BAD MEDICINE

How a **Political Agenda** Is Undermining Abortion Care and Access in Louisiana

Across the country, politicians are enacting anti-abortion laws that ignore evidence and science and 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. *Bad Medicine: How a Political Agenda Is Undermining Abortion Care and Access*, a 2018 report by the National Partnership for Women & Families, documents this trend.[1] The report finds that a large majority of states have one or more of these "bad medicine" laws.

Louisiana is a key offender, with multiple abortion restrictions that bear no relationship to medical standards; undermine health care providers' efforts to provide high-quality, patient-centered care; and take decision-making away from women. These restrictions punish women – particularly women of color and low-income women – who face multiple disparities and structural barriers that increase their likelihood of experiencing the harm caused by obstacles to abortion care.[2]

In June 2016, the U.S. Supreme Court struck down two onerous Texas abortion restrictions in *Whole Woman's Health v. Hellerstedt*. In that decision, the Court made clear that politicians are not allowed to make up facts in order to justify restrictions on abortion – unfortunately, a common practice in many places. The opinion strengthened the current legal standard used to determine whether abortion restrictions are unconstitutional by stating that restrictions must have enough benefit to justify the burdens on access they impose, and that states cannot rely on junk science.[3] Recently, the well-respected, nonpartisan National Academies of Sciences, Engineering, and Medicine released a definitive report making clear the harms that medically unnecessary abortion restrictions cause for women around the country.[4] Despite these clear legal and scientific strikes against bad medicine laws, Louisiana has not taken any steps to remove from its books laws that disregard evidence and interfere in a woman's ability to obtain care.

This issue brief details how Louisiana politicians legislate bad medicine. It highlights examples of laws that undermine quality abortion care by interfering in the patient-provider relationship and advancing an ideological agenda that flouts medical evidence and scientific integrity.[5] Taken collectively or individually, these Louisiana laws create significant burdens on a woman's access to abortion care.

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Louisiana's bad medicine laws include:

MANDATORY PROVISION OF BIASED AND INACCURATE INFORMATION.

Under Louisiana law, providers are required to give women state-drafted materials that include biased and misleading information, such as a deceptive statement about the risk of abortion complications and the potential impact on future fertility[6] and the implication that abortion is linked to breast cancer, despite numerous studies finding that no such link exists.[7] Additionally, the state-drafted materials discuss only negative emotional responses to abortion, including suicidal thoughts, depression or emotional distress – even though it is well documented that an "overwhelming majority" of women feel relief after, and do not regret having, an abortion.[8] Patients rely on their health care providers to give them accurate information based on medical evidence and their health needs, not on politicians' ideology. When a state requires 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, diminishes the trust that is essential to the patient-provider relationship and undermines women's ability to make informed medical decisions.[9]

DISPLAY AND DESCRIBE ULTRASOUND MANDATE.

In Louisiana, prior to an abortion, health care providers are required to administer an ultrasound, display the image and give a detailed, pre-scripted description of what the ultrasound image depicts – even when the woman objects.[10] Providers must also make the fetal heartbeat audible.[11] These mandates cause unnecessary delays, make care inefficient and directly undermine a provider's ability to make health care decisions with a patient based on what is medically appropriate in her particular circumstances.[12] The ultrasound mandate also flies in the face 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.'"[13] It is a violation of medical standards to use a procedure to influence, shame or demean a patient.[14] Forced ultrasound, by definition, is not quality care.

PROVISION OF INFORMATION ABOUT FAKE WOMEN'S HEALTH CENTERS.

Louisiana law requires physicians to provide patients with a state-created list of "facilities" that "offer . . . ultrasounds free of charge," but the list excludes any facility that "counsels, refers, performs, induces, prescribes, or provides any means for abortion."[15] This requires physicians to share with patients a list of anti-abortion facilities, known as fake women's health centers, which shame and lie to women to try to prevent them from accessing abortion care. Further, women who obtain an ultrasound at one of these facilities and choose to have an abortion are then required to have another ultrasound at the abortion clinic.

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MANDATORY DELAY IN CARE AND AN EXTRA VISIT TO THE CLINIC FOR NO MEDICAL REASON.

Under Louisiana law, a patient must wait 24 hours after receiving a state-mandated ultrasound and biased information before being able to obtain abortion care[16] – despite the fact that such a delay serves no medical purpose and actually undermines the provision of care.[17] As a result of the mandatory delay, a woman seeking abortion care must make a medically unnecessary second trip to the clinic to receive an abortion. Most women seeking abortion care have already had at least one child[18] and thus may need to secure child care, transportation and time off work. Because Louisiana requires two trips to the clinic, women may have to do each of these things twice. The burden on many women is worsened by the fact that there is no law in Louisiana guaranteeing that private sector employees can earn paid sick days, and more than 45 percent of private sector workers in Louisiana cannot earn a single paid sick day.[19] In other words, many women are forced to go without pay, and even risk losing their jobs, in order to make the trips required to obtain an abortion. As a result of these compounding factors, unnecessary delay requirements place the heaviest burden on rural, young and low-income people, exacerbating health disparities.[20] In 2016, Louisiana enacted a 72-hour mandatory delay – triple the current wait time.[21] This delay is not currently enforced due to ongoing litigation.

BAN ON PROVIDING MEDICATION ABORTION VIA TELEMEDICINE.

Louisiana prohibits the provision of medication abortion via telemedicine,[22] disregarding medical evidence demonstrating that it is safe and improves access. Telemedicine is a safe way to make health care more accessible, especially to individuals in rural or underserved areas.[23] 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 video conference with an abortion provider who has reviewed her medical records, after which the medication is dispensed to the patient.[24] Studies comparing medication abortion provided in person with those provided via telemedicine show equivalent effectiveness and rates of positive patient experience.[25] As the American College of Obstetricians and Gynecologists (ACOG) has noted, the two types of visits are "medically identical."[26]

TARGETED FACILITY LICENSING REQUIREMENTS.

Under Louisiana law, abortion clinics must meet unnecessary and burdensome facility licensing specifications that are similar to those required of ambulatory surgical centers (ASCs).[27] ASCs are designed for the delivery of complex and invasive surgeries historically provided in hospital settings.[28] In the *Whole Woman's Health* decision, the Supreme Court found "considerable evidence . . . that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary."[29] In its decision, the Court noted that "risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities."[30] It also found that patients "will not obtain better care or experience more frequent positive outcomes" at ASCs.[31] The Court determined that abortion procedures were "safer than numerous procedures that take place outside hospitals and to which [the state] does not apply its surgical-center requirements," and that the provision "provid[ed] no benefit when complications arise in the context of a [medication abortion]."[32] Despite the decision, Louisiana still has similar requirements in place.

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HOSPITAL ADMITTING PRIVILEGES AND RELATED REQUIREMENTS.

Until this restriction was blocked in April 2017 under the precedent set by the *Whole Woman's Health* decision, Louisiana law required abortion providers to maintain admitting privileges with a hospital within 30 miles of where they perform abortions.[33] Admitting privileges can be difficult or impossible for abortion providers to secure for reasons that have nothing to do with a provider's skills.[34] Some hospitals only grant admitting privileges to physicians who accept faculty appointments.[35] Others require physicians to admit a certain number of patients per year before granting admitting privileges but, because abortion is such a safe procedure, abortion providers are unlikely to admit a sufficient number of patients.[36] Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.[37] And hospitals that adhere to religious directives that run counter to established medical standards[38] may refuse to grant privileges to abortion providers.[39] Moreover, admitting privileges requirements for abortion providers ignore the way modern medicine is practiced. Not only are emergency rooms required to admit and treat any patient with an emergent condition, but they rely on in-hospital doctors to provide care on-site – not outside physicians.[40] Louisiana's law is blocked by a court order,[41] though the state is appealing that order in spite of the law's clear unconstitutionality under *Whole Woman's Health*.[42]

PHYSICIAN-ONLY REQUIREMENT.

In Louisiana, abortion care – including medication abortion – can only be provided by a physician currently enrolled in or who has completed a family medicine or obstetrics and gynecology residency.[43] This is despite evidence that advanced practice clinicians, such as nurse practitioners, certified nurse-midwives and physician assistants, can safely and effectively provide abortion care and do so in other states.[44] This Louisiana law ignores the extensive training that advanced practice clinicians have in providing primary health care, managing chronic conditions and performing procedures that are more complex than abortion.[45] The law further ignores that leading medical organizations like ACOG recommend the pool of abortion providers be expanded to include "appropriately trained and credentialed advanced practice clinicians. . . ."[46]

BURIAL OR CREMATION REQUIREMENT FOR EMBRYONIC AND FETAL TISSUE.

Under Louisiana law, providers must ensure that the embryonic or fetal tissue resulting from an abortion be cremated or buried, regardless of gestation or a patient's individual circumstances.[47] This law treats embryonic and fetal tissue differently than all other tissue resulting from medical procedures. This medically unnecessary requirement creates an additional burden on providers and increases cost without improving the quality of care. It could ultimately force providers to close if they are unable to arrange for affordable services. Moreover, it diminishes patient experience by mandating a non-medical ritual designed to shame and stigmatize the patient. This law is currently not in effect due to ongoing litigation.

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Conclusion

Health care providers should not be forced to choose between following their medical and ethical obligations to their patients and following the law. However, that is exactly what is happening in Louisiana. Numerous laws in Louisiana directly interfere in medical decision-making and undermine the patient-provider relationship by usurping providers' medical judgment and ignoring patients' needs and preferences. It is time for those of us who oppose government interference in our most personal decisions to combat these bad medicine laws by standing up for medically accurate, patient-centered care that takes politics out of the exam room.

Below are five recommendations for state policymakers, the medical community, advocates and activists to join us in fighting back against bad medicine laws.

- **REJECT.** **Lawmakers and everyone who makes policy should reject legislative and regulatory proposals that interfere in the patient-provider relationship; force providers to violate accepted, evidence-based medical practices and ethical standards; and undermine patients' medical decision-making.**
- **REPEAL.** **Lawmakers should repeal laws that were enacted based on politicians' ideology rather than sound medical evidence, including biased counseling laws, ultrasound requirements, mandatory delay laws, restrictions on medication abortion and laws that place unnecessary licensing and credentialing requirements on providers.**
- **PROTECT.** **Lawmakers should advance legislation that proactively prohibits interference in health care to ensure patients receive care that is based on medical evidence, not politics.**
- **SPEAK OUT.** **The medical community should speak out against political interference in health care, including requirements that force providers to violate their professional standards or deliver care that disregards accepted, evidence-based medical practices.**
- **RISE UP.** **Activists and advocates should continue to call out harmful laws – and the deception behind them – every time we see them, and rally in support of proactive policies that expand access to high-quality, affordable abortion care and other reproductive health services. Together, we will keep fighting back until *every* woman in Louisiana is able to access the care she needs with dignity and without barriers.**

Endnotes

[1] National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access* (3rd ed.). Retrieved 8 May 2018, from http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf

[2] Blount, L. G., Yeung, M., & González-Rojas, J. (2015, April 30). Women of Color Leaders Call for a Change: End Barriers to Abortion Care. *TruthOut*. Retrieved 8 May 2018, from http://www.truth-out.org/opinion/item/30520-women-of-color-leaders-call-for-a-change-end-barriers-to-abortion-care; National Partnership for Women & Families. (2016, September). *A Double Bind: When States Deny Abortion Coverage and Fail to Support Expecting and New Parents* (p. 4). Retrieved 8 May 2018, from http://www.nationalpartnership.org/research-library/repro/abortion/a-double-bind.pdf (For example, due to pervasive inequalities in access to quality health care, women of color are at a higher risk for unintended pregnancy – more than twice as much as white women.). Additionally, the one-two punch of racism and sexism against women of color helps create conditions of socioeconomic inequality, meaning financial barriers can be more difficult to surmount. Women of color who also experience other intersecting identities, such as insecure immigration status, disability and/or language barriers, among others, will necessarily experience discrimination and barriers based on these intersections. See, e.g., Desmond-Harris, J. (2017, January 21). To Understand the Women's March on Washington, You Need to Understand Intersectional Feminism. *Vox*. Retrieved 8 May 2018, from http://www.vox.com/identities/2017/1/17/14267766/womens-march-on-washington-inauguration-trump-feminism-intersectionaltiy-race-class (discussing the concept of multiple barriers – intersectionality – and how it operates in the lives of women of color in particular). It stands to reason that any obstacles to abortion will fall hardest on women of color, especially on women of color who are also low-income or experiencing other intersecting barriers to care.

[3] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2310 (2016).

[4] National Academies of Sciences, Engineering, and Medicine. (2018). *The Safety and Quality of Abortion Care in the United States*. Washington, DC: The National Academies Press. Retrieved 8 May 2018, from https://www.nap.edu/24950

[5] The examples discussed in this report are illustrative of the ways in which Louisiana restricts abortion care and undermines the practice of medicine. Sadly, Louisiana has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2018, January). *State Facts About Abortion: Louisiana*. Retrieved 8 May 2018, from https://www.guttmacher.org/sites/default/files/factsheet/sfaa-la.pdf

[6] See La. Rev. Stat. Ann. § 40:1061.17(B)(5) (2016); Louisiana Department of Health and Hospitals. (n.d.). *Women's Right to Know* (pp. 21–22). Retrieved 8 May 2018, from http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf. But see, e.g., Lowit, A., Bhattacharya, S., & Bhattacharya, S. (2010). Obstetric performance following an induced abortion (p. 669). *Best Practice & Research Clinic Obstetrics and Gynaecology, 24*(2010), 667–682 (detailing various studies on abortion and fertility and finding little to no evidence that abortion has an effect on future fertility).

[7] See La. Rev. Stat. Ann. § 40:1061.17(B)(5); Louisiana Department of Health and Hospitals. (n.d.). *Women's Right to Know* (p. 21). Retrieved 8 May 2018, from http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf. But see, e.g., Collaborative Group on Hormonal Factors in Breast Cancer. (2004). Breast cancer and abortion: Collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries. *The Lancet, 363*(9414), 1007–1016; American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. (2009, June; reaffirmed 2015). *Committee Opinion No. 434, Induced Abortion and Breast Cancer Risk*. Retrieved 8 May 2018, from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co434.pdf?dmc=1&ts=20140618T1023081652 ("[R]igorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk."); American Cancer Society. (2014, June). *Is Abortion Linked to Breast Cancer?* Retrieved 8 May 2018, 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.")

[8] Louisiana Department of Health and Hospitals. (n.d.). *Women's Right to Know* (pp. 21–22). Retrieved 8 May 2018, from http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf. But see, e.g., Rocca, C. H., Kimport, K., Roberts, S. C. M., Gould, H., Neuhaus, J., & Foster, D. G. (2015, July). Decision rightness and emotional responses to abortion in the United States: A longitudinal study (p. 2). *PLoS ONE, 10*(7); see also 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), 122–131; 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 8 May 2018, 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 relative risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.")

[9] See note 1.

[10] With narrow exceptions. La. Rev. Stat. Ann. § 40:1061.10(D)(2)(a) (2016).

[11] Ibid.

[12] See, e.g., note 4, pp. 2-5, 2-27, 5-5.

[13] Stuart v. Loomis, 992 F. Supp. 2d 585, 591 (M.D.N.C. 2014), *aff'd sub nom.* Stuart v. Camnitz, 774 F.3d 238 (4th Cir. 2014), *cert. denied*, 135 S. Ct. 2838 (2015) (quoting Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2015). *Committee Opinion No. 439, Informed Consent* (p. 1). Retrieved 8 May 2018, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809).

[14] See, e.g., Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2015). *Committee Opinion No. 439, Informed Consent* (p. 3). Retrieved 8 May 2018, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809 ("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 8 May 2018, from https://www.ama-assn.org/sites/default/files/media-browser/principles-of-medical-ethics.pdf ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."); American College of Physicians. *ACP Ethics Manual* (6th ed.). Retrieved 8 May 2018, 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.")

[15] La. Rev. Stat. Ann. § 40:1061.17(B)(5)(a), (D)(2) (2016).

[16] La. Rev. Stat. Ann. § 40:1061.17(B)(3), (B)(5)(a); § 40:1061.10(2)(a) (2016) (describing that the provider must give the woman a copy of the state-created printed materials, inform the woman orally of specified information and perform the obstetric ultrasound at least 72 hours prior to an abortion). The 72-hour waiting period is not currently enforced pending litigation, but a 24-hour waiting period is still in place. June Med. Servs. LLC v. Gee, 280 F. Supp. 3d 849, 869 (2017).

[17] Mandatory delays disregard a fundamental principle of quality care articulated by the National Academy of Medicine: care should be timely, reduce waits and delays, and be provided according to medical need and the patient's best interests. Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (pp. 2–3). Retrieved 8 May 2018, from http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. (The Institute of Medicine was renamed in 2015 to the National Academy of Medicine.) It is the patient, in consultation with her health care provider, who must make decisions about timing — not politicians. See also note 4, p. 2-26.

[18] Guttmacher Institute. (2018, January). *Fact Sheet: Induced Abortion in the United States* (p. 1). Retrieved 8 May 2018, from https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf

[19] Institute for Women's Policy Research & National Partnership for Women & Families. (2015, May). *Workers' Access to Paid Sick Days in the States* (p. 2). Retrieved 8 May 2018, from http://www.nationalpartnership.org/research-library/work-family/psd/workers-access-to-paid-sick-days-in-the-states.pdf

[20] See, e.g., Guttmacher Institute. (2018, January). *Evidence You Can Use: Waiting Periods for Abortion.* Retrieved 8 May 2018, from https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion#harm-in-requiring-two-trips; Joyce, T. J., Henshaw, S. K., Dennis, A., Finer, L. B., & Blanchard, K. (2009, April). *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* (p. 4). Guttmacher Institute. Retrieved 8 May 2018, from https://www.guttmacher.org/sites/default/files/report_pdf/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); Texas Policy Evaluation Project. (2013, April). *Research Brief: Impact of Abortion Restrictions in Texas* (p. 1). Retrieved 8 May 2018, from http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf ("These laws have had the greatest impact on low-income women and women in rural counties."); American Civil Liberties Union. (n.d.). *Government-Mandated Delays Before Abortion.* Retrieved 8 May 2018, from https://www.aclu.org/other/government-mandated-delays-abortion

[21] 2016 La. Sess. Law Serv. Act 97 (H.B. 386) (West). See also note 16.

[22] La. Rev. Stat. Ann. § 40:1061.11(A) (2016).

[23] See note 4, pp. 2-10 to 2-11.

[24] See Boonstra, H. D. (2013). Medication abortion restrictions burden women and providers – and threaten U.S. trend toward very early abortion (p. 20). *Guttmacher Policy Review, 16*(1), 18–23. Retrieved 8 May 2018, from http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf

[25] See, e.g., Grossman, D., Grindlay, K., Buchacker, T., Lane, K., & Blanchard, K. (2011, August). Effectiveness and acceptability of medical abortion provided through telemedicine (p. 302). *Obstetrics & Gynecology, 118*(2), 296–303.

[26] Final Amicus Curiae Brief for Am. Coll. of Obstetricians & Gynecologists at 10, Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).

[27] See generally La. Admin. Code tit. 48, § 4401–4453 (2018).

[28] See, e.g., Brief for Amici Curiae Am. Coll. of Obstetricians & Gynecologists et al. in Support of Petitioners at 10, Whole Woman's Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016).

[29] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2315 (2016).

[30] Ibid (quoting Whole Woman's Health v. Lakey, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).

[31] Ibid.

[32] Ibid.

[33] La. Rev. Stat. Ann. § 40:1061.10(A)(2)(a) (2016). This law is currently enjoined. See June Med. Servs. LLC v. Kliebert, 250 F. Supp. 3d 27, 35 (M.D. La. 2017), *appeal filed*, June Med. Servs. LLC v. Caldwell, No. 17-30397 (5th Cir. May 12, 2017).

[34] See, e.g., note 28, p. 4.

[35] Ibid., p. 16.

[36] Ibid.

[37] *Amici Curiae* Brief of Pub. Health Deans et al. in Support of Petitioners at 17, Whole Woman's Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016).

[38] See generally Catholics for Choice. (2011, April). *Memorandum from Catholics for Choice to Colleagues Regarding the Ethical and Religious Directives for Catholic Health Care Services.* Retrieved 8 May 2018, from http://www.catholicsforchoice.org/wp-content/uploads/2014/01/CFCMemoontheDirectivesweb.pdf

[39] See, e.g., Brief of Amicus Curiae Am. Pub. Health Ass'n in Support of Petitioners at 15, Whole Woman's Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (citations omitted.).

[40] See note 28, pp. 18–19.

[41] June Med. Servs. LLC v. Kliebert 250 F. Supp. 3d 27, 35 (M.D. La. 2017), *appeal filed*, June Medical Servs. LLC v. Caldwell, No. 17-30397 (5th Cir. May 12, 2017).

[42] June Medical Servs. LLC v. Caldwell, No. 17-30397 (5th Cir. May 12, 2017).

[43] La. Rev. Stat. Ann. § 40:1061.10(A)(1) (2016). A provision of this law, not currently enforced, would further limit the types of physicians that can perform abortions.

[44] Studies show that advanced practice clinicians can provide safe and effective abortion care. See Advancing New Standards in Reproductive Health. (2014, June). *Health Workforce Pilot Project #171 Final Data Update* (p. 2). Retrieved 8 May 2018, from http://www.ansirh.org/sites/default/files/documents/hwppupdate-june2014.pdf (concluding that nurse practitioners, certified nurse midwives and physician assistants "can provide early abortion care that is clinically as safe as physicians"); see also National Abortion Federation. (2018). *2018 Clinical Policy Guidelines* (p. 1). Retrieved 8 May 2018, from https://prochoice.org/education-and-advocacy/cpg/ ("Abortion is a safe procedure when provided by qualified practitioners. . . . This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, and other health professionals."). As of March 2015, advanced practice clinicians provide aspiration abortion care in California, Montana, New Hampshire, Oregon and Vermont. See Barry, D., & Rugg, J. (2015, March 26). *Improving Abortion Access by Expanding Those Who Provide Care.* Center for American Progress. Retrieved 8 May 2018, from https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/

[45] See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 8 May 2018, from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants

[46] American College of Obstetricians and Gynecologists Committee on Healthcare for Underserved Women. (2014, November). *Committee Opinion No. 613, Increasing Access to Abortion* (p. 1). Retrieved 8 May 2018, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion. See also note 4, pp. 3-7 to 3-9.

[47] La. Rev. Stat. Ann. § 40:1061.25 (2016). Part of this provision is currently blocked in pending litigation.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at **NationalPartnership.org**.

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