

BAD MEDICINE

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

THIRD EDITION



BAD MEDICINE

ABOUT THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

For more than 45 years, the National Partnership for Women & Families has fought for every major policy advance that has helped this nation's women and families.

We work to foster a society in which workplaces are fair and family friendly, discrimination is a thing of the past, women's reproductive health and rights are secure, everyone has access to quality, affordable health care and every person has the opportunity to achieve economic security and live with dignity.

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 and are current as of February 1, 2018.

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Dear Readers,

Since the National Partnership for Women & Families published the last edition of *Bad Medicine* in early 2016, the landscape for abortion rights and access has changed dramatically. The U.S. Supreme Court handed down a landmark decision in *Whole Woman's Health v. Hellerstedt* reaffirming that every woman has a constitutional right to make her own decisions about abortion. The Court made clear that politicians are not allowed to make up facts in order to justify restrictions on abortion, and condemned medically unnecessary restrictions that burden access. And yet, emboldened by the Trump administration, states continue to pass burdensome abortion restrictions that push care further out of reach.

At the federal level, we face threats as never before. The current administration, steeped in misogyny, is using every lever at its disposal to limit women's access to reproductive health

care and roll back our rights. One casualty of its relentless anti-abortion crusade is truth – a cornerstone of our democracy. We see this when the administration appoints a deputy assistant secretary of the U.S. Department of Health and Human Services (HHS) Office of Population Affairs who is on the record saying contraception does not work, and an HHS chief public affairs officer who has promoted the lie that abortion causes breast cancer. We see it when government officials force vulnerable young immigrant women to receive biased “counseling” at fake women's health centers that traffic in misinformation and seek to coerce and shame women. We see it in action after action from this administration – and from like-minded members of Congress – and we know the threats to science, evidence-based policy and women's autonomy could not be more urgent.

Sincerely,



Debra L. Ness
President

The third edition of *Bad Medicine* documents how, over time, this kind of disregard for science and evidence, coupled with hostility toward women's dignity and self-determination, has translated into anti-abortion state laws across the country, and the very real harm these laws cause to women.

This report is also a call to action. We must resist. We must call out elected officials and fight back every time they imperil our health, constrain our lives and endanger our communities. Anti-abortion lawmakers have shamelessly turned lies and misinformation into harmful state laws, and now they are making gains at the federal level. We can and must stop them.

In reading this report, we hope you feel this urgency, too, and that you will continue to fight to protect and expand access to abortion care and justice for all people.



Sarah Lipton-Lubet
Vice President for Reproductive
Health and Rights

Introduction

“[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*

Across the country, politicians are enacting 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. As this report explains, these laws undermine the high-quality, patient-centered care that health care providers and advocates strive to achieve. These laws are political interference with the provision of health care – they are **bad medicine**.

BAD MEDICINE LAWS INCLUDE:ⁱ

- **Biased Counseling Laws:** These requirements dictate the information that a health care provider must give to a patient, including requirements to provide biased or medically inaccurate information.
- **Ultrasound Requirements:** These restrictions require a health care provider to give – and a patient to receive – diagnostic tests that are not supported by evidence, the provider’s medical judgment or the patient’s wishes.
- **Mandatory Delays:** These requirements force a health care provider to delay time-sensitive

care regardless of the provider’s medical judgment or the patient’s needs.

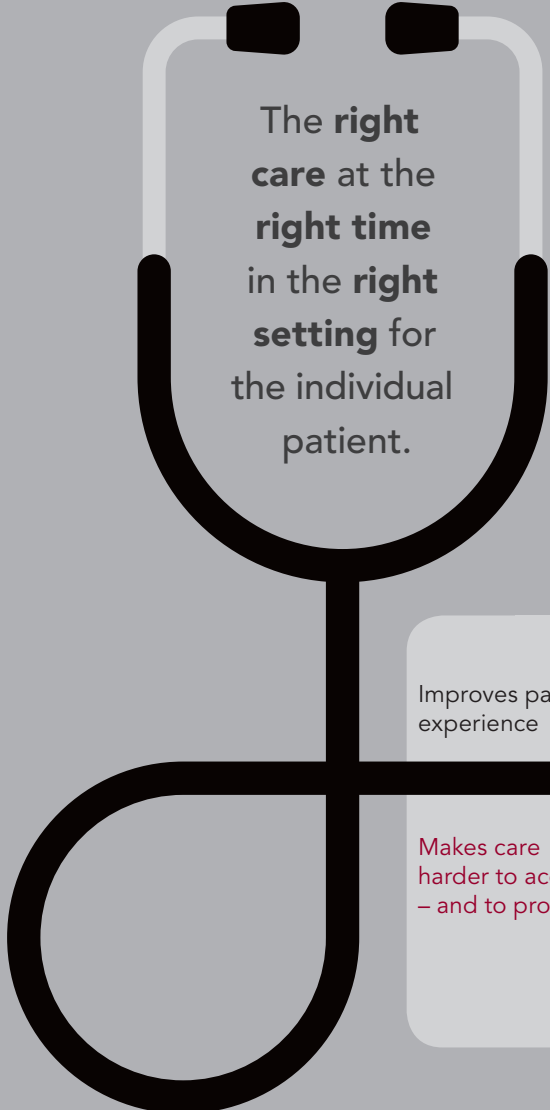
- **Medication Abortion Restrictions:** These restrictions prohibit a health care provider from prescribing medication using the best and most current evidence, medical protocols and methods.
- **Targeted Regulation of Abortion Providers (TRAP Laws):** These restrictions force a health care provider and/or medical facility to conform to burdensome requirements that are not based on scientific evidence, do not further patients’ health or interests and are not required of other health care providers.

This report focuses on the provision of abortion care. However, anti-science, anti-evidence policies are on the rise and have broad, troubling implications for everyone’s health. We all deserve access to scientific advancements and to reliable, accurate, up-to-date information. For politicians to base laws on lies, or to dictate how health care providers treat patients in order to advance a political agenda, undermines women’sⁱⁱ health, violates our dignity and harms us and our families.

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 deliver 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.

ⁱⁱ We use the term “women” in this report, but recognize that barriers to abortion access affect people of many gender identities – transgender, nonbinary and cisgender alike. Barriers to abortion access are often exacerbated for people in the LGBTQ community due in part to added stigma and lack of cultural competency. The National Partnership works to remove these barriers so everyone is able to access the care they need.

WHAT IS QUALITY HEALTH CARE?



The **right care** at the **right time** in the **right setting** for the individual patient.

According to the National Academy of Medicine – an independent, nonprofit organization – quality care is care that meets the patient’s “needs and is based on the best scientific knowledge.”¹ It is the right care at the right time in the right setting for the individual patient.² Quality care aligns with the patient’s values, preferences and needs. It should be accessible and affordable.

Unfortunately, anti-abortion politicians are pushing abortion care in the opposite direction. They are enacting laws that force health care providers to deliver care that is not based on the best medical knowledge and that disregards patients’ needs and interests. These laws make care harder for patients to access and often drive up costs without improving patient experience or health. Anti-abortion lawmakers are also actively promoting junk science and enshrining it into state law.

QUALITY HEALTH CARE...

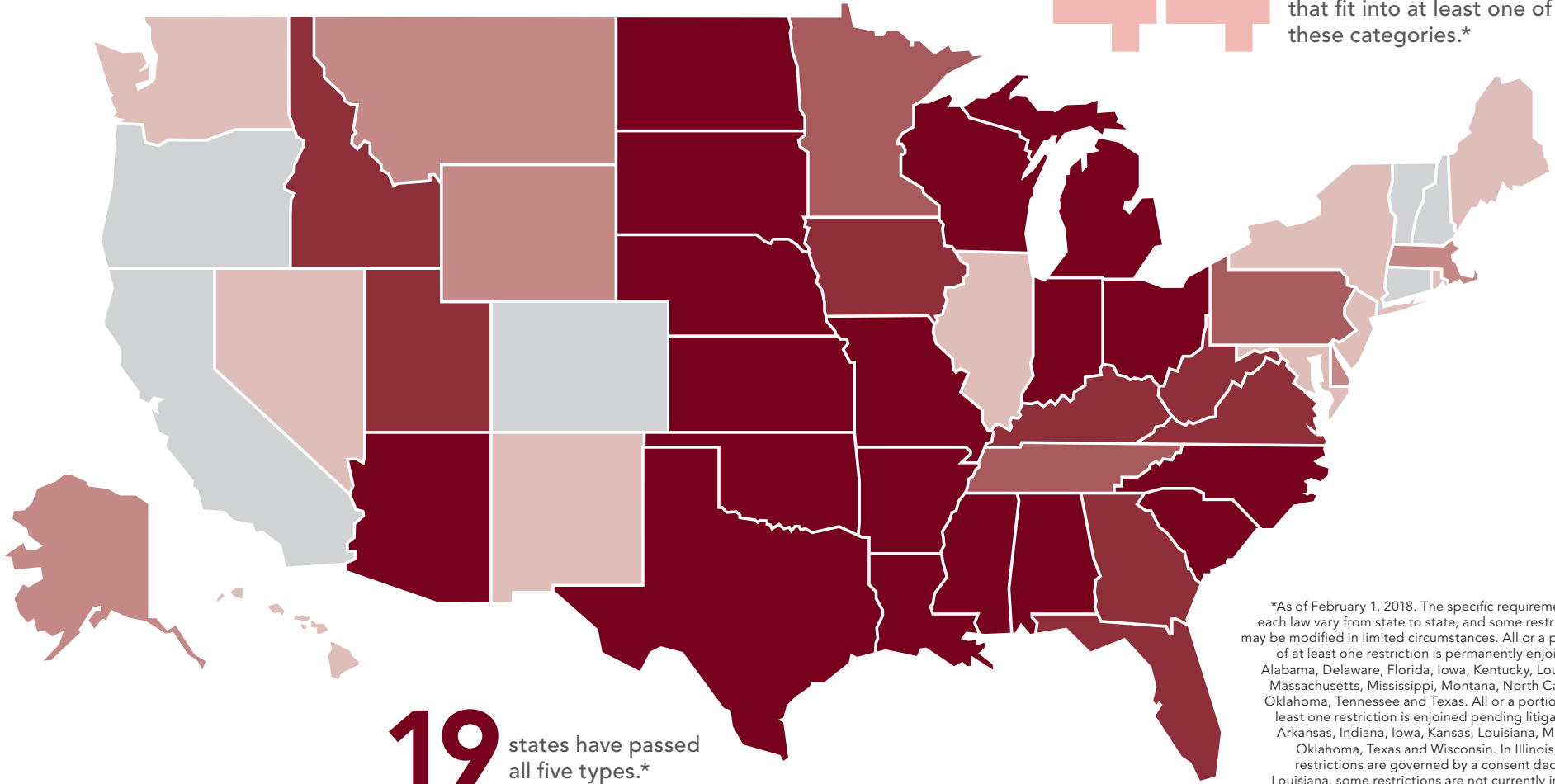
Improves patient experience	Is based on the best scientific evidence	Is centered on patient needs	Improves health outcomes	Makes the best use of health care resources	Follows standards of care
Makes care harder to access – and to provide	Disregards scientific evidence	Forces health care providers to ignore patient needs, experiences and preferences	Forces health care providers to delay time-sensitive care	Increases costs needlessly	Ignores standards of care to advance a political agenda

BAD MEDICINE...

MAPPING BAD MEDICINE LAWS

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states have passed restrictions that fit into at least one of these categories.*



*As of February 1, 2018. The specific requirements of each law vary from state to state, and some restrictions may be modified in limited circumstances. All or a portion of at least one restriction is permanently enjoined in Alabama, Delaware, Florida, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, North Carolina, Oklahoma, Tennessee and Texas. All or a portion of at least one restriction is enjoined pending litigation in Arkansas, Indiana, Iowa, Kansas, Louisiana, Missouri, Oklahoma, Texas and Wisconsin. In Illinois, some restrictions are governed by a consent decree. In Louisiana, some restrictions are not currently in force pending litigation. As used in this report, the term "permanent" indicates that a law has been enjoined and the litigation has concluded.

0 BAD MEDICINE RESTRICTIONS

1 TYPE OF RESTRICTION

2 TYPES OF RESTRICTIONS

3 TYPES OF RESTRICTIONS

4 TYPES OF RESTRICTIONS

5 TYPES OF RESTRICTIONS

Forty-four states have passed at least one of the types of bad medicine laws described in this report; 19 states have passed all five types.³ⁱⁱⁱ Courts have enjoined several of these laws, either permanently or while litigation is pending. As a result, 43 states have at least one restriction in force and in 18 states, all five types of restrictions are in force.⁴

ⁱⁱⁱ As of February 1, 2018. The specific requirements of each law vary from state to state, and some restrictions may be modified in limited circumstances. All or a portion of at least one restriction is permanently enjoined in Alabama, Delaware, Florida, Iowa, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, North Carolina, Oklahoma, Tennessee and Texas. All or a portion of at least one restriction is enjoined pending litigation in Arkansas, Indiana, Iowa, Kansas, Louisiana, Missouri, Oklahoma, Texas and Wisconsin. In Illinois, some restrictions are governed by a consent decree. In Louisiana, some restrictions are not currently in force pending litigation. As used in this report, the term “permanent” indicates that a law has been enjoined and the litigation has concluded.



Biased
Counseling



Ultrasound
Requirements



Mandatory
Delays



Medication
Abortion
Restrictions



TRAP Laws



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 and is foundational to patient-centered care and the patient-provider relationship.⁵ The medical community has well-established standards for informed consent that health care providers have a professional and ethical obligation to follow.⁶ 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 care and make her own decisions and judgments. High-quality, patient-centered care requires providing medically accurate information that is tailored to the patient's individual circumstances.⁷

By contrast, biased counseling laws mandate that providers ensure women receive information that is false, biased, irrelevant or otherwise outside the

medical profession's evidence-based standards of care. These laws require providers to convey statements that are derived from junk science and include lies and misinformation about abortion safety, about the abortion procedure and about women's physical and mental health after abortion.

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 – and often is patently false – a patient can no longer trust that she is receiving the best possible care. This undermines the trust that is essential to the patient-provider relationship and a woman's ability to make informed medical decisions.

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states have passed measures requiring that health care providers give or offer the patient abortion-specific, state-developed written materials (measure is enjoined in Montana).

“The whole point of informed consent is to provide medically accurate information and then to work with the patient to come up with a treatment plan that’s agreeable to them . . . If we’re having to give people incorrect information and then saying, ‘Well, you know, the state requires me to say this. It’s not actually true,’ it undermines the patients’ confidence in us as providers.”

— Dr. Diane Horvath-Cosper in *“A State-by-State List of the Lies Abortion Doctors Are Forced to Tell Women,”* *Broadly*, Aug. 2016

MAPPING BIASED COUNSELING LAWS

Thirty states have passed measures requiring that health care providers give or offer the patient abortion-specific, state-developed written materials.^{8iv} These requirements apply a one-size-fits-all approach and force a woman seeking an abortion to receive information unrelated to her individual circumstances.

Twenty states have requirements that providers give or offer verbal or written statements that are medically inaccurate, biased or false.⁹ These statements include:

- **In 13 states,^{10v} an unfounded assertion that fetuses can feel pain, despite the lack of scientific evidence.¹¹**
- **In eight states,¹² content emphasizing negative emotional responses to abortion, even though it is well documented that an “overwhelming majority” of women feel relief after, and do not regret having, an abortion.¹³**
- **In four states,¹⁴ erroneous statements about the impact of abortion on future fertility.¹⁵**

- **In five states,¹⁶ false links between abortion and breast cancer, despite numerous studies finding that no such link exists.¹⁷**
- **In six states,¹⁸ ideological assertions that personhood begins at conception.**
- **In three states,^{19vi} false or biased information about medication abortion – information that medical experts have deemed to be unsubstantiated, inappropriate and non-scientific.²⁰**

Twenty-four states have requirements that providers give or offer patients descriptions of all common abortion procedures.^{21vii} As procedures vary greatly depending on the stage of gestation, the information presented may be 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.^{22viii} What’s more, research shows that there are rampant inaccuracies about embryonic and fetal development in state informational booklets.²³ Experts found evidence

of misrepresentation regarding accelerated fetal development – meaning a fetus was represented as more developmentally advanced at certain ages than is medically understood. Specifically, characterizations of the development of extremities such as limbs, fingers and toes were inaccurate in nearly 30 percent of state materials studied.²⁴ These statements misinform women seeking abortion and frustrate providers who must work to correct these inaccuracies aloud when counseling the patient for informed consent.²⁵ For details on each restriction by state, see Appendix A.

^{iv} Enforcement is permanently enjoined in Montana.

^v This requirement is not enforced against Planned Parenthood of Indiana due to a court case.

^{vi} Arizona previously had a biased counseling requirement that included inaccurate information about medication abortion reversal. This measure was recently repealed.

^{vii} Enforcement is permanently enjoined in Montana.

^{viii} Enforcement is permanently enjoined in Montana.



Ultrasound Requirements

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

According to best practices and medical ethics, health care providers should administer an ultrasound as part of abortion care when it is necessary for medical purposes or the patient requests it.²⁶ Unfortunately, bad medicine laws require an ultrasound whether or not it is warranted or wanted. Several states force providers to place the ultrasound image in the patient’s view and then give a detailed, pre-scripted description of that image, even if she objects. In some cases, 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 imparts the state’s opposition to abortion.²⁷

Additional mandates such as a mandatory delay after the ultrasound or a requirement

that the ultrasound and the abortion be performed by the same provider can exacerbate the challenges a woman faces in accessing abortion care. 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. Ultrasound requirements also fly 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.”²⁸ It is a violation of medical standards to use a procedure to influence, shame or demean a patient.²⁹ Forced ultrasound, by definition, is not quality care.

“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*

Fake Women's Health Centers Lie to Women

Some states require providers to give patients information about accessing ultrasound services at facilities that do not provide or refer for abortion care. These fake women's health centers are anti-abortion organizations posing as comprehensive health care clinics. Under the guise of providing reproductive health services and pregnancy-related information, many of these fake clinics shame and lie to women to try to prevent them from accessing abortion care.

Often camouflaged as health care facilities and located near abortion clinics, fake women's health centers use deceptive tactics to try to lure women away from facilities that can actually meet their needs.³⁰ Some states provide free advertising for these centers by including them in state materials that doctors are required to give to women, including in state materials that refer women to fake clinics for mandatory pre-abortion ultrasounds.³¹

When a woman enters a fake health center, she may be forced to undergo biased counseling or religious seminars.³² Often, she hears false claims about fetal development and the health effects and safety of abortion care³³ (which is one of the safest medical procedures in the United States).³⁴ Fake women's health centers peddle lies that have been repeatedly discredited by extensive scientific research and the country's most prominent medical associations.³⁵

During an ultrasound, personnel at these centers sometimes lie further, presenting inaccurate medical information, providing erroneous readings or even misrepresenting how far along a woman is in her pregnancy.³⁶

Bad medicine ultrasound laws are made worse when women are referred to deceptive fake clinics where they also face unwanted biased counseling.

MAPPING ULTRASOUND REQUIREMENTS

Twenty-seven states regulate the provision of ultrasound by abortion providers.³⁷^x 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, potentially including forced referral to an anti-abortion center; or requiring a provider to offer specific information if an ultrasound is already included in the patient's care.³⁸

Of the 27 states regulating ultrasound by abortion providers, 15 have passed laws mandating an ultrasound before an abortion.³⁹ Of those 15 states, six have passed laws requiring the provider to display and describe the image, forcing the provider to give – and the patient to receive – information the patient may not want or need.⁴⁰^x Most other states with ultrasound mandates require the provider to offer the patient the opportunity to see the image.⁴¹ Early in pregnancy, a transvaginal ultrasound may be necessary to meet the requirements of many of these laws.⁴²

In addition to the laws mandating ultrasounds, 21 states have laws regulating pre-abortion

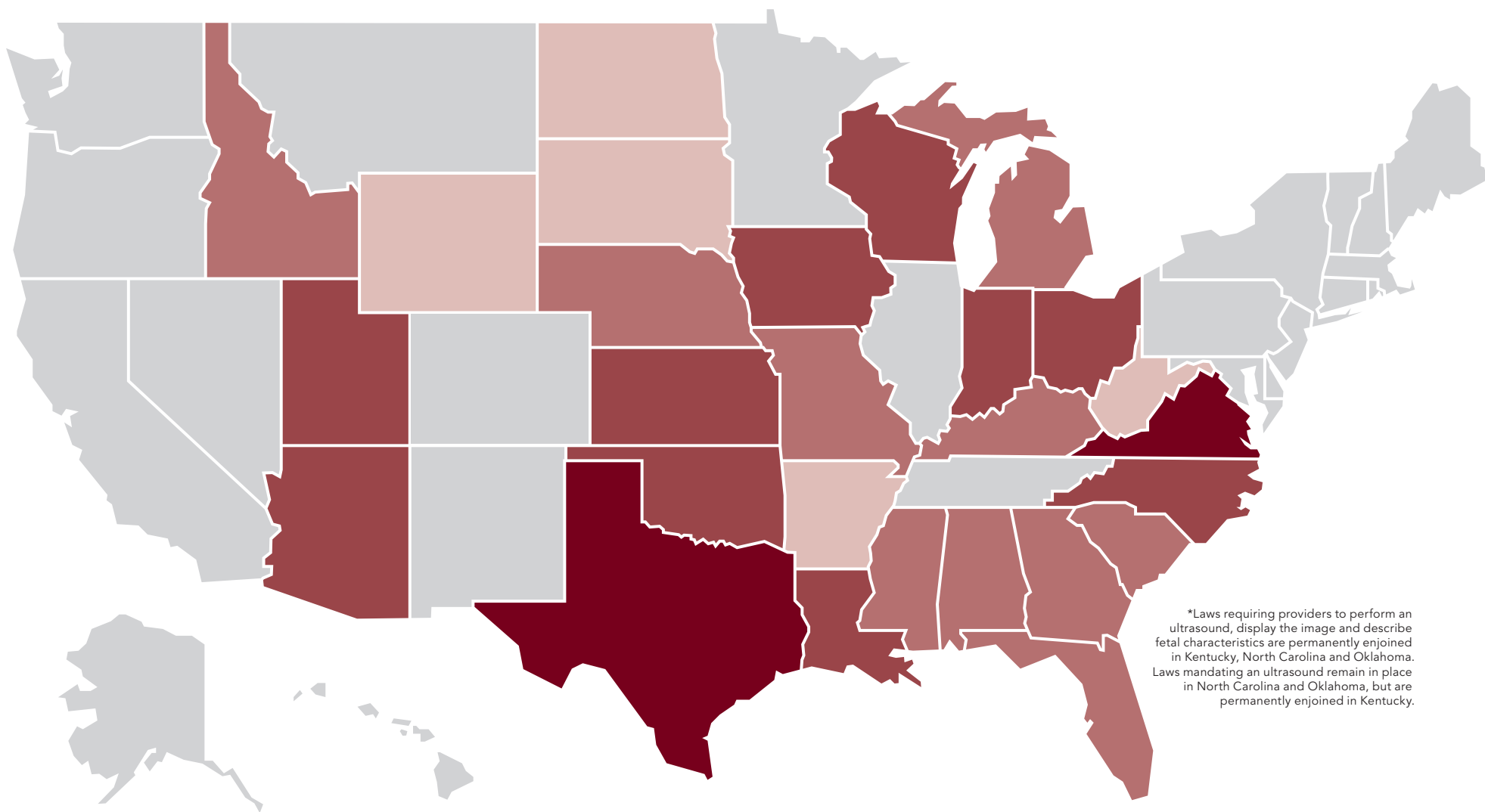
ultrasound in other ways.⁴³ In six states, the provider is required to offer an ultrasound.⁴⁴ In nine states, a patient must be explicitly offered the opportunity to view the ultrasound image if the provider performs one.⁴⁵ Fourteen states require that the woman be given or offered information on how to access ultrasound services.⁴⁶

In four states, the ultrasound must take place at least 24 hours before the abortion procedure for most women,⁴⁷ thus creating a mandatory delay of a time-sensitive procedure without regard for the wishes of the patient and without any medical rationale. For details on each restriction by state, see Appendix B.

^x Enforcement is permanently enjoined in Kentucky.

^x Enforcement is permanently enjoined in Kentucky, North Carolina and Oklahoma.

MAPPING ULTRASOUND REQUIREMENTS*



*Laws requiring providers to perform an ultrasound, display the image and describe fetal characteristics are permanently enjoined in Kentucky, North Carolina and Oklahoma. Laws mandating an ultrasound remain in place in North Carolina and Oklahoma, but are permanently enjoined in Kentucky.

0 TYPES OF RESTRICTIONS

1 TYPE OF RESTRICTION

2 TYPES OF RESTRICTIONS

3 TYPES OF RESTRICTIONS

4 TYPES OF RESTRICTIONS



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 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 National Academy of Medicine: that care should be timely, according to medical need and in the patient's best interests.⁴⁸ 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 a woman receive specific information or an ultrasound before a delay period begins. In many states, this means women must make at least one extra trip to the clinic for no medical reason.⁴⁹ By contrast, quality health care reduces duplicative, unnecessary medical visits for the patient.⁵⁰

According to the World Health Organization (WHO):

“Information, counselling 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.”⁵¹

In other words, a patient – not the state – should make decisions about timing.

Mandatory delays compound the problems created by the national shortage of abortion providers, forcing some women to wait even longer for care than the state-mandated period. Eighty-nine percent of counties in the United States do not have a single abortion clinic.⁵² Even in counties that do have one or more clinics, abortion services might be available only on certain days. Some states have only one clinic that offers abortion care,⁵³ and some clinics rely on physicians to fly in from out of state.⁵⁴

Given the provider shortage, many women must travel long distances to reach an abortion clinic. In fact, one in five women has to travel 42 miles or more to reach the nearest abortion clinic – a significant barrier, particularly for low-income women.⁵⁵ Most women seeking abortion care have already had at least one child⁵⁶ and thus may need to secure child care in addition to transportation and time off work. In states that require at least two trips to a clinic, women may have to do each of those things at least twice. Because there is no federal law allowing private sector employees to

earn paid sick days, and because 32 percent of private sector workers in the United States cannot earn a single paid sick day,⁵⁷ many women must go without pay, and even risk losing their jobs, to make these trips. Mandatory delays place the heaviest burden on rural, young and low-income women, exacerbating health disparities.⁵⁸ Access to quality health care should not depend on where a patient lives or how much money she makes.

MAPPING MANDATORY DELAYS

Thirty-two states have passed laws imposing a mandatory delay before a woman can have an abortion.^{59xi} Of these, 16 states have requirements that a woman receive state-mandated counseling in person, necessitating at least two trips to a clinic.^{60xii} In most states, the mandatory delay is 24 hours. It is 48 hours in Alabama, Arkansas and Tennessee and 72 hours in Iowa, Missouri, North Carolina, Oklahoma, South Dakota and Utah. South Dakota excludes weekends and state holidays from the 72-hour mandatory delay,⁶¹ meaning some women must wait at least six days if a long weekend follows her first appointment. For details on each restriction by state, see Appendix C.

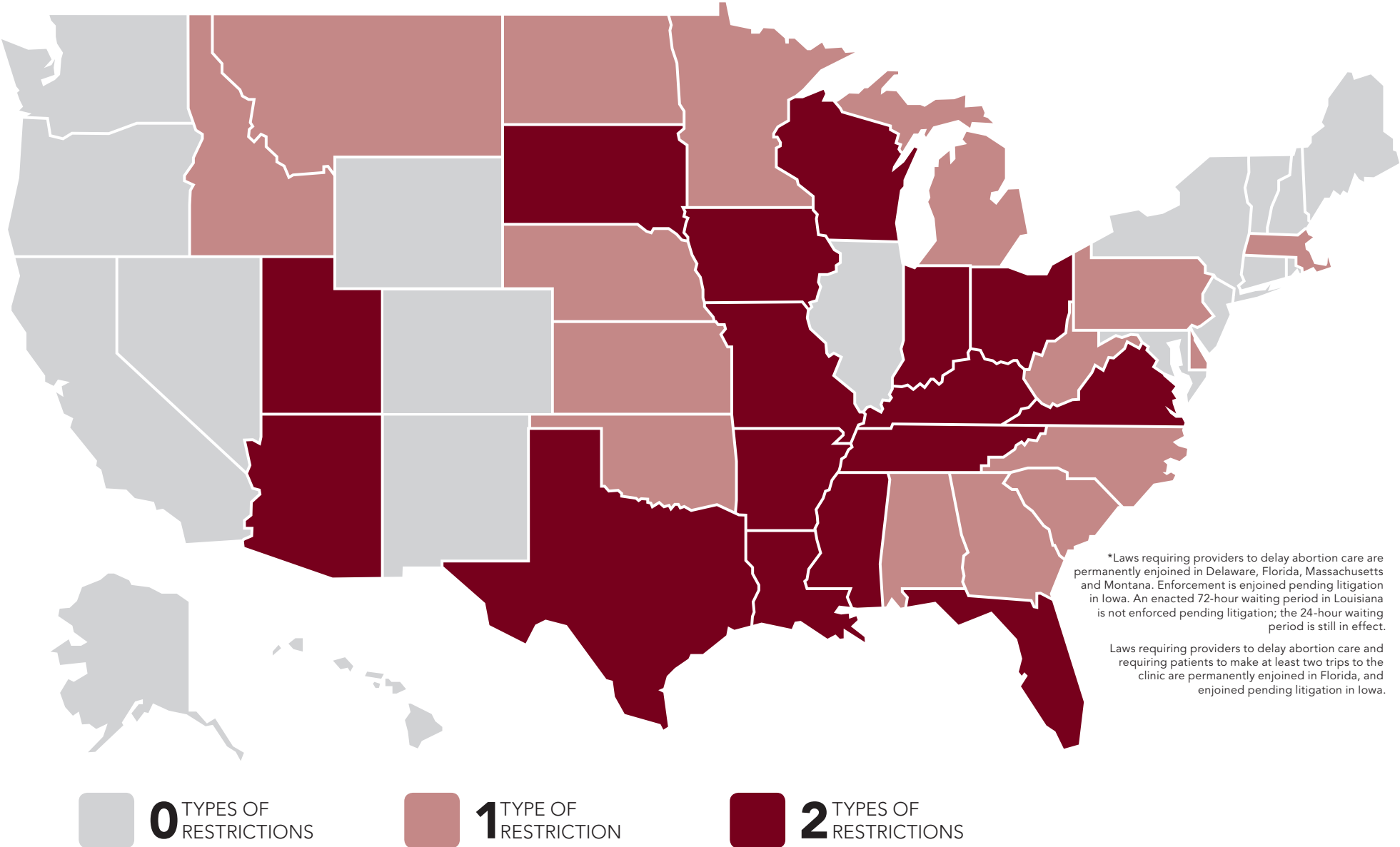
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states have passed laws imposing a mandatory delay before a woman can have an abortion (laws are enjoined in some states).

^{xi} Enforcement is permanently enjoined in Delaware, Florida, Massachusetts and Montana. Enforcement is enjoined pending litigation in Iowa. An enacted 72-hour waiting period in Louisiana is not enforced pending litigation; the 24-hour waiting period is still in effect.

^{xii} Enforcement is permanently enjoined in Florida. Enforcement is enjoined pending litigation in Iowa.

MAPPING MANDATORY DELAYS*

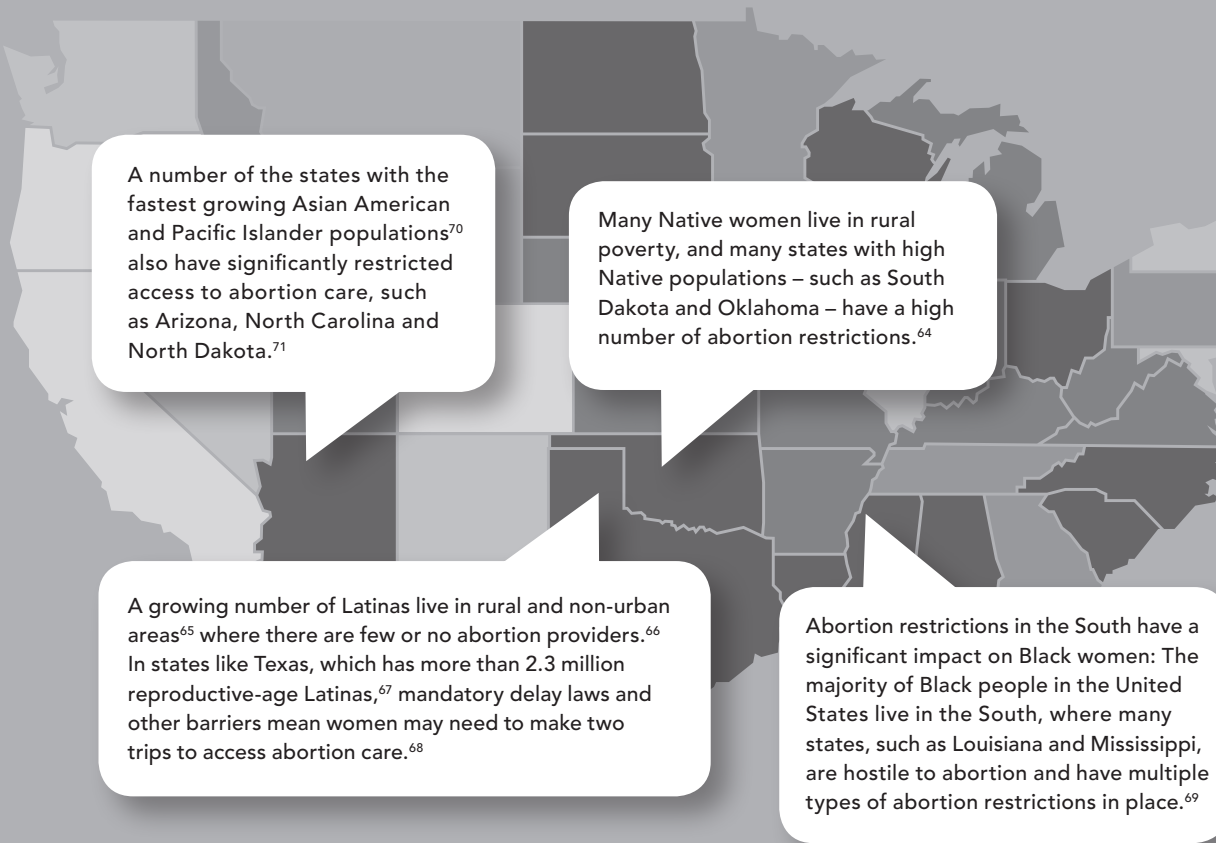


Bad Medicine Laws Disproportionately Harm Women of Color

As a result of many factors, including systemic racism, women of color disproportionately face geographic, transportation, infrastructure and economic barriers to obtaining abortion care.

Women of color are too often unable to afford abortion care and forced to decide between paying for necessities such as rent or groceries and paying for an abortion. This is due in part to coverage bans – abortion restrictions that prohibit coverage for abortion in public or private health insurance, or make it more difficult to obtain. These bans – a result of the federal Hyde Amendment and similar state laws – effectively deny women access to abortion based on how much money they have.

Women of color live at the intersection of multiple disparities and structural barriers that lead to a higher likelihood of being Medicaid-eligible and therefore, subject to Hyde. In addition, women of color are more likely to work in jobs that lack the supports that help women raise families, like paid leave, fair pay and freedom from pregnancy discrimination.



Bad medicine laws compound the negative effects of coverage bans, creating additional barriers to abortion care that affect women of color the most. Women of color are also often dealing with a distrust of the health care system due to a legacy of reproductive control and years of coercive policies and practices based on race.⁶² This distrust can be exacerbated by bad medicine laws that undermine the patient-provider relationship and access to care.⁶³ The map at left highlights just a few examples of the disproportionate impact of bad medicine laws on communities of color.

Across the country, women of color are leading the fight against abortion restrictions that harm their communities. Check out *In Our Own Voice: National Black Women’s Reproductive Justice Agenda*, *National Latina Institute for Reproductive Health*, *National Asian Pacific American Women’s Forum* and *Native American Women’s Health Education Resource Center* for expert analyses of health disparities and to see their policy priorities and recommendations.⁷²



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 number of states have passed laws that prohibit providers from administering medication abortion according to the most up-to-date medical standards, or prevent providers from using advances in medical technology. These laws undermine quality care by restricting a patient's ability to access appropriate, effective care when and where she needs it.

Medication abortion involves the use of medications to end a pregnancy.⁷³ A patient usually takes two different medications, one or more days apart, according to her provider's written and verbal guidelines. This method is medically indicated for certain women; others may choose it because it provides more control and privacy.⁷⁴ This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure.⁷⁵ Like all types of abortion care, medication abortion is overwhelmingly safe; the rate of complications is exceedingly low – lower, in fact, than for commonly used drugs currently available without a prescription.⁷⁶

Despite its proven safety, many states impose restrictions on medication abortion, including:

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

PROHIBITIONS AGAINST TELEMEDICINE

Telemedicine is the delivery of a health care service or the transmission of health information using telecommunications technology.⁷⁷ One common method uses video conferencing to allow a patient to interact with a remote provider.⁷⁸ Telemedicine makes health care more accessible, especially to people in underserved areas, yet some states prohibit providers from using it to administer medication abortion. According to the American College of Obstetricians and Gynecologists (ACOG), “[T]elemedicine is safe, effective, highly acceptable to patients, and facilitates access to care for women in rural areas.”⁷⁹

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.⁸⁰

Telemedicine can improve the quality and efficiency of health care, and is becoming more widespread across the United States.⁸¹ For example, telemedicine is used regularly to expand access to mammography, chronic disease management, stroke diagnosis and treatment, high-risk pregnancy management and primary care.⁸²

“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,”* *Ibis Reproductive Health*, July 2011

It can be particularly important for connecting the 19 million rural women in the United States⁸³ to care because of the significant shortage of reproductive health providers in rural areas.⁸⁴ Studies and practice have shown that telemedicine can reduce health disparities for rural women and increase access to specialty care.⁸⁵

Medication abortion via telemedicine is an effective way to improve access to and timeliness of care and offers a high degree of patient satisfaction. Studies comparing medication abortion provided in person with telemedicine medication abortion show equivalent effectiveness and rates of positive patient experience.⁸⁶ As ACOG has noted, the two types of visits are “medically identical.”⁸⁷ In one study, telemedicine patients reported particularly valuing being able to receive abortion care at clinics closer to their homes, and the vast majority of patients reported they would recommend telemedicine to their friends.⁸⁸

Despite the proven safety and success of telemedicine abortion, many states subvert quality care by banning this effective, accessible method of abortion care.

⁸³ We use the term “women with disabilities” in this report, which is derived from the “people-first approach” taken in the United Nations’ *Convention on the Rights of Persons with Disabilities*. We acknowledge that some activists prefer “disabled people” as a way to reflect “structural barriers to social inclusion as the main problem, rather than the impairment itself.” Center for Reproductive Rights. (2017, May). *Shifting the Frame on Disability Rights for the U.S. Reproductive Rights Movement* (p. 3). Retrieved 30 January 2018, from <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Disability-Briefing-Paper-FINAL.pdf> (describing how the reproductive rights movement can incorporate a disability lens).

Bad Medicine Laws Disproportionately Harm Women With Disabilities

Twenty percent of women in the United States have disabilities,^{xiii} and yet they are often left out of conversations about abortion rights. This can be due to misinformation about women with disabilities, a lack of knowledge, or general discomfort with discussing disability and abortion in the same article or report. In fact, women with disabilities are disproportionately affected by abortion restrictions.

In addition to the fact that many states’ counseling materials are biased or inaccurate, they may also fail to include information specific to the reproductive needs and lives of women with disabilities. Mandatory delays that require two or more trips to the clinic can be especially difficult for women with disabilities, who often face challenges getting around, whether because of mobility issues (including inadequate accessibility of public transit options) or other reasons.⁸⁹ This is compounded when women live in rural areas where public transportation is lacking, and because women with disabilities who live in non-metropolitan areas are more likely to be living on an extremely low income.⁹⁰ Because telemedicine increases access to health care for people with disabilities, telemedicine abortion bans disproportionately harm women with disabilities. Abortion provider scarcity is worse for women with disabilities, who have the additional hurdle of finding a provider that is accessible, physically and/or culturally. All of these barriers are exacerbated by the fact that many women with disabilities rely on Medicare or Medicaid for insurance,⁹¹ and are therefore denied coverage for abortion care because of the Hyde Amendment. Due in part to discrimination against people with disabilities more broadly, women with disabilities are more likely to be living on a low income or without work, further limiting their access to care.⁹² Finally, women with disabilities face heightened abortion stigma, particularly because of the history of eugenics and the continued risk of coercion regarding their health care decision-making.⁹³

It is critical that the reproductive rights community center the voices, experiences and leadership of women with disabilities in advocacy around abortion care and access.

PROHIBITIONS ON THE USE OF EVIDENCE-BASED STANDARDS

Several states prohibit the use of evidence-based prescribing for medication abortion. In these states, providers are required to adhere to the U.S. Food and Drug Administration (FDA) protocol that is found on the label for mifepristone (brand name Mifeprex), the first of two drugs in a medication abortion regimen.⁹⁴ When these restrictions were enacted, the FDA label was significantly outdated, and requiring adherence to the outdated label substantially limited providers' ability to give their patients the best care. Under these restrictions, providers had to give a higher dosage of mifepristone than necessary and were unable to provide medication abortion beyond seven weeks of pregnancy, even though research and practice have shown it is effective through at least 10 weeks.⁹⁵ A study examining the effects of Ohio's law prohibiting evidence-based prescribing for medication abortion found that patients were three times more likely to need additional intervention to complete their abortion than was the case prior to the law's enactment, when providers were permitted to administer medication abortion using the most up-to-date standards and research.⁹⁶

The way a drug is administered often evolves after the FDA has approved its use. Providers adjust practice based on experience, research and clinical studies that occur in the years after FDA approval.⁹⁷ It is common practice – and often 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.⁹⁸ The FDA label itself is usually only updated if the manufacturer requests it and completes a complicated and expensive updating process.⁹⁹ As ACOG has explained, “[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.”¹⁰⁰ The American Medical Association (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 off-label indication when such use is based upon sound scientific evidence or sound medical opinion”¹⁰¹ Nonetheless, laws restricting medication abortion in this way can make it illegal for a health care provider to follow the most up-to-date standard of care.

In 2016, the FDA updated the medication abortion label for Mifeprex to reflect the evidence-based regimen developed since the drug's initial approval in 2000.¹⁰² The update reduced the required dosage of medication, decreased the number of visits a woman must make to her health care provider and extended the timeframe in which the drug has been shown to be effective from seven weeks to 10 weeks of pregnancy.¹⁰³

Despite the important update to the FDA label, providers in states with FDA label adherence requirements will still be limited in their ability to provide the most up-to-date care as the label becomes outdated again.¹⁰⁴ This restriction not only undermines women's access to a safe option for abortion care, but also threatens a central tenet of the practice of medicine: that evidence and research inform improvements in treatment.

Risk Evaluation and Mitigation Strategy (REMS): Needlessly Impeding Access to Medication Abortion

When the U.S. Food and Drug Administration (FDA) updated the label for Mifeprex (the brand name for the mifepristone pill in a medication abortion regimen), it left in place a REMS, a requirement for heightened risk management “intended for drugs that are known or suspected to cause serious adverse effects that cannot be mitigated simply by the label instructions.”¹⁰⁵ Given the overwhelming evidence that Mifeprex is safe, the REMS in this case serves to impede access to medication abortion without any medical benefit.¹⁰⁶ In fact, the imposition of a REMS on Mifeprex can be incredibly harmful for some women because it substantially reduces access to a safe medication.

For example, because of the REMS, if providers at a hospital, medical office or clinic want to stock Mifeprex, they must register with the drug manufacturer.¹⁰⁷ Meeting this requirement is difficult or unachievable for some health care providers for a number of reasons. First, some providers must navigate administrative opposition to abortion at their hospital or medical clinic, and the institution may withhold registration approval.¹⁰⁸ Second, some providers are unfamiliar with the process of certification, contracting and ordering that is required to provide Mifeprex – a process far more complicated than for the vast majority of drugs.¹⁰⁹ Third, due to violence against and harassment of abortion providers¹¹⁰ – illustrated most recently by the murder of several people at a Colorado abortion clinic¹¹¹ – some would-be providers are uncomfortable with having their names on the drug manufacturer’s list of medication abortion providers lest that list be made public.¹¹²

Many professional and academic organizations oppose the imposition of a REMS on Mifeprex. The American College of Obstetricians and Gynecologists, the American Public Health Association and the Society of Family Planning, along with other medical and scientific experts, have asked the FDA to eliminate the Mifeprex REMS.¹¹³ Moreover, it is clear that Mifeprex fails to meet the FDA’s own criteria for imposing a REMS.¹¹⁴ For example, in a 2016 review, a team of FDA experts stated that the Mifeprex Patient Agreement Requirement of the REMS “is duplicative of informed consent laws and standards, ‘does not add to safe use conditions . . . and is a burden for patients.’”¹¹⁵

In a recent case, the American Civil Liberties Union (ACLU) of Hawai’i argued that the imposition of a REMS on Mifeprex is unconstitutional, in part because it creates an undue burden on abortion access.¹¹⁶ Indeed, the REMS delays timely care when a clinician cannot provide the patient with both drugs required for a medication abortion.¹¹⁷ Instead, the patient has to make yet another trip to another provider for that medication. For patients in the ACLU of Hawai’i case, this means they have to fly to another island because there are no medication abortion providers on Kaua’i.¹¹⁸ The case highlights that “the Mifeprex REMS makes health care less safe and more costly for rural women”¹¹⁹ and that the REMS disproportionately affects people of color and women who are already struggling financially.¹²⁰

MAPPING MEDICATION ABORTION RESTRICTIONS

Twenty-one states have passed medically unnecessary restrictions on how providers can administer medication abortion.^{121xiv} Twenty states have passed measures prohibiting providers from administering medication abortion via telemedicine.^{122xv} Five 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.^{123xvi} Four states have passed both of these restrictions.^{124xvii} For details on each restriction by state, see Appendix D.

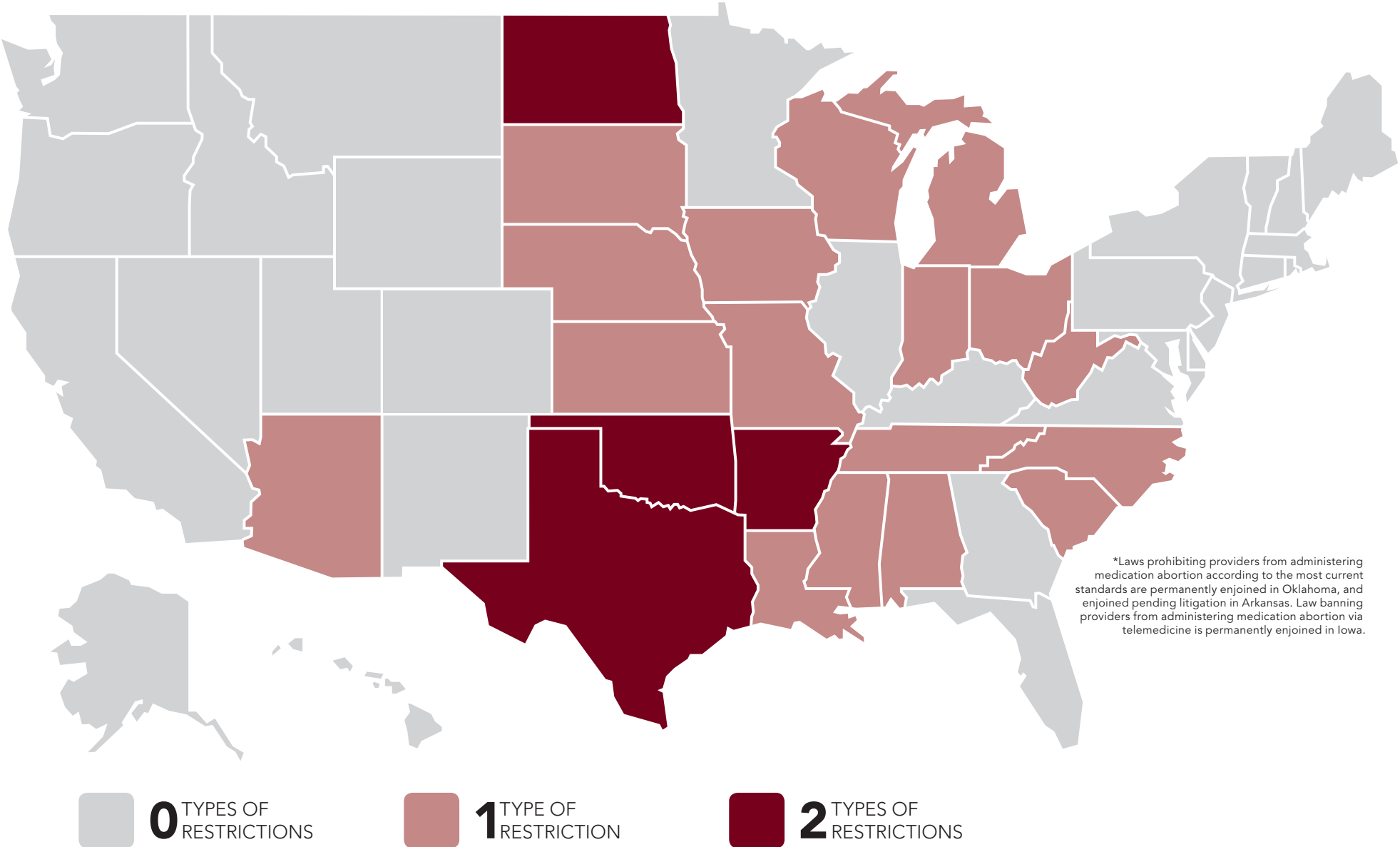
^{xiv} Enforcement of at least one medication abortion restriction is permanently enjoined in Iowa and Oklahoma, and enjoined pending litigation in Arkansas. Arizona and Idaho both previously had restrictions on medication abortion that they recently repealed.

^{xv} Enforcement is permanently enjoined in Iowa.

^{xvi} Enforcement is permanently enjoined in Oklahoma, and enjoined pending litigation in Arkansas.

^{xvii} In states that have passed both medication abortion restrictions, enforcement of the FDA protocol restriction is permanently enjoined in Oklahoma and enjoined pending litigation in Arkansas.

MAPPING MEDICATION ABORTION RESTRICTIONS*





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 do not apply to comparable medical facilities and health care providers. While proponents of these restrictions often pass them under the guise of supporting “patient safety,” in truth they make it harder for women to access care because they force clinics to close and drive experienced providers out of practice. The U.S. Supreme Court recognized this in *Whole Woman’s Health v. Hellerstedt* when it struck down two TRAP laws in Texas. Similar laws across the nation are falling with the help of the standard established in that case.

The reality is that abortion is one of the safest medical procedures in the United States.¹²⁵ 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.¹²⁶ In the rare instances when adverse

effects did occur, the majority were so minor that they could be handled promptly at the clinic.¹²⁷ Despite this impressive safety record, state after state has enacted TRAP laws, including:

- **Requiring abortion clinics to meet certain facilities standards comparable to those for ambulatory surgical centers (ASCs), or to meet other medically unnecessary facility licensing requirements;**
- **Mandating that abortion providers obtain admitting privileges at a hospital near their practice;**
- **Mandating that an abortion be provided only by a physician, barring other trained clinicians from providing care; and**
- **Requiring providers and clinics to cremate or bury embryonic and fetal tissue from abortions.**

“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, the American Medical Association, the American Academy of Family Physicians and the American Osteopathic Association in *Amicus Brief Supporting Certiorari in Whole Woman’s Health v. Hellerstedt*, Oct. 2015

TRAP laws provide no medical benefit, force clinics to close, raise the cost of care, increase the distance women must travel and may increase the time women must wait to obtain care.¹²⁸ Each of these burdens undermines efforts to create a health care system that delivers better care and better outcomes while reducing costs.¹²⁹

ASC AND OTHER FACILITY LICENSING REQUIREMENTS

ASCs are designed for the delivery of complex and invasive surgeries historically provided in hospital settings.¹³⁰ Before the U.S. Supreme Court’s 2016 decision in *Whole Woman’s Health*, nearly half the states had policies in place requiring abortion clinics to meet specifications comparable to those required of ASCs.^{131xviii} As of February 1, 2018, four ASC requirements have been repealed or enjoined based on the standard in *Whole Woman’s Health*.¹³²

In the *Whole Woman’s Health* decision, the 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.”¹³³ 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.”¹³⁴ It also found that patients “will not obtain better care or experience more frequent positive outcomes” at ASCs.¹³⁵ The Court determined that abortion procedures were “safer than numerous procedures that take place outside hospitals and to which Texas 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].”¹³⁶

Despite the decision, many states still have ASC requirements,^{137xix} and others impose non-ASC facility licensing requirements on abortion clinics, driving up the cost of care and making it more difficult for clinics to remain open.¹³⁸

A review of 57 studies of complications from first trimester aspiration abortion found the number of major complications was similar for office-based settings, hospital-based settings and ASCs.¹³⁹ Moreover, when complications did occur, they were effectively managed at the clinic, regardless of whether the clinic was subject to ASC requirements.¹⁴⁰ Physicians’ offices and clinics are similarly equipped to provide second trimester abortion procedures.¹⁴¹ In

fact, many procedures comparable to abortion care – including hysteroscopy, sigmoidoscopy, management of early pregnancy loss (miscarriage) and vasectomy – are routinely performed in office and clinic settings.¹⁴² In other words, there is no evidence that forcing clinics providing abortion care to meet ASC specifications provides a benefit to patients.¹⁴³

Medically unnecessary 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.¹⁴⁴ Indeed, in a number of states, unnecessary facility requirements even apply to clinics that provide medication abortion, for which a health care provider merely prescribes and dispenses medication.¹⁴⁵ 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.”¹⁴⁶ Similarly, the WHO has cautioned against “excessive requirements for infrastructure, equipment, or staff that are not essential to the provision of safe services”¹⁴⁷ and counseled that facility requirements that are not

^{xviii} As of May 1, 2016, enforcement was enjoined pending litigation in Kansas and Texas. In Illinois, the law is governed by a consent decree.

^{xix} In Illinois, this restriction is governed by a consent decree. Enforcement is permanently enjoined in Tennessee and Texas, and enjoined pending litigation in Kansas and Missouri.

evidence-based nor tied to safety and efficiency should be eschewed.¹⁴⁸

When clinics close because of these types of burdensome restrictions, women seeking abortion care face longer wait times for appointments,¹⁴⁹ must travel farther to access care¹⁵⁰ and, in some cases, are turned away altogether.¹⁵¹ This undermines quality care by reducing access, increasing costs and harming women's health.

HOSPITAL ADMITTING PRIVILEGES AND RELATED REQUIREMENTS

A number of states have passed laws requiring abortion providers to maintain admitting privileges or an alternative formal admitting arrangement with a hospital in a certain geographic range.¹⁵² 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, as the Supreme Court recognized in *Whole Woman's Health*.

One of the Texas abortion restrictions at issue in *Whole Woman's Health* required physicians providing abortions to obtain admitting privileges at a hospital within 30 miles of the abortion clinic.¹⁵³ The Supreme Court rejected Texas' pretense that the law protected women's health and found that the admitting privileges provision did not "confer[] medical benefits sufficient to justify the burdens upon access that [it] impose[d]."¹⁵⁴ Relying on peer-reviewed studies and expert testimony, the Court "found nothing . . . that show[ed]" the provisions

improved women's health, adding that Texas could not produce evidence "of a single instance in which the [admitting privileges] requirement would have helped even one woman obtain better treatment" ¹⁵⁵

In the modern health care system, hospitals rely on hospitalists (physicians focused primarily on "general medical care of hospitalized patients"),¹⁵⁶ not outside physicians, to provide care on-site.¹⁵⁷ 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.¹⁵⁸

Similarly, admitting privileges are irrelevant to a patient's ability to 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.¹⁵⁹ Moreover, emergency room admission is unlikely – abortion clinics have the staffing, training and equipment to handle the rare adverse events that occur.¹⁶⁰

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.¹⁶¹ Some hospitals only grant admitting privileges to physicians who accept faculty appointments.¹⁶² 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.¹⁶³ Some

hospitals only grant privileges to physicians who live within a certain radius of the hospital.¹⁶⁴ And hospitals that adhere to religious directives that run counter to established medical standards¹⁶⁵ may refuse to grant privileges to abortion providers.¹⁶⁶ None of these reasons are related to ensuring 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."¹⁶⁷ Moreover, the AMA, ACOG, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have all concluded that "[r]equiring that clinicians obtain hospital privileges – when such privileges may be denied for reasons unrelated to the quality of care that they provide – does not promote the wellbeing of . . . women."¹⁶⁸

Stopping Bad Medicine Laws: The Implications of the *Whole Woman's Health v. Hellerstedt* Decision

“Targeted Regulation of Abortion Providers laws like H.B. 2 that ‘do little or nothing for health, but rather strew impediments to abortion’ cannot survive judicial inspection.”

— U.S. Supreme Court Justice Ruth Bader Ginsburg, concurring in *Whole Woman's Health v. Hellerstedt*, June 2016

In June 2016, in the most significant abortion rights case in a generation, the U.S. Supreme Court struck down two Texas abortion restrictions as unconstitutional.¹⁶⁹ The Court made clear that states are not allowed to make up facts to justify restrictions on abortion – an unfortunately common practice.¹⁷⁰ 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.¹⁷¹ This was a victory for science and abortion rights alike. With this decision, the Court paved the way for legal challenges to medically unnecessary abortion restrictions in states across the country, as well as undergirded a proactive push by abortion rights advocates to fight back against lawmakers who are trying to turn lies into anti-abortion laws.

Using the case, advocates have made great strides in changing the landscape of abortion restrictions. In some states, proponents of abortion access have used the *Whole Woman's Health* decision in litigation that challenges medically unnecessary abortion restrictions. In other states, legislators and policymakers have repealed or attempted to repeal abortion restrictions like those struck down in *Whole Woman's Health*. For example, in 2017, the Virginia State Board of Health amended its regulations to remove ambulatory surgical center and transfer agreement requirements, using the *Whole Woman's Health* decision as support.¹⁷² Additionally, several Pennsylvania state senators proposed repealing an ambulatory surgical center requirement from a health care facilities licensing statute after the decision was issued.¹⁷³ In Georgia, Missouri, North Carolina, Texas and Virginia, abortion rights advocates have been working with lawmakers to introduce the “Whole Woman’s Health Act,” a model bill that would help protect women and abortion providers from medically unnecessary regulations.¹⁷⁴

Despite this progress, some states continue to defend unconstitutional abortion laws in litigation, blatantly ignoring Supreme Court precedent in order to block women’s access to care.

PHYSICIAN-ONLY REQUIREMENTS

Despite evidence that advanced practice clinicians such as nurse practitioners, certified nurse-midwives and physician assistants can safely and effectively provide abortion care,¹⁷⁵ most states require provision by a physician, including for medication abortion.¹⁷⁶ These laws ignore the extensive training that advanced practice clinicians have in providing primary health care, managing conditions and performing procedures that are more complex than abortion.¹⁷⁷

ACOG states in its guidelines on medication abortion that “[i]n addition to physicians, advanced practice clinicians, such as nurse-midwives, physician assistants, and nurse practitioners, possess the clinical and counseling skills necessary to provide first-trimester [medication] abortion.”¹⁷⁸ ACOG has similarly recommended that the pool of aspiration abortion providers be expanded to include “appropriately trained and credentialed advanced practice clinicians”¹⁷⁹

A study conducted by the Advancing New Standards in Reproductive Health program at the University of California, San Francisco evaluated the safety, effectiveness and level of patient satisfaction associated with advanced practice clinicians in providing abortion care. Researchers confirmed that advanced practice clinicians can be trained to successfully provide first trimester aspiration abortion procedures as safely and effectively as physicians. Additionally, patients reported high satisfaction with their experience, whether an advanced practice clinician or a physician provided their care.¹⁸⁰

Some states take the physician-only requirement further by mandating that abortion providers obtain and maintain additional credentials, such as board certification in obstetrics and gynecology. Physicians licensed in many specialties – such as family medicine and pediatrics – can safely provide abortion care.¹⁸¹ Unnecessarily narrow credentialing requirements “improperly regulate medical care” without improving patient care overall.¹⁸²

Allowing advanced practice clinicians to provide abortion care can help reduce barriers to care created by the shortage of abortion providers.¹⁸³ Professional medical associations recognize the importance of advanced practice clinicians as abortion providers and their role in increasing the number of qualified providers.¹⁸⁴ However, by imposing non-evidence-based physician-only requirements, states cut off a crucial avenue for improving access to much-needed care.

BURIAL OR CREMATION REQUIREMENTS FOR EMBRYONIC AND FETAL TISSUE

Recently, several states have begun to require that providers bury or cremate embryonic and fetal tissue following an abortion, a procedure to manage miscarriage, or ectopic pregnancy surgery.¹⁸⁵ This type of restriction 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.

These laws require that providers ensure that the embryonic or fetal tissue resulting from an abortion or miscarriage be cremated or buried, regardless of gestation or a patient’s individual circumstances.¹⁸⁶ This requirement interferes with a provider’s ability to deliver individualized, patient-centered care by forcing him or her to adhere to burial or cremation rituals that may be out of step with a woman’s personal beliefs, values or desires. This requirement may also interfere with pathology and crime lab testing, depriving patients of necessary diagnostic information or criminal evidence in sexual assault cases.¹⁸⁷ Because providers are responsible for compliance, they risk liability for how pathology or crime labs manage the tissue after testing. This could chill providers’ ability to offer the standard of care to their patients and could deny women important medical knowledge.¹⁸⁸

These restrictions also threaten to limit the availability of abortion care further. In order to continue offering care, providers subject to these restrictions will be dependent on third-party vendors’ ability and willingness to comply with this potentially costly restriction. Clinics providing abortion care that are unable to arrange for affordable burial or cremation services could be forced to close.¹⁸⁹

42

states have passed TRAP laws that impose medically unnecessary requirements on abortion providers or clinics.

MAPPING TRAP LAWS

Forty-two states have passed TRAP laws that impose medically unnecessary requirements on abortion providers or clinics.^{190xx} Such provisions include ASC and other facilities requirements, admitting privileges or transfer agreements with local hospitals, physician-only laws and fetal tissue burial or cremation requirements.

Of the 42 states with TRAP requirements, 21 states have passed measures that require abortion clinics to meet specifications comparable to those required of ASCs.^{191xxi} Fourteen states have passed unnecessary facilities requirements such as corridor width or room size, sometimes on top of their ASC requirements.^{192xxii} Nineteen states apply unnecessary facility requirements to clinics that provide medication abortion, for which a health care provider merely prescribes and dispenses medication.^{193xxiii}

Twenty-two states have measures that require abortion providers or clinics to have a formal arrangement with a hospital, such as admitting privileges or a transfer agreement.¹⁹⁴ Of these states, 11 have passed measures that require abortion providers to obtain admitting

privileges.^{195xxiv} Ten states have passed measures that 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.^{196xxv} Five states have passed both of these requirements.^{197xxvi} In addition, eight states have measures requiring facilities to have transfer agreements with local hospitals.¹⁹⁸ Two states have passed measures requiring both transfer agreements and admitting privileges.^{199xxvii}

Forty-one states have passed measures specifying that only physicians may provide abortion,^{200xxviii} and two of those states have passed additional licensing requirements for those physicians, such as board certification.^{201xxix}

Three states have passed measures that require that embryonic or fetal tissue be cremated or buried.^{202xxx}

Two states – Louisiana and Texas – have passed restrictions in every TRAP category listed in this section.^{xxxi}

For details on each restriction by state, see Appendix E.

^{xx} In Illinois, some restrictions are governed by a consent decree. All 42 states have at least one TRAP restriction in effect.

^{xxi} In Illinois, this restriction is governed by a consent decree. Enforcement is permanently enjoined in Tennessee and Texas, and enjoined pending litigation in Kansas and Missouri.

^{xxii} In Illinois, this restriction is governed by a consent decree. Enforcement is enjoined pending litigation in Missouri.

^{xxiii} Enforcement is enjoined pending litigation in Kansas.

^{xxiv} Enforcement is enjoined pending litigation in Kansas, Missouri, Oklahoma and Wisconsin. Enforcement is permanently enjoined in Alabama, Louisiana, Mississippi, Tennessee and Texas.

^{xxv} In Illinois, this restriction is governed by a consent decree. Enforcement is enjoined pending litigation in Arkansas.

^{xxvi} Enforcement of the admitting privileges-only requirement is enjoined pending litigation in Oklahoma. In all five states, an “admitting privileges or alternative agreement” provision remains in place and enforceable.

^{xxvii} Enforcement of the admitting privileges requirement is permanently enjoined in Tennessee and enjoined pending litigation in Wisconsin.

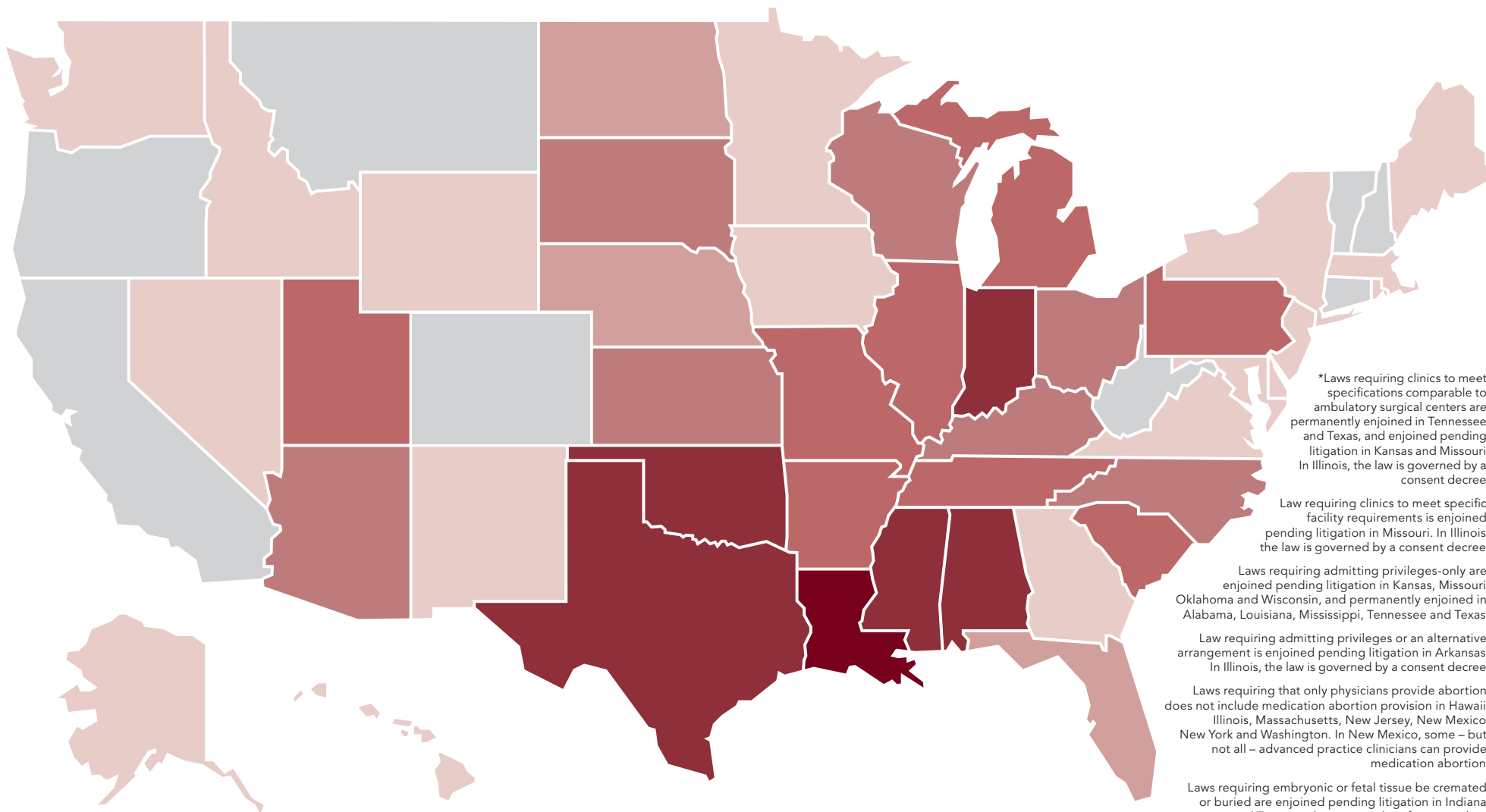
^{xxviii} Enforcement of this measure does not include medication abortion provision in Hawaii, Illinois, Massachusetts, New Jersey, New Mexico, New York and Washington. In New Mexico, some – but not all – advanced practice clinicians can provide medication abortion.

^{xxix} Not currently in force pending litigation in Louisiana.

^{xxx} Enforcement is enjoined pending litigation in Indiana and Texas, and not currently in force pending litigation in Louisiana.

^{xxxi} Enforcement of some restrictions is temporarily or permanently enjoined in both states.

MAPPING TRAP LAWS*



*Laws requiring clinics to meet specifications comparable to ambulatory surgical centers are permanently enjoined in Tennessee and Texas, and enjoined pending litigation in Kansas and Missouri. In Illinois, the law is governed by a consent decree.

Law requiring clinics to meet specific facility requirements is enjoined pending litigation in Missouri. In Illinois, the law is governed by a consent decree.

Laws requiring admitting privileges-only are enjoined pending litigation in Kansas, Missouri, Oklahoma and Wisconsin, and permanently enjoined in Alabama, Louisiana, Mississippi, Tennessee and Texas.

Law requiring admitting privileges or an alternative arrangement is enjoined pending litigation in Arkansas. In Illinois, the law is governed by a consent decree.

Laws requiring that only physicians provide abortion does not include medication abortion provision in Hawaii, Illinois, Massachusetts, New Jersey, New Mexico, New York and Washington. In New Mexico, some – but not all – advanced practice clinicians can provide medication abortion.

Laws requiring embryonic or fetal tissue be cremated or buried are enjoined pending litigation in Indiana and Texas, and not currently in force pending litigation in Louisiana.

0 TYPES OF RESTRICTIONS
1 TYPE OF RESTRICTION

2 TYPES OF RESTRICTIONS
3 TYPES OF RESTRICTIONS

4 TYPES OF RESTRICTIONS
5 TYPES OF RESTRICTIONS

6 TYPES OF RESTRICTIONS

Conclusion

Our nation is at a pivotal moment when it comes to protecting abortion rights and access. For more than 45 years, anti-abortion politicians have been gradually undermining women's right to abortion care by passing the kind of bad medicine laws discussed in this report. Now, anti-abortion extremists are in positions of power within the federal government, imperiling the reproductive health and rights of even more women.

The attacks are coming from all sides, and the threat to women's access to abortion care is more pressing than ever. But abortion rights supporters are fighting back every step of the way. The National Partnership and its allies will continue exposing the lies – and liars – behind harmful abortion restrictions and anti-abortion rhetoric at all levels.

We will keep fighting to get politicians out of exam rooms in states where they are interfering in the delivery of quality health care, and we will raise up the good work of state advocates who fight every day to support women's decisions and make abortion accessible.

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 TRAP 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 is able to access the care she needs with dignity and without barriers.

The attacks are coming from all sides, and the threat to women's access to abortion care is more pressing than ever. But abortion rights supporters are fighting back every step of the way. The National Partnership and its allies will continue exposing the lies – and liars – behind harmful abortion restrictions and anti-abortion rhetoric at all levels.



Reject



Repeal



Protect



Speak Out




Rise Up

APPENDIX A: BIASED COUNSELING LAWS

The table below identifies the specific biased counseling laws in each state; it excludes states that have not passed any biased counseling laws. Thank you to the Guttmacher Institute for providing most of the state-specific data included here.

Provider must give or offer the following medically inaccurate or biased information:	AL	AK	AZ	AR	FL	GA	ID	IN	KS	KY	LA	MI	MN	MS	MO	MT	NE	NC	ND	OH	OK	PA	SC	SD	TX	UT	VA	WV	WI	Total		
Unfounded assertion that fetuses can feel pain		●		●		●		●	●		●		●		●						●			●	●	●				●	13	
Ideological assertions that personhood begins at conception								●	●						●				●		●			●							6	
False or biased information about medication abortion				●																				●		●					3	
Erroneous statements about the impact of abortion on future fertility			●						●															●	●						4	
False links between abortion and breast cancer		●							●					●							●					●					5	
Content emphasizing negative emotional responses to abortion									●		●	●					●	●						●	●			●			8	
Descriptions of all common abortion procedures	●	●	●	●		●	●	●	●		●		●		●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	24
Descriptions of fetal development throughout pregnancy	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	29
Total # of biased counseling restrictions	2	4	3	4	1	3	2	4	7	1	4	2	3	2	4	2	3	3	3	1	5	2	2	7	6	4	2	3	3			

 enjoined pending litigation

 permanently enjoined

APPENDIX B: ULTRASOUND REQUIREMENTS

The table below identifies the specific ultrasound requirements in each state; it excludes states that have not passed any ultrasound requirements. Thank you to the Guttmacher Institute for providing most of the state-specific data included here.

Restriction Type	AL	AZ	AR	FL	GA	ID	IN	IA	KS	KY	LA	MI	MS	MO	NE	NC	ND	OH	OK	SC	SD	TX	UT	VA	WV	WI	WY	Total
Provider must offer or give patient information about obtaining ultrasound					●	●	●		●			●		●	●	●			●	●		●	●	●		●		14
Provider must offer ultrasound procedure								●						●			●				●		●				●	6
Provider must offer opportunity to view ultrasound image if performing ultrasound procedure			●		●	●					●				●			●		●			●		●		9	
Provider must perform ultrasound	●	●		●			●	●	●	●	●		●			●		●	●			●		●	●		15	
Provider must perform ultrasound and offer opportunity to view image	●	●		●			●	●	●				●					●						●			9	
Provider must perform ultrasound, display image and describe fetal characteristics										●	●					●			●	●			●		●		6	
Provider must perform ultrasound 24 hours in advance of abortion care		●									●											●		●			4	
Total # of ultrasound restrictions	2	3	1	2	2	2	3	3	3	2	3	2	2	2	2	3	1	3	3	2	1	4	3	4	1	3	1	



APPENDIX C: MANDATORY DELAYS

The table below identifies the specific mandatory delay laws in each state; it excludes states that have not passed any mandatory delay laws. Thank you to the Guttmacher Institute for providing most of the state-specific data included here.

Type of restriction	AL	AZ	AR	DE	FL	GA	ID	IN	IA	KS	KY	LA*	MA	MI	MN	MS	MO	MT	NE	NC	ND	OH	OK	PA	SC	SD	TN	TX	UT	VA	WV	WI	Total
Provider must delay abortion care by a specified number of hours	48	24	48	24	24	24	24	18	72	24	24	24	24	24	24	24	72	24	24	72	24	24	72	24	24	72	48	24	72	24	24	24	32
At least two clinic visits are required		●	●	●	●			●	●		●	●				●	●					●				●	●	●	●	●		●	16
Total # of mandatory delay restrictions	1	2	2	1	2	1	1	2	2	1	2	2	1	1	1	2	2	1	1	1	1	2	1	1	1	2	2	2	2	2	1	2	

* An enacted 72-hour waiting period in Louisiana is not enforced pending litigation; the 24-hour waiting period is still in effect.



enjoined pending litigation



permanently enjoined

APPENDIX D: MEDICATION ABORTION RESTRICTIONS

The table below identifies the specific medication abortion requirements in each state; it excludes states that have not passed any medication abortion restrictions. Thank you to the Guttmacher Institute for providing most of the state-specific data included here.

Type of restriction	AL	AZ	AR	IN	IA	KS	LA	MI	MS	MO	NE	NC	ND	OH	OK	SC	SD	TN	TX	WV	WI	Total	
Provider is prohibited from administering medication abortion according to the most current standards			●										●	●	●				●				5
Provider is banned from administering medication abortion via telemedicine	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	20
Total # of medication abortion restrictions	1	1	2	1	1	1	1	1	1	1	1	1	2	1	2	1	1	1	2	1	1		

-  enjoined pending litigation
-  permanently enjoined

APPENDIX E: TRAP LAWS


The table below identifies the specific TRAP laws in each state; it excludes states that have not passed any TRAP Laws. Thank you to the Guttmacher Institute for providing most of the state-specific data included here.


Type of restriction	AL	AK	AZ	AR	DE	FL	GA	HI	ID	IL*	IN	IA	KS	KY	LA**	ME	MD	MA	MI	MN	MS	MO	
Provider must have admitting privileges at a nearby hospital	●												●		●							●	●
Provider must have admitting privileges or an alternative arrangement	●		●	●						●	●				●							●	
Facility must have a transfer agreement with a nearby hospital						●								●						●			
Clinic must meet specifications comparable to ambulatory surgical centers	●		●	●						●	●		●	●	●					●		●	●
Clinic must satisfy specific facility requirements	●			●						●	●				●					●		●	●
Only physicians can provide abortion care	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Fetal tissue must be buried or cremated										●					●								
Total # of TRAP restrictions	5	1	3	4	1	2	1	1	1	4	5	1	3	3	6	1	1	1	4	1	5	4	

Type of restriction	NE	NV	NJ	NM	NY	NC	ND	OH	OK	PA	RI	SC	SD	TN	TX	UT	VA	WA	WI	WY	Total	
Provider must have admitting privileges at a nearby hospital							●		●					●	●	●			●			11
Provider must have admitting privileges or an alternative arrangement									●			●			●							10
Facility must have a transfer agreement with a nearby hospital						●		●		●				●						●		8
Clinic must meet specifications comparable to ambulatory surgical centers						●		●	●	●	●	●	●	●	●	●						21
Clinic must satisfy specific facility requirements	●								●	●		●	●			●						14
Only physicians can provide abortion care	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	41
Fetal tissue must be buried or cremated															●							3
Total # of TRAP restrictions	2	1	1	1	1	3	2	3	5	4	1	4	3	4	5	4	1	1	3	1		

* In Illinois, some restrictions are governed by a consent decree.

** Some restrictions are not currently in force pending litigation in Louisiana.

 enjoined pending litigation

 permanently enjoined

ENDNOTES

- ¹ Institute of Medicine (now the National Academy of Medicine). (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p. 1). Retrieved 21 January 2018, from <http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>
- ² See *Hearing Before the Subcomm. on Health Care of the Comm. on Fin.*, 111th Cong. 11 (2009) (statement of Carolyn Clancy, MD, Director of the Agency for Healthcare Research and Quality) (describing quality health care as “the right care, for the right patient, at the right time, every time”).
- ³ The 44 states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. The 19 states are Alabama, Arizona, Arkansas, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas and Wisconsin.
- ⁴ The 43 states are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming. The 18 states are Alabama, Arizona, Arkansas, Indiana, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas and Wisconsin.
- ⁵ See, e.g., Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2015). *Committee Opinion No. 439, Informed Consent* (p. 1). Retrieved 21 January 2018, from <https://www.acog.org/~/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809> (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., Richardson, C. T., & Nash, E. (2006). Misinformed consent: The medical accuracy of state-developed abortion counseling materials (p. 6). *Guttmacher Policy Review*, 9(4), 6–11; see generally Manian, M. (2009). The irrational woman: Informed consent and abortion decision making. *Duke Journal of Gender Law & Policy*, 16, 232–292 (providing background on the long history of informed consent doctrine).
- ⁶ See, e.g., College Executive Board, American College of Obstetricians and Gynecologists. (2014, November). *College Statement of Policy: Abortion Policy* (p. 1). Retrieved 21 January 2018, from <https://www.acog.org/~/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20171106T1939574760>; see note 5, American College of Obstetricians and Gynecologists, 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”); National Abortion Federation. (2017). *2017 Clinical Policy Guidelines for Abortion Care* (pp. 3–4). Retrieved 21 January 2018, from <https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2017-CPGs-for-Abortion-Care.pdf>
- ⁷ See American Medical Association. (2016, June). *Code of Medical Ethics, Opinion 2.1.1 Informed Consent*. Retrieved 21 January 2018, from <https://www.ama-assn.org/delivering-care/informed-consent> (“[P]hysicians should . . . [p]resent relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information.”); Epstein, R.M., & Street, R.L. (2011, March). The Values and Value of Patient-Centered Care. *Annals of Family Medicine*, 9(2), 100–103 (describing patient-centered care as “based on deep respect for patients as unique living beings, and the obligation to care for them on their terms. Thus, patients are known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care . . .”).
- ⁸ Guttmacher Institute. (2018, February). *State Laws and Policies: Counseling and Waiting Periods for Abortion*. Retrieved 6 February 2018, from http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, 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.); MONT. CODE ANN. § 50-20-304 (2017).
- ⁹ See note 8, Guttmacher Institute. (Alaska, Arizona, Arkansas, Georgia, Indiana, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah, West Virginia and Wisconsin. In some states, the specific information is required by law; in others, it is included in the written materials.)
- ¹⁰ *Ibid.* (Alaska, Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma, South Dakota, Texas, Utah and Wisconsin. Alaska, South Dakota, Texas and Wisconsin include this information in their state-drafted written materials, but it is not mandated by state law. In Arkansas, Minnesota, Oklahoma, and Utah this information must only be verbally provided to women at 20 weeks gestation or above, though this information is always included in these states’ written materials. In Utah, this requirement can be waived in certain circumstances. In Missouri, this is only required in written materials to women at 22 weeks gestation or above.)
- ¹¹ See, e.g., Royal College of Obstetricians and Gynaecologists. (2010, March). *Fetal Awareness: Review of Research and Recommendations for Practice* (p. viii). Retrieved 21 January 2018, 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 and thus “the fetus cannot experience pain in any sense prior to [24 weeks] gestation,” and further concluding that even those connections are insufficient for pain experience, since “experience of external stimuli requires consciousness . . . [and] there is increasing evidence that the fetus never experiences a sense of true wakefulness *in utero* and is kept, by the presence of its chemical environment, in a continuous sleep-like unconsciousness or sedation”); 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.
- ¹² See note 8, Guttmacher Institute. (Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas and West Virginia. Texas includes this information in their state-drafted written materials but it is not mandated by state law.)
- ¹³ 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. *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 21 January 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.”).
- ¹⁴ See note 8, Guttmacher Institute. (Arizona, Kansas, South Dakota and Texas. Arizona, Kansas and South Dakota include this information in their state-drafted written materials, but it is not mandated by state law.)
- ¹⁵ 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).
- ¹⁶ See note 8, Guttmacher Institute. (Alaska, Kansas, Mississippi, Oklahoma and Texas. Alaska, Mississippi and Oklahoma include this information in their state-drafted written materials, but it is not mandated by state law.)
- ¹⁷ 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; Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. (2009, June; reaffirmed 2015). *Committee Opinion No. 434, Induced Abortion and Breast Cancer Risk*. Retrieved 21 January 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 21 January 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.”)
- ¹⁸ See note 8, Guttmacher Institute. (Indiana, Kansas, Missouri, North Dakota, Oklahoma and South Dakota.)

- ¹⁹ See note 8, Guttmacher Institute. (Arkansas, South Dakota and Utah.) Arizona previously had a medication abortion reversal biased counseling requirement, which the legislature recently repealed. See Pitzl, M. J. (2016, Aug. 23). Court: Arizona Abortion-Reversal Law Is No More. *Arizona Republic*. Retrieved 30 January 2018, from <https://www.azcentral.com/story/news/politics/arizona/2016/08/23/court-arizona-abortion-reversal-law-no-more/89229028/>
- ²⁰ See, e.g., American College of Obstetricians and Gynecologists. (2017, August). *Facts Are Important: Medication Abortion "Reversal" Is Not Supported by Science*. Retrieved 14 February 2018, from <https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/FactsAreImportantMedicationAbortionReversal.pdf?dmc=1&ts=20180206T1955451745> (noting that medication abortion "reversal" is not supported by scientific evidence); Borkowski, L., Strasser, J., Allina, A., & Wood, S. (2015, December). *Medication Abortion: Overview of Research & Policy in the United States* (p. 27). Retrieved 30 January 2018, from https://publichealth.gwu.edu/sites/default/files/Medication_Abortion_white_paper.pdf
- ²¹ See note 8, Guttmacher Institute. (Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Louisiana, Minnesota, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin. Texas includes this information in its state-drafted written materials, but it is not mandated by state law.); MONT. CODE ANN. § 50-20-304.
- ²² See note 8, Guttmacher Institute. (Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin.); MONT. CODE ANN. § 50-20-304.
- ²³ See, e.g., Daniels, C.R. (2016). *Informed Consent Project: Our Findings*. Retrieved 21 January 2018, from <http://informedconsentproject.com/our-findings/>
- ²⁴ Daniels, C.R. (2016). *Informed Consent Project: Finding 3: Fetal Descriptions*. Retrieved 21 January 2018, from <http://informedconsentproject.com/our-findings/finding-3-fetal-descriptions/>
- ²⁵ See, e.g., Ness, M. (Producer), & Porter, D. (Director). (2016, June). *TRAPPED* [Motion picture]. United States: Trilogy Films.
- ²⁶ See, e.g., Minkoff, H., & Ecker, J. (2012, September). When legislators play doctor: The ethics of mandatory preabortion ultrasound examinations. *Obstetrics & Gynecology*, 120(3), 647–649 ("Ultrasound 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."); cf. 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 21 January 2018, from <http://www.acog.org/-/media/Committee%20Opinions/Committee%20on%20Ethics/co390.pdf?dmc=1&ts=20120305T0654106237> ("A patient's right to make her own decisions about medical issues extends to the right to refuse . . . medical treatment."); see note 6, American College of Obstetricians and Gynecologists, 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"); see note 6, National Abortion Federation, p. 15.
- ²⁷ See note 26, Minkoff & Ecker ("There are no circumstances in which a patient's viewing of the fetus is medically necessary.") (describing how 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 also Stuart v. Loomis, 992 F. Supp. 2d 585, 598-99 (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).
- ²⁸ See 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 21 January 2018, from <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809>).
- ²⁹ See, e.g., note 5, American College of Obstetricians and Gynecologists, p. 3 ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."); cf. American Medical Association. (2016). *AMA Code of Medical Ethics: Principles of Medical Ethics*. Retrieved 21 January 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. (2012). *ACP Ethics Manual* (6th ed.). Retrieved 21 January 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.")
- ³⁰ See, e.g., Svokos, A. (2017, August 7). Crisis Pregnancy Centers Worry Abortion Clinics Like Hartford GYN. *Elite Daily*. Retrieved 21 January 2018, from <https://www.elitedaily.com/news/politics/happens-crisis-pregnancy-center-moves-next-door-abortion-clinic/2034122>
- ³¹ NARAL Pro-Choice America. (2016). *The Truth about Crisis Pregnancy Centers* (p. 10). Retrieved 21 January 2018, from <https://www.prochoiceamerica.org/wp-content/uploads/2016/12/6.-The-Truth-About-Crisis-Pregnancy-Centers.pdf>
- ³² See, e.g., Resnick, S. (2012, November 29). Crisis Pregnancy Center That Makes Expectant Parents "Earn" Baby Supplies Through Bible Study Seeks Federal Loans for Expansion. *Rewire*. Retrieved 21 January 2018, from <https://rewire.news/article/2012/11/29/christian-anti-abortion-group-sues-government-taxpayer-funding/>
- ³³ See note 31, pp. 6–7.
- ³⁴ Guttmacher Institute. (2017, October). *Fact Sheet: Induced Abortion in the United States* (p. 2). Retrieved 21 January 2018, from https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf (noting that "[a] first-trimester abortion is one of the safest medical procedures")
- ³⁵ See, e.g., United States House of Representatives Committee on Government Reform, Special Investigations Division. (2006, July). *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers* (pp. 7–13). Retrieved 21 January 2018, from <https://www.chsourcebook.com/articles/waxman2.pdf>; cf. note 31, p. 5.
- ³⁶ See note 31, pp. 5–7.
- ³⁷ Guttmacher Institute. (2018, February). *State Laws and Policies: Requirements for Ultrasound*. Retrieved 6 February 2018, from http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming.)
- ³⁸ *Ibid.*
- ³⁹ *Ibid.* (Alabama, Arizona, Florida, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, North Carolina, Ohio, 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.)
- ⁴⁰ *Ibid.* (Kentucky, Louisiana, North Carolina, Oklahoma, Texas and Wisconsin.)
- ⁴¹ *Ibid.* (Alabama, Arizona, Florida, Indiana, Iowa, Kansas, Mississippi, Ohio and Virginia. In Arizona and Virginia, the ultrasound must take place at least 24 hours before the abortion. In Ohio, the provider must test for the fetal heartbeat, which requires an ultrasound if the woman is in the first trimester of pregnancy – which is when most abortions are provided.)
- ⁴² See, e.g., Kaur, A., & Kaur, A. (2011, May). Transvaginal ultrasonography in first trimester of pregnancy and its comparison with transabdominal ultrasonography. *Journal of Pharmacy and Bioallied Sciences*, 3(3), 329–338 (concluding that transvaginal ultrasonography accurately reflects pregnancy and developmental markers at an earlier stage in pregnancy than transabdominal ultrasonography); cf. note 34 (noting that the vast majority of abortions occur during the first trimester).
- ⁴³ See note 37. (Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming.)
- ⁴⁴ *Ibid.* (Iowa, Missouri, North Dakota, South Dakota, Utah and Wyoming.)
- ⁴⁵ *Ibid.* (Arkansas, Georgia, Idaho, Michigan, Nebraska, Ohio, South Carolina, Utah and West Virginia.)
- ⁴⁶ *Ibid.* (Georgia, Idaho, Indiana, Kansas, Michigan, 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.)
- ⁴⁷ *Ibid.* (Arizona, Louisiana, Texas and Virginia); but see N.D. CENT. CODE ANN. § 14-02.1-04 (West 2018).

- ⁴⁸ See note 1, p.1.
- ⁴⁹ See note 8, Guttmacher Institute.
- ⁵⁰ See, e.g., Burns, M., Dyer, M., & Bailit, M. (2014, January). *Reducing Overuse and Misuse: State Strategies to Improve Quality and Cost of Health Care*. Retrieved 30 January 2018, from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409990
- ⁵¹ World Health Organization. (2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed.) (p. 36). Retrieved 21 January 2018, from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf
- ⁵² Jones, R. K., & Jerman, J. (2017, March). Abortion incidence and service availability in the United States, 2014. *Perspectives on Sexual and Reproductive Health*, 49(1), 17–27.
- ⁵³ McCann, A. (2017, May 23). The Last Clinics. *Vice News*. Retrieved 21 January 2018, from <https://news.vice.com/story/last-clinics-seven-states-one-abortion-clinic-left>
- ⁵⁴ McCammon, S. (2017, October 3). For Many Women, the Nearest Abortion Provider Is Hundreds of Miles Away. *NPR Shots*. Retrieved 20 January 2018, from <https://www.npr.org/sections/health-shots/2017/10/03/555166033/for-many-women-the-nearest-abortion-clinic-is-hundreds-of-miles-away>
- ⁵⁵ Bearak, J. M., Burke, K. L., & Jones, R. K. (2017, October). Disparities and change over time in distance women would need to travel to have an abortion in the USA: A spatial analysis. *The Lancet Public Health*, 2(11), 493–500.
- ⁵⁶ See note 34, p. 1.
- ⁵⁷ See U.S. Bureau of Labor Statistics. (2017, July 21). *Employee benefits in the United States – March 2017* (p. 16, Table 6). Retrieved 21 January 2018, from <http://www.bls.gov/news.release/pdf/ebs2.pdf>
- ⁵⁸ See, e.g., Guttmacher Institute. (2018, January). *Evidence You Can Use: Waiting Periods for Abortion*. Retrieved 21 January 2018, from <https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion#harm-in-requiring-two-trips>; cf. 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 21 January 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 21 January 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 21 January 2018, from <https://www.aclu.org/other/government-mandated-delays-abortion>
- ⁵⁹ See note 8, Guttmacher Institute. (Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, 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. All states waive mandatory waiting period requirements in a medical emergency or when the woman’s life or health is threatened.)
- ⁶⁰ *Ibid.* (Arizona, Arkansas, Florida, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Ohio, South Dakota, Tennessee, Texas, Utah, Virginia and Wisconsin.)
- ⁶¹ See note 8, Guttmacher Institute.
- ⁶² See, e.g., Texas Freedom Network. (2017, March 3). *On your left, empty seats symbolizing the politicians absent from today’s “people’s hearing.” On your right, real medical experts here to talk about the lies and misinformation used to justify anti-abortion laws.* [Facebook Live video]. Retrieved 25 January 2018, from <https://www.facebook.com/TexasFreedomNetwork/videos/10154387134648034/> (During the hearing, Marsha Jones of the Afiya Center discusses how bad medicine laws exacerbate problems with patient-provider trust for Black women.)
- ⁶³ *Ibid.*
- ⁶⁴ See United States Census Bureau. (2015, November 2). *Facts for features: American Indian and Alaska Native Heritage Month: November 2015* [Press release]. Retrieved 15 February 2018, from <https://www.census.gov/newsroom/facts-for-features/2015/cb15-ff22.html> (describing how Oklahoma and South Dakota rank second and fourth respectively in an analysis of states with the highest proportion of individuals identifying as American Indian or Alaska Native); Rose, C. (2014, January 22). Native History: Roe v. Wade Passes, But Indigenous Women Lack Access. *Indian Country Today*. Retrieved 15 February 2018, from <https://indiancountrymedianetwork.com/history/events/native-history-roe-v-wade-passes-but-indigenous-women-lack-access/> (describing how “[t]he legality of abortion did nothing to create access to abortions for impoverished women living in rural areas and on [Native American] reservations”); see generally Gurr, B. (2014). *Reproductive Justice: The Politics of Health Care for Native American Women*. New Brunswick, NJ: Rutgers University Press.
- ⁶⁵ Housing Assistance Council. (2012, April). *Rural Research Brief* (p. 4). Retrieved January 22 2018, from http://www.ruralhome.org/storage/research_notes/rrn-race-and-ethnicity-web.pdf (describing how a significant demographic trend between 2000 and 2010 has been the increasing Hispanic population in the United States, particularly in rural communities. More than half of the growth in all rural and small towns over this period is attributable to the Hispanic population.)
- ⁶⁶ See, e.g., Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, February; reaffirmed 2016). *Committee Opinion No. 586, Health Disparities in Rural Women* (pp. 2–3). Retrieved 22 January 2018, from <http://www.acog.org/-/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co586.pdf?dmc=1&ts=20140422T1410168732>
- ⁶⁷ U.S. Census Bureau. (2016). *American Community Survey 1-Year Estimates 2016, Table B01001: Sex by Age (Hispanic or Latino)*. Retrieved 19 January 2018, from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_B01001&prodType=table (Calculation is based on women aged 15–44. The total estimate is 2,362,143 Latina women of reproductive age.)
- ⁶⁸ See, e.g., note 58, American Civil Liberties Union.
- ⁶⁹ See United States Census Bureau. (2011, September). *The Black population: 2010 Census Briefs* (C2010BR-06) (pp. 7, 9). Retrieved 15 February 2018, from <https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf> (“The majority of Blacks in the United States lived in the South. According to the 2010 Census, of all respondents who reported Black alone-or-in-combination, 55 percent lived in the South, 18 percent in the Midwest, 17 percent in the Northeast, and 10 percent in the West . . .”) (“The Black alone-or-in-combination population represented 38 percent of the total population in Mississippi (see Table 5). This was followed by Louisiana (33 percent), Georgia (32 percent), Maryland (31 percent), South Carolina (29 percent), and Alabama (27 percent).”); Wolfers, J. (2015, April 21). Areas with Large Black Populations Have the Smallest Shares of Black Men. *New York Times*. Retrieved 15 February 2018, from <https://www.nytimes.com/2015/04/22/upshot/areas-with-large-black-populations-have-the-smallest-shares-of-black-men.html> (describing the extent to which Black women outnumber Black men in many states, including Mississippi and Louisiana); see also In Our Own Voice: Black Women’s Reproductive Justice Agenda. (2017, June). *The State of Black Women & Reproductive Justice* (p. 23). Retrieved 21 January 2018, from http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf (noting that “Black women . . . are likely to live in states with both coverage restrictions and other legal barriers. Women living in states that have the largest percentage of Black residents (i.e., Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) face numerous barriers to exercising their right to abortion.”) (Citation omitted.)
- ⁷⁰ National Asian Pacific American Women’s Forum. (2017). *Still Fierce, Still Fighting: A Reproductive Justice Agenda for Asian Americans and Pacific Islanders* (p. 4). Retrieved 21 January 2018, from http://www.napawf.org/uploads/1/1/4/9/114909119/stillfiercestillfighting_3.pdf
- ⁷¹ See, e.g., NARAL Pro-Choice America. (n.d.). *State Governments: What Anti-Choice Measures Are in Place in Your State?* Retrieved 16 January 2018, from <https://www.prochoiceamerica.org/laws-policy/state-government/>
- ⁷² See, e.g., In Our Own Voice National Black Women’s Reproductive Justice Agenda. (n.d.). Retrieved 13 February 2018, from <http://blackrj.org/>; see, e.g., National Latina Institute for Reproductive Health. (n.d.). Retrieved 13 February 2018, from <http://www.latinainstitute.org/>; see, e.g., National Asian Pacific American Women’s Forum. (n.d.). Retrieved 13 February 2018, from <https://www.napawf.org/>; see, e.g., Native American Women’s Health Education Resource Center. (n.d.). Retrieved 13 February 2018, from <http://www.nativeshop.org/>
- ⁷³ See Boonstra, H. (2013). Medication abortion restrictions burden women and providers—and threaten U.S. trend toward very early abortion. *Guttmacher Policy Review*, 16(1), 18–23.
- ⁷⁴ See, e.g., Brief of Amicus Curiae on Behalf of Iowa Coal. Against Domestic Violence, et al., in Support of Petitioners-Appellants at 6, 23, *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252 (Iowa 2015) (No. 17-1579).
- ⁷⁵ *Ibid.*, pp. 24–25.

- ⁷⁶ Cf. Gatter, M., Cleland, K., & Nucatola, D. L. (2015, April). Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days. *Contraception*, 91(4), 269–273; Association of Reproductive Health Professionals. (2008, April). *Mifepristone Safety Overview* (p. 1). Retrieved 21 January 2018, from <http://www.arhp.org/uploadDocs/mifepristonefactsheet.pdf> (“Mifepristone is safer than acetaminophen (Tylenol®) [and] Aspirin® . . .”)
- ⁷⁷ American Telemedicine Association. (n.d.). *About Telemedicine*. Retrieved 21 January 2018, from [http://www.americantelemed.org/about/telehealth-faqs-; Medicaid.gov. \(n.d.\). Telemedicine. Retrieved 21 January 2018, from https://www.medicaid.gov/medicaid/benefits/telemed/index.html](http://www.americantelemed.org/about/telehealth-faqs-; Medicaid.gov. (n.d.). Telemedicine. Retrieved 21 January 2018, from https://www.medicaid.gov/medicaid/benefits/telemed/index.html)
- ⁷⁸ Center for Connected Health Policy, Public Health Institute. (n.d.). *Video Conferencing*. Retrieved 30 January 2018, from <http://www.cchpca.org/what-is-telehealth/video-conferencing>
- ⁷⁹ Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, November; reaffirmed 2017). *Committee Opinion No. 613, Increasing Access to Abortion* (p. 4). Retrieved 21 January 2018, from <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20180122T0424256502>
- ⁸⁰ See note 73.
- ⁸¹ Cf. Wicklund, E. (2018, January 22). Telemedicine Programs Feature Prominently in Latest USDA DLT Grants. *mHealthIntelligence Telehealth News*. Retrieved 7 February 2018, from <https://mhealthintelligence.com/news/telemedicine-programs-feature-prominently-in-latest-usda-dlt-grants>
- ⁸² See, e.g., Lopez, A. M. (2014). Telemedicine, telehealth, and e-health technologies in cancer prevention. In D. Alberts, & L. M. Hess (Eds.), *Fundamentals of cancer prevention* (pp. 266–267). Heidelberg: Springer; National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. (2014, October). *Telemedicine Interventions for Chronic Disease Management*. Retrieved 22 January 2018, from http://www.cdc.gov/dhdsp/pubs/docs/sib_oct2014.pdf; Mayo Clinic. (n.d.). *Stroke Telemedicine (Telastroke)*. Retrieved 22 January 2018, from [http://www.adph.org/ALPHTN/assets/StateMedicaidBestPracticeforHighRiskPregnancy.pdf](https://www.mayoclinic.org/tests-procedures/stroke-telemedicine/basics/definition/prc-20021080; Wechsler, L. R., Demaerschalk, B. M., Schwamm, L. H., Adeoye, O. M., Audebert, H. J., Fanale, C. V., . . . Switzer, J. A. (2016). Telemedicine quality and outcomes in stroke: A scientific statement for healthcare professionals from the American Heart Association/American Stroke Association (p. e3). <i>Stroke</i>, 47, e1–e23; American Telemedicine Association. (2014, January). <i>State Medicaid Best Practice: Telehealth for High-Risk Pregnancy</i>. Retrieved 22 January 2018, from <a href=); Brunk, D. (2017, May 10). Using telemedicine to improve maternal safety. *Ob.Gyn. News*. Retrieved 5 February 2018 from [http://www.va.gov/health/newsfeatures/2014/june/connecting-veterans-with-telehealth.asp](https://www.mdedge.com/obgynnews/article/137919/obstetrics/using-telemedicine-improve-maternal-safety; Uscher-Pines, L., & Mehrotra, A. (2014, February). Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider (p. 263). <i>Health Affairs</i>, 33(2), 258–264; cf. Peterson, H. (2014, June 23). <i>Connecting Veterans with Telehealth</i>. Retrieved 22 January 2018 from <a href=); see note 81.
- ⁸³ See U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2013). *Women’s Health USA 2013*. Retrieved 22 January 2018, from <https://mchb.hrsa.gov/whusa13/population-characteristics/p/rural-urban-women.html>; see generally U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2016, June). *Telehealth: Mapping the evidence for patient outcomes from systematic reviews* (Technical Briefs No. 26). Retrieved 5 February 2018, from https://www.ncbi.nlm.nih.gov/books/NBK379320/pdf/Bookshelf_NBK379320.pdf
- ⁸⁴ See note 79.
- ⁸⁵ See, e.g., note 66; Uscher-Pines, L., & Mehrotra, A. (2014, February). Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider. *Health Affairs*, 33(2), 258–264; Lewis, N. (2016, December 6). Telehealth Helps Close Health Care Disparity Gap in Rural Areas. *AAMC News*. Retrieved 22 January 2018, from <https://www.aamc.org/patient-care/article/telehealth-health-care-disparity-gap/>; Rural Health Information Hub. (2017, November 13). *Madison Outreach and Services through Telehealth (MOST) Network*. Retrieved 22 January 2018, from <https://www.ruralhealthinfo.org/community-health/project-examples/856> (for example, in collaboration with Texas A&M University, the Madison Outreach and Services through Telehealth (MOST) Network uses telemedicine to provide mental health and substance abuse prevention treatment programs to rural Brazos Valley, Texas, creating access to services that many in the community would otherwise go without. The MOST program is the only provider of Latino/a-focused health and social services in the county).
- ⁸⁶ See Grossman, D., Grindlay, K., Buchacker, T., Lane, K., & Blanchard, K. (2011, August). Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics & Gynecology*, 118(2), 296–303; see also Grindlay, K., Lane, K., & Grossman, D. (2013). Women’s and providers’ experiences with medical abortion provided through telemedicine: A qualitative study. *Women’s Health Issues*, 23(2), e117–122; Gomberts, R. J., Jelinska, K., Davies, S., Gemzell-Danielsson, K., & Kleiverda, G. (2008, July). Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. *BJOG: An International Journal of Obstetrics and Gynaecology*, 115(9), 1171–1178.
- ⁸⁷ Final Amicus Curiae Brief of the Am. Coll. of Obstetricians & Gynecologists at 8, *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).
- ⁸⁸ See note 86, Grossman.
- ⁸⁹ Cf. Rosenbloom, S. (2007). *Transportation Patterns and Problems of People with Disabilities*. Retrieved 22 January 2018, from <https://www.ncbi.nlm.nih.gov/books/NBK11420/>
- ⁹⁰ See Baylor College of Medicine, Center for Research on Women with Disabilities (CROWD). (n.d.). *Demographics*. Retrieved 22 January 2018, from <https://www.bcm.edu/research/centers/research-on-women-with-disabilities/general-info/demographics>
- ⁹¹ Cf. Center for Reproductive Rights. (2017, May). *Shifting the Frame on Disability Rights for the U.S. Reproductive Rights Movement* (pp. 19–20). Retrieved 22 January 2018, from <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Disability-Briefing-Paper-FINAL.pdf>
- ⁹² See note 90.
- ⁹³ See, e.g., note 91, pp. 21–22.
- ⁹⁴ Guttmacher Institute. (2018, February). *State Laws and Policies: Medication Abortion*. Retrieved 6 February 2018, from http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (Arkansas, North Dakota, Ohio, Oklahoma, and Texas. Enforcement is permanently enjoined in Oklahoma, and enjoined pending litigation in Arkansas. Texas law requires providers to adhere to much of the outdated FDA protocol, but permits providers to use medication levels recommended by ACOG in 2013.)
- ⁹⁵ See Jones, R. K., & Boonstra, H. D. (2016, June). *The Public Health Implications of the FDA Update to the Medication Abortion Label*. Retrieved 22 January 2018, from <https://www.guttmacher.org/article/2016/06/public-health-implications-fda-update-medication-abortion-label>
- ⁹⁶ Upadhyay, U. D., Johns, N. E., Combellick, S. L., Kohn, J. E., Keder, L. M., & Roberts, S. C. M. (2016, August). Comparison of outcomes before and after Ohio’s law mandating use of the FDA-approved protocol for medication abortion: A retrospective cohort study. *PLoS Medicine*, 13(8), 1–23.
- ⁹⁷ See note 20, Borkowski, p. 6.
- ⁹⁸ *Ibid.* (“Off-label prescribing is a common phenomenon across many types of care, and different protocols or uses often arise after a drug is approved for a specific condition.”)
- ⁹⁹ See, e.g., *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 909 (9th Cir. 2014), *cert. denied*, 135 S. Ct. 870 (2014). (Citation omitted.)
- ¹⁰⁰ See note 87, p. 25. (Emphasis omitted.)
- ¹⁰¹ See Reference Committee on Amendments to Constitution and Bylaws, American Medical Association. (2015). *Report of the Reference Committee on Amendments to Constitution and Bylaws: H-120.988 Patient Access to Treatments Prescribed by Their Physicians* (p. 558). Retrieved 30 January 2018, from <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/a15-hod-reference-committee-reports.pdf>
- ¹⁰² U.S. Food and Drug Administration. (2016). *Mifeprex (mifepristone) Information*. Retrieved 22 January 2018, from <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm>
- ¹⁰³ See note 95.
- ¹⁰⁴ See, e.g., note 6, National Abortion Federation, p. 20 (“Medical abortion regimens and follow-up have evolved rapidly over the past decade, and are likely to continue to improve.”).
- ¹⁰⁵ Mifeprex REMS Study Group (2017, February). Sixteen years of overregulation: Time to unburden Mifeprex (p. 790). *New England Journal of Medicine*, 376(8), 790–794.
- ¹⁰⁶ *Ibid.*, p. 792.
- ¹⁰⁷ See, e.g., *Complaint at 5, Chelius v. Wright*, No. 1:17-cv-00493-DKW-KSC (D. Haw. Oct. 3, 2017), 2017 WL 4401999.
- ¹⁰⁸ See, e.g., *ibid.*
- ¹⁰⁹ See, e.g., *ibid.*

- ¹¹⁰ Cf. National Abortion Federation. (2016). *2016 Violence and Disruption Statistics*. Retrieved 30 January 2018, from <https://prochoice.org/wp-content/uploads/2016-NAF-Violence-and-Disruption-Statistics.pdf>
- ¹¹¹ See Stack, L. (2015, November 29). A Brief History of Deadly Attacks on Abortion Providers. *New York Times*. Retrieved 22 January 2018, from <https://www.nytimes.com/interactive/2015/11/29/us/30abortion-clinic-violence.html>
- ¹¹² See, e.g., note 107.
- ¹¹³ *Ibid.*, p. 24.
- ¹¹⁴ *Ibid.*, pp. 32–37.
- ¹¹⁵ *Ibid.*, p. 6 (quoting U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research, 020687Orig1s020, Mifeprex Summary Review 25 (Mar. 29, 2016)). In fact, mifepristone is approved under the brand name Korlym for daily use by patients with endogenous Cushing's syndrome – in higher doses than it is used for medication abortion. Yet, Korlym is not subject to a REMS; see, e.g., *ibid.*, p.18, 35.
- ¹¹⁶ *Ibid.*, pp. 59–60.
- ¹¹⁷ *Ibid.*, p. 56.
- ¹¹⁸ *Ibid.*, p. 7.
- ¹¹⁹ *Ibid.*
- ¹²⁰ *Ibid.*, pp. 26–27 (quoting Letter from Soc'y of Family Planning et al., to Stephen Ostroff, M.D., Robert M. Califf, M.D., & Janet Woodcock, M.D. (Feb. 4, 2016)).
- ¹²¹ See note 94, Guttmacher Institute. (Alabama, Arizona, Arkansas, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia and Wisconsin.)
- ¹²² *Ibid.* (Alabama, Arizona, Arkansas, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia and Wisconsin.)
- ¹²³ *Ibid.* (Arkansas, North Dakota, Ohio, Oklahoma and Texas. Texas law requires providers to adhere to much of the outdated FDA protocol, but permits providers to use medication levels recommended by ACOG in 2013.)
- ¹²⁴ *Ibid.* (Arkansas, North Dakota, Oklahoma and Texas.)
- ¹²⁵ See note 34, p. 2 (noting that “[a] first-trimester abortion is one of the safest medical procedures”).
- ¹²⁶ Weitz, T. A., Taylor, D., Desai, S., Upadhyay, U. D., Waldman, J., Battistelli, M. F., & Drey, E. A. (2013, March). Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. *American Journal of Public Health*, 103(3), 454–461 (examining the safety of first trimester abortion procedures specifically).
- ¹²⁷ Cf. Upadhyay, U. D., Desai, S., Zlizar, V., Weitz, T. A., Grossman, D., Anderson, P., & Taylor, D. (2015, January). Incidence of emergency department visits and complications after abortion. *Obstetrics & Gynecology*, 125(1), 175–183.
- ¹²⁸ *Amici Curiae* Brief of Pub. Health Deans et al. in Support of Petitioners at 8–9, 15–16, 25–26, 30–37, *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).
- ¹²⁹ Cf. Institute for Healthcare Improvement. (n.d.). *IHI Triple Aim Initiative*. Retrieved 22 January 2018, from <http://www.ihio.org/engage/initiatives/tripleaim/Pages/default.aspx>
- ¹³⁰ See, e.g., Brief for *Amici Curiae* Am. Coll. of Obstetricians & Gynecologists et al. in Support of Petitioners at 10, *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).
- ¹³¹ Guttmacher Institute. (2016, May). *State Laws and Policies: Targeted Regulation of Abortion Providers*. On file with authors. (Alabama, Arizona, Arkansas, Connecticut, Florida, Illinois, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah and Virginia.)
- ¹³² Tennessee and Texas permanently enjoined those requirements. See *Whole Woman's Health v. Hellerstedt*, 833 F.3d 565 (2016), *enforcing* 136 S. Ct. 2292 (2016); Partial Judgment on Consent at 2–3, *Adams & Boyle v. Slatery*, No. 3:15-cv-00705 (M.D. Tenn. Apr. 14, 2017); see also Center for Reproductive Rights. (2013, September 27). *Federal court permanently blocks clinic shutdown laws in Tennessee* [Press release]. Retrieved 22 January 2018, from <https://www.reproductiverights.org/press-room/federal-court-permanently-blocks-clinic-shutdown-laws-in-tennessee>. Missouri temporarily enjoined their requirements. See Comprehensive Health of Planned Parenthood Great Plains v. Williams, 263 F. Supp. 3d 729 (W.D. Mo. 2017) (temporarily enjoining the ASC requirement in Missouri). Virginia repealed its requirements by re-working the offending regulations. See 33 Va. REG. RECS. 1427, 1427–35 (2017); see also Center for Reproductive Rights. (2016, October 24). *Virginia Board of Health protects women's access to constitutionally protected health care, votes to amend Texas-style clinic shutdown regulations* [Press release]. Retrieved 22 January 2018, from <https://www.reproductiverights.org/press-room/va-board-of-health-protects-womens-access-to-constitutionally-protected-health-care>
- ¹³³ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016).
- ¹³⁴ *Ibid.* (Quoting *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).
- ¹³⁵ *Ibid.* (Quoting *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).
- ¹³⁶ *Ibid.* (Citations omitted.)
- ¹³⁷ Guttmacher Institute. (2018, February). *State Laws and Policies: Targeted Regulation of Abortion Providers*. Retrieved 6 February 2018, from <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers> (Alabama, Arizona, Arkansas, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas and Utah.)
- ¹³⁸ See, e.g., Gold, R. B., & Nash, E. (2013). TRAP laws gain political traction while abortion clinics—and the women they serve—pay the price. *Guttmacher Policy Review*, 16(2), 7–12.
- ¹³⁹ White, K., Carroll, E., & Grossman, D. (2015, November). Complications from first-trimester aspiration abortion: A systematic review of the literature. *Contraception*, 92(5), 422–438. Additionally, there is no reason to believe that second trimester abortions are better provided in ASCs; cf. Jones, B. S., & Weitz, T. A. (2009, April). Legal barriers to second-trimester abortion provision and public health consequences. *American Journal of Public Health*, 99(4), 623–630.
- ¹⁴⁰ *Ibid.*, White, p. 434.
- ¹⁴¹ Cf. note 6, National Abortion Federation, p. 32, 37 (“Abortion by dilation and evacuation (D&E) after 14 weeks from [last menstrual period] is a safe outpatient surgical procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.”) (“Policy Statement: Medical induction abortion is a safe and effective method for termination of pregnancies beyond the first trimester when performed by trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.”); see also note 139, Jones (“[N]o 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.”).
- ¹⁴² See note 139, Jones (“Procedures that are comparable to abortions in the first or second trimester and that are often performed in outpatient clinics or physicians’ offices rather than ASCs include hysteroscopy, surgical completion of miscarriage, vasectomy, sigmoidoscopy, and minor neck and throat surgeries.”). (Citation omitted.)
- ¹⁴³ See, e.g., note 139, Jones (“[N]o 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.”).
- ¹⁴⁴ See note 138.
- ¹⁴⁵ See note 137, Guttmacher Institute.
- ¹⁴⁶ Brief of Amicus Curiae Am. Pub. Health Ass’n 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).
- ¹⁴⁷ See note 51, p. 67.
- ¹⁴⁸ See note 51, p. 96.
- ¹⁴⁹ See generally, e.g., Texas Policy Evaluation Project. (2015, October). *Research Brief: Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*. Retrieved 1 February 2018, from http://sites.utexas.edu/txpep/files/2016/01/Abortion_Wait_Time_Brief.pdf
- ¹⁵⁰ See, e.g., note 128, pp. 30–37.
- ¹⁵¹ See, e.g., Brief for Nat’l Abortion Fed’n and Abortion Providers as *Amici Curiae* in Support of Petitioners at 20, *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).
- ¹⁵² See, e.g., note 137.
- ¹⁵³ See note 133, p. 2300 (citing TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a) (West Cum. Supp. 2015)).

- ¹⁵⁴ See note 133, p. 2300.
- ¹⁵⁵ *Ibid.*, p. 2311.
- ¹⁵⁶ University of California, San Diego Department of Medicine. (n.d.). *About Us: What is a Hospitalist?* Retrieved 23 January 2018, from <http://hospitalmedicine.ucsd.edu/people/about.shtml>
- ¹⁵⁷ See, e.g., note 130, pp. 18–19.
- ¹⁵⁸ *Ibid.*
- ¹⁵⁹ 42 U.S.C. § 1395dd (2012). See also *Planned Parenthood of Wisc., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015).
- ¹⁶⁰ See note 127.
- ¹⁶¹ See, e.g., note 130, p. 4.
- ¹⁶² *Ibid.*, p. 16.
- ¹⁶³ *Ibid.*
- ¹⁶⁴ See, e.g., note 128, pp. 30–37.
- ¹⁶⁵ Catholics for Choice. (2011, April). *Memorandum from Catholics for Choice to Colleagues Regarding The Ethical and Religious Directives for Catholic Health Care Services*. Retrieved 23 January 2018, from <http://www.catholicsforchoice.org/wp-content/uploads/2014/01/CFCMemoontheDirectivesweb.pdf>
- ¹⁶⁶ See, e.g., note 146, p. 15. (Citations omitted.)
- ¹⁶⁷ *Ibid.*
- ¹⁶⁸ See note 130, p. 17.
- ¹⁶⁹ See note 133, p. 2300.
- ¹⁷⁰ *Cf. ibid.*
- ¹⁷¹ See note 133, p. 2310.
- ¹⁷² 33 VA. REG. REGS.1427, 1427–35 (2017); see also Center for Reproductive Rights. (2016, October 24). *Virginia Board of Health protects women’s access to constitutionally protected health care, votes to amend Texas-style clinic shutdown regulations* [Press release]. Retrieved 22 January 2018, from <https://www.reproductiverights.org/press-room/va-board-of-health-protects-womens-access-to-constitutionally-protected-health-care>
- ¹⁷³ See S. 210, Gen. Assemb. (Pa. 2017).
- ¹⁷⁴ See H.B. 455, Gen. Assemb., Reg. Sess. (Ga. 2017); H.B. 1173, 99th Gen. Assemb., 1st Reg. Sess. (Mo. 2017); S.B. 588, Gen. Assemb. (N.C. 2017); S.B. 1632, 85th Leg. (Tex. 2017); H.B. 2186, Reg. Sess. (Va. 2017).
- ¹⁷⁵ See, e.g., *Advancing New Standards in Reproductive Health*, University of California, San Francisco. (2014, June). *Health Workforce Pilot Project #171 Final Data Update*. Retrieved 23 January 2018, from <https://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 note 6, *National Abortion Federation*, p. 1 (“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.”). Currently, advanced practice clinicians provide aspiration abortion care in California, Montana, New Hampshire, Oregon and Vermont. See Barry, D., & Rugg, J. (2015, March). *Improving Abortion Access by Expanding Those Who Provide Care* (p. 6). Center for American Progress. Retrieved 23 January 2018, from <https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/>
- ¹⁷⁶ Guttmacher Institute. (2018, February). *State Laws and Policies: An Overview of Abortion Laws*. Retrieved 6 February 2018, from <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>
- ¹⁷⁷ See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 23 January 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>
- ¹⁷⁸ American College of Obstetricians and Gynecologists. (2014, March; reaffirmed 2016). *Practice Bulletin No. 143, Medical Management of First-Trimester Abortion* (p. 10). Retrieved 23 January 2018, from <https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1&ts=20180131T0745390907>
- ¹⁷⁹ See note 79, p. 1.
- ¹⁸⁰ See note 175, *Advancing New Standards in Reproductive Health*, p. 2 (“Patients report high satisfaction during their abortion experience whether they are seen by [an advance practice clinician] or a physician.”).
- ¹⁸¹ See, e.g., note 79, p. 3.
- ¹⁸² *Ibid.*
- ¹⁸³ See, e.g., note 175, Barry.
- ¹⁸⁴ See, e.g., note 79, p. 1 (supporting expansion of “the pool of first-trimester medication and aspiration abortion providers to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements”); *National Abortion Federation and Clinicians for Choice*. (n.d.). *Role of CNMs, NPs, and PAs in Abortion Care*. Retrieved 23 January 2018, from https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/CNM_NP_PA_org_statements.pdf (listing professional clinical associations that support an increased role of appropriately trained certified nurse-midwives, nurse practitioners or physician assistants, including American Academy of Physician Assistants, American College of Nurse-Midwives, American Medical Women’s Association, American Public Health Association, Association of Physician Assistants in Obstetrics and Gynecology and National Association of Nurse Practitioners in Women’s Health).
- ¹⁸⁵ See TEX. HEALTH & SAFETY CODE ANN. §§ 697.001–.009 (West 2017); see also 25 TEX. ADMIN. CODE §§ 1.132-137 (2016); 41 Tex. Reg. 9709 (Dec. 9, 2016). The regulation is temporarily blocked through litigation. *Whole Woman’s Health v. Hellerstedt*, 231 F. Supp. 3d 218, 233 (W.D. Tex. 2017) (granting Plaintiffs’ request for a stay pending the outcome of a preliminary injunction appeal). The legislation is also temporarily blocked through litigation. *Whole Woman’s Health v. Hellerstedt*, No. 1:16-cv-01300-DAE (W.D. Tex. Jan. 29, 2018). See IND. CODE § 16-34-3-
- 1 to -6 (2015) (permanently enjoined by *Planned Parenthood of Ind. & Ky., Inc. v. Commissioner*, 265 F. Supp. 3d 859 (S.D. Ind. 2017), *appeal filed*, No. 17-3163 (Oct. 19, 2017)). See LA. STAT. ANN. § 40:1061.25 (2016). This statute is currently not enforced pending litigation.
- ¹⁸⁶ *Ibid.*
- ¹⁸⁷ See, e.g., *Complaint at 12–13, Whole Woman’s Health v. Hellerstedt*, 231 F. Supp. 3d 218, 233 (W.D. Tex. 2017) (No. 1:16cv1300).
- ¹⁸⁸ *Ibid.*
- ¹⁸⁹ See note 187, p. 14.
- ¹⁹⁰ See note 137, *Guttmacher Institute*; see note 176. (Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin and Wyoming.)
- ¹⁹¹ See note 137. (Alabama, Arizona, Arkansas, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas and Utah.)
- ¹⁹² *Ibid.* (Alabama, Arkansas, Illinois, Indiana, Louisiana, Michigan, Mississippi, Missouri, Nebraska, Oklahoma, Pennsylvania, South Carolina, South Dakota, and Utah.)
- ¹⁹³ *Ibid.* (Alabama, Arizona, Arkansas, Florida, Indiana, Kansas, Kentucky, Michigan, Mississippi, Nebraska, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia and Wisconsin.)
- ¹⁹⁴ *Ibid.* (Alabama, Arizona, Arkansas, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah and Wisconsin.)
- ¹⁹⁵ *Ibid.* (Alabama, Kansas, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, Tennessee, Texas, Utah and Wisconsin.)
- ¹⁹⁶ *Ibid.* (Alabama, Arizona, Arkansas, Illinois, Indiana, Louisiana, Mississippi, Oklahoma, South Carolina and Texas.)
- ¹⁹⁷ *Ibid.* (Alabama, Louisiana, Mississippi, Oklahoma and Texas.)
- ¹⁹⁸ *Ibid.* (Florida, Kentucky, Michigan, North Carolina, Ohio, Pennsylvania, Tennessee and Wisconsin.)
- ¹⁹⁹ *Ibid.* (Tennessee and Wisconsin.)
- ²⁰⁰ See note 176. (Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin and Wyoming.)
- ²⁰¹ *Ibid.* (Louisiana and Mississippi.)
- ²⁰² See note 185.

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