrasound*. Retrieved 10 December 2015, from http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin.)

[17] See note 16.

[18] See note 16. (Alabama, Arizona, Florida, Indiana, Kansas, Louisiana, Mississippi, North Carolina, Oklahoma, Texas, Virginia and Wisconsin; Ohio mandates that a provider check for the fetal heartbeat, which requires an ultrasound in the first trimester – when the great majority of abortions take place.)

[19] See note 16. (Louisiana, North Carolina, Oklahoma, Texas and Wisconsin.)

[20] Kaur, A. & Kaur, A. (2011, July). Transvaginal ultrasonography in first trimester of pregnancy and its comparison with transabdominal ultrasonography. *Journal of Pharmacy and Bioallied Sciences, 3*(3), 329–338. Retrieved 15 December 2015, from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178938 (Concluding that transvaginal ultrasonography accurately reflects pregnancy and developmental markers at an earlier stage in pregnancy than transabdominal ultrasonography.); Eckholm, E. & Severson, K. (2012, February 28). Virginia senate passes ultrasound bill as other states take notice. *New York Times*. Retrieved 15 December 2015, from http://www.nytimes.com/2012/02/29/us/virginia-senate-passes-revised-ultrasound-bill.html?pagewanted=all&_r=0 ("Through most of the first 12 weeks of pregnancy, medical experts say, only the [vaginal ultrasound] procedure can provide a clear image of the tiny fetus or an audible record of the heartbeat, and most abortions occur within this period."); Guttmacher Institute. (2014, July). *Fact Sheet: Induced Abortion in the United States*. Retrieved 15 December 2015, from http://www.guttmacher.org/pubs/fb_induced_abortion.html (Noting that the vast majority of abortions occur during the first trimester.)

[21] See note 16. (Iowa, Missouri, North Dakota, South Dakota and Utah; this count does not include Indiana, which has an offer requirement, because that state also has a mandatory ultrasound requirement.)

[22] See note 16. (Arkansas, Georgia, Idaho, Michigan, Nebraska, Ohio, South Carolina, Utah and West Virginia; this count does not include Kansas, which has an offer to display requirement if the provider performs an ultrasound, because that state also has a mandatory ultrasound requirement.)

[23] See note 16. (Georgia, Indiana, Kansas, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, Texas, Utah, Virginia and Wisconsin; Michigan includes this information in its state-drafted written materials but it is not mandated by state law.)

[24] See note 16. (Arizona, Louisiana, North Dakota, Texas and Virginia.)

[25] American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2012). *ACOG Committee Opinion: Informed Consent*. Retrieved 3 September 2015, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed%20Consent Informed Consent (Stating that informed consent is "integral to contemporary medical ethics and medical practice . . . [It] expresses respect for the patient as a person; . . . ensures the protection of the patient against unwanted medical treatment, [. . .] [and] also makes possible the patient's active involvement in her medical planning and care.") (Informed consent is required by law in all 50 states. See, e.g., Manian, M. (2009, August). Article: The Irrational Woman: Informed Consent and Abortion Decision Making. *Duke Journal of Gender Law & Policy, 16,* 232-92.)

[26] American Medical Association. (2006, June). *AMA Code of Medical Ethics, Opinion 8.08 – Informed Consent*. Retrieved 15 December 2015, from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page ("The physician's obligation is to present the medical facts accurately to the patient . . . .") ("Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.")

[27] College Executive Board, American College of Obstetricians and Gynecologists. (Revised and approved 2014). *College Statement of Policy, Abortion Policy*. Retrieved 15 December 2015, from https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20151215T1746509747; See note 11, ACOG Opinion 439. p.7. (Advising that refusing information can "be itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy.")

[28] See note 27.

[29] See note 26.

[30] American Medical Association. (2001, June). *AMA Code of Medical Ethics, Opinion 10.015 – The Patient-Physician Relationship*. Retrieved 15 December 2015, from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page

[31] Guttmacher Institute. (2015, December 1). *State Policies in Brief: Counseling and Waiting Periods for Abortion*. Retrieved 10 December 2015, from http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf; Mont. Code Ann., § 50-20-104. (Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin.) (In some states, the specific information is required by law; in others, it is otherwise included in the written materials.)

[32] Ibid. (Alaska, Arizona, Arkansas, Georgia, Indiana, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah and West Virginia.)

[33] Ibid. (Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma and Utah; Alaska, South Dakota and Texas include this information in their state-drafted written materials but it is not mandated by state law.)

[34] Royal College of Obstetricians and Gynaecologists. (2010, March). *Report of Working Party, Fetal Awareness: Review of Research and Recommendations for Practice* (pp. viii, 11). Retrieved 16 December 2015, from https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf (Concluding that anatomical and physiological connections required to experience pain are not intact before 24 weeks gestation thus "the fetus cannot experience pain in any sense prior to this gestation."); Lee, S.J., Ralston, H.J.P., Drey, E.A., Partridge, J.C., & Rosen, M.A. (2005, August). Fetal Pain: A Systematic Multidisciplinary Review of the Evidence. *Journal of the American Medical Association, 294*(8), 947-954.

[35] See note 31. (Kansas, Louisiana, Michigan, Nebraska, North Carolina, Utah and West Virginia; South Dakota and Texas include this information in their state-drafted written materials but it is not mandated by state law.)

[36] Rocca, C.H., Kimport, K., Roberts, S.C.M., Gould H., Neuhaus J., & Foster DG. (2015). Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study. *PLoS ONE, 10*(7).; Rocca, C.H., Kimport, K., Gould, H., & Foster, D.G. (2013). Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States. *Perspectives on Sexual and Reproductive Health, 45*(3), p. 126; American Psychological Association Task Force on Mental Health and Abortion. (2008). *Report of the APA Task Force on Mental Health and Abortion* (p. 92). Retrieved 2 September 2015, from http://www.apa.org/pi/women/programs/abortion/mental-health.pdf ("[T]his Task Force on Mental Health and Abortion concludes that the most methodologically sound research indicates that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy for nontherapeutic reasons, the related risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.")

[37] See note 31. (Texas mandates this information by law; Arizona, Kansas and South Dakota include this information in their state-drafted written materials but it is not mandated by state law.)

[38] See note 20, Guttmacher Institute.

[39] See note 31. (Kansas and Texas; Alaska, Mississippi and Oklahoma include this information in their state-drafted written materials but it is not mandated by state law.)

[40] Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. (2009; reaffirmed 2015). *Committee Opinion No. 434, Induced Abortion and Breast Cancer Risk*. Retrieved 15 December 2015, from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co434.pdf?dmc=1&ts=20140618T1023081652; American Cancer Society. (2014, June). *Is Abortion Linked to Breast Cancer?* Retrieved 15 December 2015, from http://www.cancer.org/cancer/breastcancer/moreinformation/is-abortion-linked-to-breast-cancer ("[S]cientific research studies have not found a cause-and-effect relationship between abortion and breast cancer.")

[41] See note 31. (Indiana, Kansas, Missouri, North Dakota, Oklahoma and South Dakota.)

[42] Ibid. (Arizona and Arkansas.)

[43] Brief for Am. Coll. of Obstet. & Gyn., Am. Med. Ass'n & Ariz. Med. Ass'n as Amici Curiae Supporting Plaintiff's Motion for Preliminary Injunction, p. 3, Planned Parenthood Ariz. v. Brnovich, No. 2:15-cv-01022 (D. Ariz. 2015); Borkowski, L., Strasser, J., Allina, A., & Wood, S. (2015, December). *Medication Abortion: Overview of Research & Policy in the United States* (p. 27). Jacobs Institute of Women's Health, George Washington University: Washington, DC.

[44] See note 31; and Mont. Code Ann., § 50-20-304. (Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, West Virginia and Wisconsin; Texas includes this information in its state-drafted written materials but it is not mandated by state law.)

[45] Ibid. (Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin.)

[46] See note 6, Institute of Medicine.

[47] See note 31.

[48] Burns, M., Dyer, M., & Bailit, M. (2014, January). *Reducing Overuse and Misuse – State Strategies to Improve Quality and Cost of Health Care*. Robert Wood Johnson Foundation. Retrieved 17 December 2015, from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409990; see also note 15. (Finding that almost a third of women reported that a forced waiting period had a negative impact on their emotional well-being.)

[49] World Health Organization. (2nd. ed. 2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (p. 36). Retrieved 17 December 2015, from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

[50] See note 20, Guttmacher Institute.

[51] MSNBC. (2014, May 23). *All in with Chris Hayes: Fighting for the right to choose* [Television broadcast]. Retrieved 17 December 2015, from http://www.msnbc.com/all-in/watch/fighting-for-the-right-to-choose-264613955629

[52] See note 20, Guttmacher Institute.

[53] Joyce, T., Henshaw, S., Dennis, A., Finer, L., & Blanchard, K. (2009, April). *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* (p. 4). Guttmacher Institute Publication. Retrieved 20 November 2015, from http://www.guttmacher.org/pubs/MandatoryCounseling.pdf (Noting that while mandatory delay and counseling laws affect women across economic and age spectrums, women who have resources – that is older, more educated and non-poor women – are better able to access services despite the restrictions.); Henshaw, S. & Finer, L. (2003, February). The accessibility of abortion services in the United States, 2001. *Perspectives on Sexual and Reproductive Health, 35*(1), 16–24 (p. 19). Retrieved 20 November 2015, from https://www.guttmacher.org/pubs/journals/3501603.pdf ("Traveling a long distance to a provider can be difficult for women who need to make two or more trips to the abortion facility."); See note 15. ("These laws have had the greatest impact on low-income women and women in rural counties.")

[54] See note 31. (Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia and Wisconsin.)

[55] Ibid. (Arizona, Arkansas, Florida, Indiana, Louisiana, Mississippi, Missouri, Ohio, South Dakota, Tennessee, Texas, Utah, Virginia and Wisconsin.)

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[58] See note 57; see note 11, National Abortion Federation, p. 14.

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[61] Brief for Am. Coll. of Obstet. & Gyn. as Amicus Curiae Supporting Petitioners-Appellants, p. 25, Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).

[62] American College of Obstetricians and Gynecologists. (2014, March). *Practice Bulletin No. 143, Medical Management of First-Trimester Abortion*. Retrieved 20 November 2015, from http://www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb143.pdf?dmc=1&ts=20140618T1452186427

[63] American Medical Association. *Policy H-120.988, Patient Access to Treatments Prescribed by Their Physicians*. Retrieved 20 November 2015, from https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-120.988.HTM

[64] See note 62; see note 49, pp. 3-4; see note 57.

[65] Brief for Am. Coll. of Obstet. & Gyn. and Am. Med. Ass'n as Amici Curiae Supporting Plaintiffs-Appellees, p. 13, Planned Parenthood of Greater Tex. Surg. Health Servs. v. Abbott, 748 F.3d 583 (5th Cir. 2014) (No. 13-51008); see note 62. (Studies examining the efficacy and safety of varied dosing and administration methods indicate that many alternative regimens are as safe and effective, if not more effective, than the FDA protocol.); see note 59, National Abortion Federation; El-Refaey, H., Rajasekar, D., Abdalla, M., Calder, L., & Templeton, A. (1995, April 13). Induction of Abortion with Mifepristone (RU 486) and Oral or Vaginal Misoprostol. *New England Journal of Medicine, 332*, pp. 985-86 (Finding that vaginal administration of misoprostol "is more effective and better tolerated" than oral administration for inducing first trimester abortion within the first 63 days of pregnancy.); Schaff, E.A., Fielding, S.L., Eisinger, S.H., Stadalius, L.S., & Fuller, L. (2000). Low-dose Mifepristone Followed by Vaginal Misoprostol at 48 Hours for Abortion Up to 63 Days (abstract). *Contraception, 61*(1) (Concluding that 200 mg mifepristone in

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66 Brief for Am. Coll. of Obstet. & Gyn. and Am. Med. Ass'n as Amici Curiae Supporting Plaintiffs-Appellees, p. 16, Planned Parenthood Ariz. v. Humble, 753 F.3d 905 (9th Cir. 2014) (No. 14-15624).

67 Ibid. (In a brief to the Iowa Supreme Court, ACOG explains that "[T]he purpose [of an FDA-approved label] is not to restrict physicians in their practice of medicine, but rather to inform physicians about information gathered during the approval process, so as to enable physicians to practice medicine using all available scientific and medical evidence."); see note 61.

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[97] Texas Policy Evaluation Project. (2015, July 6). *Fact sheet: Ambulatory surgical center laws and the provision of first-trimester abortion care*. Retrieved 17 December 2015, from http://www.utexas.edu/cola/txpep/_files/pdf/ASC%20fact%20sheet%20updated%20July%206.pdf

[98] See note 96, Scott Jones & Weitz. ("Nonetheless, no data exist to show that providing abortions in ASCs positively affects complication rates or patient health outcomes or that physicians' offices and outpatient clinics are inadequate or unsafe facilities for the performance of abortions.")

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[106] Brief for Nat'l Abortion Fed'n as Amicus Curiae Supporting Petitioners for Writ of Certiorari, p. 13, Whole Woman's Health v. Cole, No. 15-274 (filed Oct. 5, 2015).

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[113] Planned Parenthood Federation of America & American Congress of Obstetricians and Gynecologists. (n.d.). *Protect Safe and Legal Abortion*. Retrieved 11 November 2015, from https://www.plannedparenthood.org/files/6014/2194/2001/Protect_Safe_and_Legal_Abortion.pdf

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[122] See note 99. (Alabama, Arizona, Arkansas, Connecticut, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia and Wisconsin.)

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[125] Ibid. (Alabama, Arizona, Arkansas, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia and Wisconsin.)

[126] Ibid. (Alabama, Kansas, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, Tennessee, Texas, Utah and Wisconsin.)

[127] Ibid. (Alabama, Arizona, Arkansas, Florida, Illinois, Indiana, Louisiana, Mississippi, Oklahoma and South Carolina).

[128] Ibid. (Alabama, Lousiana, Mississippi and Oklahoma.)

[129] Ibid. (Kentucky, Michigan, Nebraska, Ohio, Pennsylvania, Tennessee, Texas, Virginia and Wisconsin.)

[130] Ibid. (Tennessee and Wisconsin.)

[131] Ibid. (Alabama, Arizona, Arkansas, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah and Virginia.)

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