

# BAD MEDICINE

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

Across the country, politicians are enacting anti-abortion laws that ignore evidence and science and mandate how health care providers must practice medicine, regardless of the provider's professional judgment, ethical obligations or the needs of his or her patients. *Bad Medicine: How a Political Agenda Is Undermining Abortion Care and Access*, a 2018 report by the National Partnership for Women & Families, documents this trend.<sup>1</sup> The report finds that a large majority of states have one or more of these "bad medicine" laws.

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

In June 2016, the U.S. Supreme Court struck down two onerous Texas abortion restrictions in *Whole Woman's Health v. Hellerstedt*. In that decision, the Court made clear that politicians are not allowed to make up facts in order to justify restrictions on abortion – unfortunately, a common practice in many states. That opinion strengthened the 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.<sup>3</sup> In 2018, the well-respected, nonpartisan National Academies of Sciences, Engineering, and Medicine released a definitive report making clear the harms that medically unnecessary abortion restrictions cause to women around the country.<sup>4</sup> Despite these clear legal and scientific strikes against bad medicine laws, Kansas has not taken any steps to remove from its books laws that disregard evidence and interfere with a woman's ability to obtain this care.

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



Biased Counseling



Ultrasound Requirements



Mandatory Delays



Medication Abortion Restrictions



TRAP Laws

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## Kansas's bad medicine laws include:

### **MANDATORY PROVISION OF BIASED INFORMATION.**

Under Kansas law, providers are required to give women state-drafted materials that include biased, inaccurate and misleading information, such as the unfounded assertion that a fetus at 20 weeks gestation can feel pain<sup>6</sup> and that "survival rates for infants born at 24 weeks have been reported as high as 81%."<sup>7</sup> Both of these statements are at odds with prevailing medical evidence on fetal development.<sup>8</sup> The Kansas written materials also imply there is a false link between abortion and breast cancer,<sup>9</sup> despite numerous studies finding that no such link exists.<sup>10</sup> Additionally, they contain unnecessary statements about the impact of abortion on future fertility, ideological assertions of embryonic and fetal personhood, descriptions of all common abortion procedures and descriptions of fetal development throughout the pregnancy rather than information about the gestational age relevant to the woman's pregnancy.<sup>11</sup> Finally, the written materials contain content emphasizing negative emotional responses to abortion,<sup>12</sup> even though it is well documented that an "overwhelming majority" of women feel relief after, and do not regret having, an abortion.<sup>13</sup>

Patients rely on their health care providers to give them accurate information based on medical evidence and their health needs, not on politicians' ideology. When a

state requires a health care provider to give information that is not based on scientific evidence or the interests of the patient, the patient can no longer trust that she is receiving the best possible care. That, in turn, diminishes the trust that is essential to the patient-provider relationship and undermines a woman's ability to make informed medical decisions.<sup>14</sup>

### **ULTRASOUND REQUIREMENTS.**

In Kansas, prior to an abortion, health care providers who administer an ultrasound must offer the woman the opportunity to view the ultrasound image.<sup>15</sup> Providers who use heart rate monitoring equipment prior to an abortion must also offer the woman the opportunity to listen to any fetal heartbeat, and she must sign a form stating she accepts or rejects this offer.<sup>16</sup> These requirements directly undermine a provider's ability to make health care decisions with a patient based on what is medically appropriate in her particular circumstances;<sup>17</sup> instead, politicians have inappropriately substituted their judgment as to the best course of care. Furthermore, by singling out abortion providers for political interference in the patient-provider relationship, Kansas lawmakers reveal these requirements are motivated not by concern for women's health but rather by a desire to communicate their opposition to abortion, and further complicate women's access to care.

### **PROVISION OF INFORMATION ABOUT FAKE WOMEN'S HEALTH CENTERS.**

Kansas law requires providers to give patients a state-created "list of providers of free ultrasound services . . ." <sup>18</sup> as well as a list of "agencies which offer alternatives to abortion . . ." <sup>19</sup> This may require providers to share with patients a list of anti-abortion facilities, known as fake women's health centers, which shame and lie to women to try to prevent them from accessing abortion care.

### **MANDATORY DELAY IN CARE.**

Under Kansas law, a patient must wait 24 hours after receiving biased information before being allowed to obtain abortion care<sup>20</sup> and then must wait an additional 30 minutes after initially seeing the provider at her appointment<sup>21</sup> – despite the fact that such a delay serves no medical purpose and actually undermines the provision of care.<sup>22</sup> Mandatory delays are designed to single out women seeking abortion care, implying they are unable to make informed decisions.<sup>23</sup> These laws can make abortion care more difficult and expensive to obtain.<sup>24</sup> Women are confident in their decision to have an abortion,<sup>25</sup> and mandatory delay laws only serve to postpone their care.

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## BAN ON PROVIDING MEDICATION ABORTION VIA TELEMEDICINE.

Though this restriction is currently blocked, Kansas prohibits the provision of medication abortion via telemedicine, disregarding medical evidence demonstrating that it is safe and improves access,<sup>26</sup> especially for individuals in rural or underserved areas.<sup>27</sup> 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.<sup>28</sup> Studies comparing medication abortion provided in person with those provided via telemedicine show equivalent effectiveness and similar rates of positive patient experience.<sup>29</sup> As the American College of Obstetricians and Gynecologists (ACOG) has noted, the two types of visits are “medically identical.”<sup>30</sup>

## HOSPITAL ADMITTING PRIVILEGES AND RELATED REQUIREMENTS.

Until this restriction was blocked by a Kansas state court in 2011,<sup>31</sup> Kansas law required abortion providers to maintain admitting privileges with a hospital within 30 miles of where they provide abortions.<sup>32</sup> Admitting privileges can be difficult or impossible for abortion providers to secure for reasons that have nothing to do with a provider’s skills.<sup>33</sup> Some hospitals only grant admitting privileges to physicians who accept faculty appointments.<sup>34</sup> 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.<sup>35</sup> Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.<sup>36</sup> And hospitals that adhere to religious directives that run counter to established medical standards<sup>37</sup> may refuse to grant privileges to abortion providers.<sup>38</sup> Moreover, admitting privileges requirements for abortion providers are unnecessary because of the way modern medicine is practiced. Not only are emergency rooms required to admit and treat any patient with an emergent condition,<sup>39</sup> but they rely on in-hospital doctors or on-call specialists to provide care on-site – not outside physicians.<sup>40</sup> A Kansas state court blocked this law in 2011,<sup>41</sup> and the U.S. Supreme Court struck down a similar law in *Whole Woman’s Health* in 2016.<sup>42</sup>

## PHYSICIAN-ONLY REQUIREMENT.

In Kansas, abortion care – including medication abortion – can only be provided by a physician.<sup>43</sup> This is despite evidence that advanced practice clinicians, such as nurse practitioners, certified nurse-midwives and physician assistants, can safely and effectively provide abortion care and do so in other states.<sup>44</sup> This Kansas law ignores the extensive training that advanced practice clinicians have in providing primary health care, managing chronic conditions and providing procedures that are more complex than abortion.<sup>45</sup> The law further ignores the fact that highly regarded organizations like ACOG recommend the pool of abortion providers be expanded to include “appropriately trained and credentialed advanced practice clinicians . . .”<sup>46</sup>

## TARGETED FACILITY LICENSING REQUIREMENTS.

Though these provisions are currently blocked by a Kansas state court, state law requires abortion clinics to meet unnecessary and burdensome facility licensing specifications, some of which are similar to those required of Ambulatory Surgical Centers (ASCs).<sup>47</sup> ASCs are designed for the delivery of complex and invasive surgeries historically provided in hospital settings.<sup>48</sup> In the *Whole Woman’s Health* decision, the U.S. Supreme Court found “considerable evidence . . . that the statutory provision [in Texas] requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary.”<sup>49</sup> 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,”<sup>50</sup> an assertion since reinforced by a large-scale scientific study that confirmed that abortions provided in office-based settings are just as safe as those provided in ASCs.<sup>51</sup> The Court also found that patients “will not obtain better care or experience more frequent positive outcomes” at ASCs.<sup>52</sup> The Court determined that abortion procedures were “safer than numerous procedures that take place outside hospitals and to which [the state] does not apply its surgical-center requirements[.]” Despite the decision, Kansas still has in place some requirements similar to the ones struck down in Texas.

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## Conclusion

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

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

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



Reject



Repeal



Protect



Speak Out



Rise Up

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## Endnotes

- 1 National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access* (3rd ed.). Retrieved 18 December 2018, from <http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf>
- 2 Blount, L. G., Yeung, M., & González-Rojas, J. (2015, April 30). Women of Color Leaders Call for a Change: End Barriers to Abortion Care. *TruthOut*. Retrieved 18 December 2018, from <http://www.truth-out.org/opinion/item/30520-women-of-color-leaders-call-for-a-change-end-barriers-to-abortion-care>; National Partnership for Women & Families. (2016, September). *A Double Bind: When States Deny Abortion Coverage and Fail to Support Expecting and New Parents* (p. 4). Retrieved 18 December 2018, from <http://www.nationalpartnership.org/research-library/repro/abortion/a-double-bind.pdf> (For example, due to pervasive inequalities in access to quality health care, women of color are at a higher risk for unintended pregnancy – more than twice as much as white women.) Additionally, the one-two punch of racism and sexism against women of color helps create conditions of socioeconomic inequality, meaning financial barriers can be more difficult to surmount. Women of color who also experience other intersecting identities, such as insecure immigration status, disability and/or language barriers, among others, will necessarily experience discrimination and barriers based on these intersections. See, e.g., Desmond-Harris, J. (2017, January 21). To Understand the Women's March on Washington, You Need to Understand Intersectional Feminism. *Vox*. Retrieved 18 December 2018, from <http://www.vox.com/identities/2017/1/17/14267766/womens-march-on-washington-inauguration-trump-feminism-intersectionality-race-class> (discussing the concept of multiple barriers – intersectionality – and how it operates in the lives of women of color in particular). It stands to reason that any obstacles to abortion will fall hardest on women of color, especially on women of color who are also low-income or experiencing other intersecting barriers to care.
- 3 *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016).
- 4 National Academies of Sciences, Engineering, and Medicine. (2018). *The Safety and Quality of Abortion Care in the United States*. Retrieved 18 December 2018, from <https://www.nap.edu/24950>
- 5 The examples discussed in this report are illustrative of the ways in which Kansas restricts abortion care and undermines the practice of medicine. Sadly, Kansas has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2018, May). *State Facts About Abortion: Kansas*. Retrieved 18 December 2018, from <https://www.guttmacher.org/sites/default/files/factsheet/sfaa-ks.pdf>
- 6 KAN. STAT. § 65-6710(a)(2); Kansas Department of Health and Environment. *If You Are Pregnant* (p. 3). Retrieved 18 December 2018, from [http://www.womansrighttoknow.org/download/Handbook\\_English.pdf](http://www.womansrighttoknow.org/download/Handbook_English.pdf)
- 7 KAN. STAT. § 65-6710(a)(3); see note 6, Kansas Department of Health and Environment (p. 13).
- 8 See, e.g., Anderson, J. G., Baer, R. J., Partridge, J. C., Kuppermann, M., Franck, L. S., Rand, L., . . . Rogers, E. E. (2016). Survival and major morbidity of extremely preterm infants: A population-based study (pp. 3–4). *Pediatrics*, 138(1) (finding that “[a]mong the infants born at 22, 23, and 24 weeks, survival to 1 year of age was 6%, 27%, and 60%, respectively . . .” but that roughly 57 percent of fetuses born at 24-weeks gestation had more than one major morbidity); Hoekstra, R. E., Ferrara, T. B., Couser, R. J., Payne, N. R., & Connett, J. E. (2004, January). Survival and long-term neurodevelopmental outcomes of extremely premature infants born at 23–26 weeks' gestational age at a tertiary center. *Pediatrics*, 113(1), e1–e6 (demonstrating how, even for extremely premature infants that survive, they are likely to experience long-term, severe health consequences); Lee, S. J., Ralston, H. J. R., Drey, E. A., Partridge, J. C., & Rosen, M. A. (2005, August). Fetal pain: A systematic multidisciplinary review of the evidence (p. 952). *Journal of the American Medical Association*, 294(8), 947–954 (“ . . . the capacity for conscious perception of pain can arise only after thalamocortical pathways begin to function, which may occur in the third trimester around 29 to 30 weeks' gestational age, based on the limited data available.”).
- 9 KAN. STAT. § 65-6710(a)(2); see note 6, Kansas Department of Health and Environment (p. 26).
- 10 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* (p. e1). Retrieved 18 December 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). *Abortion and Breast Cancer Risk*. Retrieved 18 December 2018, from <https://www.cancer.org/cancer/cancer-causes/medical-treatments/abortion-and-breast-cancer-risk.html> (“[S]cientific research studies have not found a cause-and-effect relationship between abortion and breast cancer.”)
- 11 See note 6, Kansas Department of Health and Environment (pp. 3-22).
- 12 *Ibid.*, p. 27.
- 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 (p. e2). *Public Library of Science ONE*, 10(7), e1-e16; 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 18 December 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 1, p. 6.
- 15 KAN. STAT. § 65-6709(h)(1).
- 16 KAN. STAT. § 65-6709(i)(2)-(4).
- 17 See, e.g., note 4, pp. 2-5, 5-5.
- 18 KAN. STAT. § 65-6709(b)(2); KAN. STAT. § 65-6710(a)(1).
- 19 KAN. STAT. § 65-6709(b)(2).
- 20 KAN. STAT. § 65-6709(b).
- 21 KAN. STAT. § 65-6709(c).
- 22 Mandatory delays disregard a fundamental principle of quality care articulated by the National Academy of Medicine: care should be timely, reduce waits and delays, and be provided according to medical need and the patient's best interests. Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (pp. 2–3). Retrieved 18 December 2018, from <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> (The Institute of Medicine was renamed in 2015 to the National Academy of Medicine.) It is the patient, in consultation with her health care provider, who must make decisions about timing — not politicians. See also note 4, p. 2-26.
- 23 See Guttmacher Institute. (July 2018). *Waiting Periods for Abortion*. Retrieved 18 December 2018, from <https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion>
- 24 American Civil Liberties Union. (n.d.). *Government-Mandated Delays Before Abortion*. Retrieved 18 December 2018, from <https://www.aclu.org/other/government-mandated-delays-abortion>

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- <sup>25</sup> See note 23.
- <sup>26</sup> Trust Women Found., Inc. v. Schmidt, No. 2018-CV-844, slip op. at 11 (3rd D. Kan., Div. 7 filed Dec. 31, 2018).
- <sup>27</sup> See note 4, pp. 2-10 to 2-11.
- <sup>28</sup> See Boonstra, H. D. (2013). Medication abortion restrictions burden women and providers – and threaten U.S. trend toward very early abortion (p. 20). *Guttmacher Policy Review*, 16(1), 18–23.
- <sup>29</sup> See, e.g., Grossman, D., Grindlay, K., Buchacker, T., Lane, K., & Blanchard, K. (2011, August). Effectiveness and acceptability of medical abortion provided through telemedicine (p. 302). *Obstetrics & Gynecology*, 118(2), 296–303.
- <sup>30</sup> Final Amicus Curiae Brief for Am. Coll. of Obstetricians & Gynecologists at 10, Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).
- <sup>31</sup> Hodes & Nausser v. Moser, No. 2:11-CV-02365-CM-KMH, 2011 WL 4553061, at \*1, \*1 (D. Kan. Sept. 29, 2011).
- <sup>32</sup> KAN. STAT. § 65-4a09(d)(3).
- <sup>33</sup> See, e.g., Brief for Amici Curiae Am. Coll. of Obstetricians & Gynecologists et al. in Support of Petitioners at 16–17, 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).
- <sup>34</sup> *Ibid.*, p. 16.
- <sup>35</sup> *Ibid.*
- <sup>36</sup> Amici Curiae Brief of Pub. Health Deans et al. in Support of Petitioners at 17, Whole Woman’s Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016).
- <sup>37</sup> See generally Catholics for Choice. (2011, April). *Memorandum from Catholics for Choice to Colleagues Regarding the Ethical and Religious Directives for Catholic Health Care Services*. Retrieved 18 December 2018, from <http://www.catholicsforchoice.org/wp-content/uploads/2014/01/CFCMemoontheDirectivesweb.pdf>
- <sup>38</sup> See, e.g., Brief of Amicus Curiae Am. Pub. Health Ass’n in Support of Petitioners at 15, Whole Woman’s Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (citations omitted).
- <sup>39</sup> 42 U.S.C. § 1395dd.
- <sup>40</sup> See note 38, p. 13.
- <sup>41</sup> Center for Reproductive Rights. (2011, November 9; revised 2015, September 11). *State: Hodes & Nausser v. Moser*. Retrieved 18 December 2018, from <https://www.reproductiverights.org/case/state-hodes-nausser-mds-pa-et-al-v-robert-moser-md-et-al>
- <sup>42</sup> See note 3, pp. 2312–2314.
- <sup>43</sup> KAN. STAT. § 65-4a10(a).
- <sup>44</sup> Studies show that advanced practice clinicians can provide safe and effective abortion care. See Advancing New Standards in Reproductive Health. (2014, June). *Health Workforce Pilot Project #171 Final Data Update* (p. 2). Retrieved 18 December 2018, from <http://www.ansirh.org/sites/default/files/documents/hwppupdate-june2014.pdf> (concluding that nurse practitioners, certified nurse-midwives and physician assistants “can provide early abortion care that is clinically as safe as physicians”); see also National Abortion Federation. (2018). *2018 Clinical Policy Guidelines* (p. 1). Retrieved 18 December 2018, from <https://prochoice.org/education-and-advocacy/cpg/> (“Abortion is a safe procedure when provided by qualified practitioners. . . This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, and other health professionals.”) As of March 2015, advanced practice clinicians provide aspiration abortion care in California, Montana, New Hampshire, Oregon and Vermont. See Barry, D., & Rugg, J. (2015, March 26). *Improving Abortion Access by Expanding Those Who Provide Care*. Center for American Progress. Retrieved 18 December 2018, from <https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/>
- <sup>45</sup> See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 18 December 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>
- <sup>46</sup> Committee on Healthcare for Underserved Women, American College of Obstetricians and Gynecologists. (2014, November; Reaffirmed 2017). *Committee Opinion No. 613, Increasing Access to Abortion* (p. 1). Retrieved 18 December 2018, from <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>; see also note 4, p. 5-4.
- <sup>47</sup> See KAN. ADMIN. REGS. §§ 28-34-126 – 144. These regulations have been temporarily blocked as legal challenges are ongoing. Hodes & Nausser v. Moser, Case No. 11-C-1298 (Kan. Dist. Ct., Shawnee Cnty. Dec. 2, 2011).
- <sup>48</sup> See, e.g., Brief for Amici Curiae Am. Coll. of Obstetricians & Gynecologists et al. in Support of Petitioners at 10, Whole Woman’s Health v. Cole, 136 S. Ct. 499 (2015) (No. 15-274), *sub nom.* Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016).
- <sup>49</sup> See note 3, p. 2315.
- <sup>50</sup> *Ibid.* (quoting Whole Woman’s Health v. Lakey, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).
- <sup>51</sup> Roberts, S. C. M., Upadhyay, U. D., Liu, G., Kerns, J. L., Ba, D., Beam, N., & Leslie, D. L. (2018). Association of facility type with procedural-related morbidities and adverse events among patients undergoing induced abortions (p. 2503). *Journal of the American Medical Association*, 319(24), 2497–2506.
- <sup>52</sup> See note 3, p. 2315.

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

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