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BAD MEDICINE

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

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.

Wisconsin 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, Wisconsin 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 Wisconsin 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 Wisconsin laws create significant burdens on a woman's access to abortion care.

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Wisconsin's bad medicine laws include:

MANDATORY PROVISION OF BIASED INFORMATION.

Under Wisconsin law, providers are required to give women state-drafted materials that include biased, inaccurate and misleading information, such as the unfounded assertion that a fetus at 20 weeks gestation "may feel pain"[6] and that, at 23 weeks gestation, "approximately 31% of babies born survive."[7] Both of these statements are at odds with prevailing medical evidence on fetal development.[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 Wisconsin, 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 offer to visually display any fetal heartbeat.[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.

Wisconsin law requires physicians to provide patients with a state-created "list of providers that perform an ultrasound at no cost to the woman …,"[15] as well as a list of "agencies that offer alternatives to abortion …."[16] This may require 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.

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

Under Wisconsin law, a patient must wait 24 hours after receiving biased information before being able to obtain abortion care[17] – despite the fact that such a delay serves no medical purpose and actually undermines the provision of care.[18] 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[19] and thus may need to secure child care, transportation and time off work. Because Wisconsin requires two trips to the clinic, women may have to do each of those things twice. The burden on many women is worsened by the fact that there is no law in Wisconsin guaranteeing that private sector employees can earn paid sick days, and more than 45 percent of private sector workers in Wisconsin cannot earn a single paid sick day.[20] 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.[21]

BAN ON PROVIDING MEDICATION ABORTION VIA TELEMEDICINE.

Wisconsin prohibits the provision of medication abortion via telemedicine, disregarding medical evidence demonstrating that it is safe and improves access.[22] 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 similar 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]

HOSPITAL ADMITTING PRIVILEGES AND RELATED REQUIREMENTS.

Until this restriction was blocked by the 7th U.S. Circuit Court of Appeals, Wisconsin law required abortion providers to maintain admitting privileges with a hospital within 30 miles of where they perform abortions.[27] Admitting privileges can be difficult or impossible for abortion providers to secure for reasons that have nothing to do with a provider's skills.[28] Some hospitals only grant admitting privileges to physicians who accept faculty appointments.[29] 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.[30] Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.[31] And hospitals that adhere to religious directives that run counter to established medical standards[32] may refuse to grant privileges to abortion providers.[33] 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.[34] Wisconsin's law was permanently blocked by the 7th Circuit in 2015,[35] and the Supreme Court declined review after it held that an identical provision in Texas was found to be unconstitutional under *Whole Woman's Health*.[36]

PHYSICIAN-ONLY REQUIREMENT.

In Wisconsin, abortion care – including medication abortion – can only be provided by a physician.[37] 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.[38] This Wisconsin 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.[39] The law further ignores that organizations like ACOG recommend the pool of abortion providers be expanded to include "appropriately trained and credentialed advanced practice clinicians …."[40]

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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 Wisconsin. Numerous laws in Wisconsin 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 physician-only and admitting privileges laws.**
- **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 Wisconsin 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 12 April 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 12 April 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 12 April 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 12 April 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 11 April 2018, from https://www.nap.edu/24950

[5] The examples discussed in this report are illustrative of the ways in which Wisconsin restricts abortion care and undermines the practice of medicine. Sadly, Wisconsin has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2018, January). *State Facts About Abortion: Wisconsin.* Retrieved 12 April 2018, from https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-wisconsin

[6] Wis. Stat. § 253.10(3)(c)(2)(d) (2017); Wisconsin Department of Health Services. *A Woman's Right to Know* . . . (p. 9). Retrieved 12 April 2018, from https://www.dhs.wisconsin.gov/publications/p4/p40074.pdf

[7] Wis. Stat. § 253.10(3)(c)(2)(d) (2017); Wisconsin Department of Health Services. *A Woman's Right to Know* . . . (p. 10). Retrieved 12 April 2018, from https://www.dhs.wisconsin.gov/publications/p4/p40074.pdf

[8] See, e.g., Anderson, J. G., Baer, R. J., Partridge, J. C., Kuppermann, M., Franck, L. S., Rand, L., . . . Rogers, E. E. (2016). Survival and major morbidity of extremely preterm infants: A population-based study (pp. 3–4). *Pediatrics,* 138(1) (finding that "[a]mong the infants born at 22, 23, and 24 weeks, survival to 1 year of age was 6%, 27%, and 60%, respectively . . . ," but that roughly 66 percent of fetuses born at 23-weeks gestation had more than one major morbidity); Hoekstra, R. E., Ferrara, T. B., Couser, R. J., Payne, N. R., & Connett, J. E. (2004, January). Survival and long-term neurodevelopmental outcomes of extremely premature infants born at 23–26 weeks' gestational age at a tertiary center. *Pediatrics,* 113(1), e1–e6 (demonstrating how, even for extremely premature infants that survive, they are likely to experience long-term, severe health consequences); Lee, S. J., Ralston, H. J. R., Drey, E. A., Partridge, J. C., & Rosen, M. A. (2005, August). Fetal pain: A systematic multidisciplinary review of the evidence (p. 952). *JAMA,* 294(8), 947–954 ("… the capacity for conscious perception of pain can arise only after thalamocortical pathways begin to function, which may occur in the third trimester around 29 to 30 weeks' gestational age, based on the limited data available.").

[9] See note 1.

[10] Wis. Stat. § 253.10(3g)(a)–(b) (2017).

[11] Wis. Stat. § 253.10(3g)(a)(5).

[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 12 April 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 12 April 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 12 April 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 12 April 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] Wis. Stat. § 253.10(3)(c)(1)(gm) (2017).

[16] Wis. Stat. § 253.10(3)(c)(2)(d).

[17] Wis. Stat. § 253.10(3)(c)(1).

[18] 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 16 April 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.

[19] Guttmacher Institute. (2018, January). *Fact Sheet: Induced Abortion in the United States* (p. 1). Retrieved 16 April 2018, from https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf

[20] Institute for Women's Policy Research & National Partnership for Women & Families. (2015, May). *Workers' Access to Paid Sick Days in the States.* Retrieved 16 April 2018, from http://www.nationalpartnership.org/research-library/work-family/psd/workers-access-to-paid-sick-days-in-the-states.pdf

[21] See, e.g., Guttmacher Institute. (2018, January). *Evidence You Can Use: Waiting Periods for Abortion.* Retrieved 16 April 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 16 April 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 16 April 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 16 April 2018, from https://www.aclu.org/other/government-mandated-delays-abortion

[22] Wis. Stat. § 253.105(2) (2017). ("No person may give an abortion-inducing drug to a woman unless the physician who prescribed, or otherwise provided, the abortion-inducing drug for the woman: (a) Performs a physical exam of the woman before the information is provided under s. 253.10(3)(c)1; (b) Is physically present in the room when the drug is given to the woman."). But see Planned Parenthood of Wis., Inc. v. Schimel, 877 N.W. 2d 604, 609, 617 (Wis. App. 2016) (finding that the statute's requirement that the physician be physically present with the woman when the medication abortion drug is "given" should be interpreted as requiring the physician to be physically present when the drug is *dispensed* to the patient, not *administered* to her. In other words, as was at issue in the case, a physician can dispense both prescriptions for medication abortion, and the patient can consume the first drug orally at the center, but then consume the second drug 24 hours later at home (not in the presence of the physician) without violating the statute).

[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 16 April 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] Wis. Stat. § 253.095(2) (2017).

[28] See, e.g., Brief for Amici Curiae Am. Coll. of Obstetricians & Gynecologists et al. in Support of Petitioners at 16–17, 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] Ibid., p. 16.

[30] Ibid.

[31] *Amici Curiae* Brief of Pub. Health Deans et al. 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).

[32] 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 16 April 2018, from http://www.catholicsforchoice.org/wp-content/uploads/2014/01/CFCMemoontheDirectivesweb.pdf

[33] 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.).

[34] See note 28, pp. 18–19.

[35] Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908, 922 (7th Cir. 2015), *cert. denied,* 136 S. Ct. 2545 (2016).

[36] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2310–14 (2016).

[37] Wis. Stat. § 940.15(5) (2017).

[38] 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 16 April 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 16 April 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 16 April 2018, from https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/

[39] See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 17 April 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

[40] Committee on Healthcare for Underserved Women, American College of Obstetricians and Gynecologists. (2014, November). *Committee Opinion No. 613, Increasing Access to Abortion* (p. 1). Retrieved 16 April 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.

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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