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BAD MEDICINE

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

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

Oklahoma 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.[2]

In June 2016, the U.S. Supreme Court struck down two onerous Texas abortion restrictions in *Whole Woman's Health v. Hellerstedt*. In that decision, the Court made clear that politicians are not allowed to make up facts in order to justify restrictions on abortion – unfortunately, a common practice in many 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.[3] 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.[4] Despite these clear legal and scientific strikes against bad medicine laws, Oklahoma 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 Oklahoma politicians legislate bad medicine. It highlights examples of laws that undermine quality abortion care by interfering in the patient-provider relationship and advancing an ideological agenda that flouts medical evidence and scientific integrity.[5] Taken collectively or individually, these Oklahoma laws create significant burdens on a woman's access to abortion care.

Biased Counseling

Ultrasound Requirements

Mandatory Delays

Medication Abortion Restrictions

TRAP Laws

Oklahoma's bad medicine laws include:

MANDATORY PROVISION OF BIASED INFORMATION.

Under Oklahoma law, providers are required to inform patients of state-drafted materials that include biased, inaccurate and deceptive information,[6] such as the misleading assertion that a fetus at 20 weeks gestation "has the physical structures necessary to experience pain."[7] This statement is at odds with prevailing medical evidence on fetal development.[8] The Oklahoma materials also include misleading information about possible links between abortion and breast cancer,[9] despite numerous studies finding no such link exists.[10] Additionally, they include the unscientific, ideological assertion that "abortion shall terminate the life of a whole, separate, unique, living human being"[11] – a statement designed to shame a woman for her decision. Patients rely on their health care providers to give them accurate information based on medical evidence and their health needs, not on politicians' ideology. When a state requires a health care provider to give information that is not based on scientific evidence or the interests of the patient, the patient can no longer trust that she is receiving the best possible care. That, in turn, diminishes the trust that is essential to the patient-provider relationship and undermines women's ability to make informed medical decisions.[12]

DISPLAY AND DESCRIBE ULTRASOUND MANDATE.

Until the provisions were ruled unconstitutional by the Oklahoma Supreme Court in 2012,[13] health care providers in the state were required to administer an ultrasound prior to abortion care,[14] display the ultrasound image and give a detailed description of what it depicts – even when a woman objected.[15] Providers were also required to visually display and describe the presence of any fetal heartbeat,[16] and to use the ultrasound method that would display the image "more clearly."[17] In 2014, the Oklahoma legislature attempted yet again to implement mandatory ultrasound measures, passing a law that required the Oklahoma State Board of Health to promulgate regulations requiring an ultrasound before abortion care.[18] This measure was also found unconstitutional by the Oklahoma Supreme Court. While neither ultrasound law is currently in effect, the Oklahoma legislature has not taken steps to repeal these provisions.

Mandatory ultrasounds 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.[19] The ultrasound mandate also flies in the face of medical ethics, which make clear that a patient's decision to decline "information is 'itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy.'"[20] It is a violation of medical standards to use a procedure to influence, shame or demean a patient.[21] Forced ultrasound, by definition, is not quality care.

PROVISION OF INFORMATION ABOUT FAKE WOMEN'S HEALTH CENTERS.

Oklahoma law requires providers to inform patients of a state-created list of agencies that provide "ultrasound imaging and heart tone monitoring that enable the pregnant woman to view her unborn child or listen to the heartbeat of the unborn child . . . at no cost,"[22] as well as a "list [of] agencies that offer alternatives to abortion . . ."[23] This may require physicians to share with patients a list of anti-abortion facilities, known as fake women's health centers, which shame and lie to women to try to prevent them from accessing abortion care.

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MANDATORY DELAY IN CARE FOR NO MEDICAL REASON.

Under Oklahoma law, a patient must wait 72 hours after receiving biased information before being allowed to obtain abortion care[24] – despite the fact that such a delay serves no medical purpose and actually undermines the provision of care.[25] Mandatory delay laws are designed to single out women seeking abortion care, implying they are unable to make informed decisions.[26] For women who are close to the cutoff for medication abortion or for a first-trimester procedure, this mandatory delay could force them to undergo procedures that are more complicated, more expensive or more time-consuming.[27] Mandatory delays compound the problems created by provider shortages, and have the biggest impact on rural, young and low-income women.[28] Mandatory delays in Oklahoma push women further into pregnancy, meaning that sometimes clinics must refer them to providers in other states for abortion care, increasing cost and burdens on women and their families.

BAN ON PROVIDING MEDICATION ABORTION VIA TELEMEDICINE.

Oklahoma prohibits the provision of medication abortion via telemedicine, disregarding medical evidence demonstrating that it is safe and improves access.[29]

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.[30] Studies comparing medication abortion provided in person with that provided via telemedicine show equivalent effectiveness and similar rates of positive patient experience.[31] As the American College of Obstetricians and Gynecologists (ACOG) has noted, the two types of visits are "medically identical."[32]

Telemedicine is especially important for individuals in rural or underserved areas[33] who may need to travel long distances to obtain care, in part because of the significant shortage of reproductive health providers in their communities.[34] The burden of this ban on telemedicine is worsened by the fact that there is no law in Oklahoma guaranteeing that private sector employees can earn paid sick days; more than 44 percent of private sector workers in Oklahoma cannot earn a single paid sick day.[35] That means many women are forced to go without pay, and even risk losing their jobs, in order to make the trip required to obtain a medication abortion.

TARGETED FACILITY LICENSING REQUIREMENTS.

Under Oklahoma law, abortion clinics must meet unnecessary and burdensome facility licensing specifications that are similar to those required of ambulatory surgical centers (ASCs).[36] ASCs are designed for the delivery of complex and invasive surgeries historically provided in hospital settings.[37] 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."[38] 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,"[39] 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.[40] The Court also found that patients "will not obtain better care or experience more frequent positive outcomes" at ASCs.[41] 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[.]"[42] Despite the decision, Oklahoma still has in place requirements similar to the ones struck down in Texas.

HOSPITAL ADMITTING PRIVILEGES.

Until this restriction was blocked by the Oklahoma Supreme Court in 2016,[43] Oklahoma law required that on the day an abortion is provided, a physician with admitting privileges at an accredited hospital within 30 miles of the abortion clinic "must remain on the premises of the facility."[44] Admitting privileges can be difficult or impossible for abortion providers to secure for reasons that have nothing to do with a provider's skills.[45] Some hospitals only grant admitting privileges to physicians who accept faculty appointments.[46] 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.[47] Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.[48] And hospitals that adhere to religious directives that run counter to established medical standards[49] may refuse to grant privileges to abortion providers.[50] 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, but they rely on in-hospital doctors to provide care on-site – not outside physicians.[51] The Oklahoma Supreme Court blocked these restrictions following the precedent set in the U.S. Supreme Court's decision in *Whole Woman's Health*,[52] in which the Court held that a similar provision in Texas was unconstitutional.[53]

PHYSICIAN-ONLY REQUIREMENT.

In Oklahoma, abortion care – including medication abortion – can only be provided by a physician.[54] 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.[55] This Oklahoma law ignores the extensive training that advanced practice clinicians have in providing primary health care, managing chronic conditions and performing procedures that are more complex than abortion.[56] 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 . . ."[57]

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 Oklahoma. Numerous laws in Oklahoma 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 Oklahoma is able to access the care she needs with dignity and without barriers.**

Reject

Repeal

Protect

Speak Out

Rise Up

Endnotes

[1] National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access* (3rd ed.). Retrieved 16 January 2019, 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 16 January 2019, 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 16 January 2019, 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 16 January 2019, from http://www.vox.com/identities/2017/1/17/14267766/womens-march-on-washington-inauguration-trump-feminism-intersectionaltiy-race-class (discussing the concept of multiple barriers – intersectionality – and how it operates in the lives of women of color in particular). It stands to reason that any obstacles to abortion will fall hardest on women of color, especially on women of color who are also low-income or experiencing other intersecting barriers to care.

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

[4] National Academies of Sciences, Engineering, and Medicine. (2018). *The Safety and Quality of Abortion Care in the United States*. Retrieved 16 January 2019, from https://www.nap.edu/24950

[5] The examples discussed in this report are illustrative of the ways in which Oklahoma restricts abortion care and undermines the practice of medicine. Sadly, Oklahoma has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2018, May). *State Facts About Abortion: Oklahoma*. Retrieved 16 January 2019, from https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-oklahoma

[6] Okla. Stat. Ann. tit. 63, §§ 1-738.2(B)(2)(c), 1-738.3(A)(2).

[7] Okla. Stat. Ann. tit. 63, § 1-738.10(A). See also Oklahoma Board of Medical Licensure and Supervision. (2015, December). *A Woman's Right to Know*. (4th ed.) (p. 5). Retrieved 16 January 2019, from http://www.awomansright.org/pdf/AWRTK_Booklet-English-sm.pdf

[8] See, e.g., 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] See note 7, Oklahoma Board of Medical Licensure and Supervision (p. 17).

[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. 1). Retrieved 17 January 2019, 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 17 January 2019, 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] Okla. Stat. Ann. tit. 63, § 1-738.3(A)(2)(d).

[12] See note 1, p. 6.

[13] Nova Health Sys. v. Pruitt, 292 P.3d 28, 28 (Okla. 2012), *cert. denied*, 571 U.S. 1010 (2013).

[14] Okla. Stat. Ann. tit. 63, § 1-738.3d(B)-(C), *ruled unconstitutional in* Nova Health Sys. v. Pruitt, 292 P.3d 28, *as corrected* (Okla. 2012).

[15] Okla. Stat. Ann. tit. 63, § 1-738.3d(B)(2)–(4).

[16] Okla. Stat. Ann. tit. 63, § 1-738.3d(B)(3)–(4).

[17] Okla. Stat. Ann. tit. 63, § 1-738.3d(B)(1).

[18] Okla. Stat. Ann. tit. 63, § 1-738(E)(3)(d), *ruled unconstitutional in* Burns v. Cline, 387 P.3d 348 (Okla. 2016).

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

[20] 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 16 January 2019, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809).

[21] See, e.g., Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2015). *Committee Opinion No. 439, Informed Consent* (p. 3). Retrieved 16 January 2019, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20151214T2054307809 ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."); American Medical Association. (2001). *AMA Code of Medical Ethics, Principles of Medical Ethics* (p. 1). Retrieved 16 January 2019, from https://www.ama-assn.org/sites/default/files/media-browser/principles-of-medical-ethics.pdf ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."); American College of Physicians. *ACP Ethics Manual* (7th ed.). Retrieved 16 January 2019, from https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-seventh-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-seventh-edition ("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.")

[22] Okla. Stat. Ann. tit. 63, § 1-738.2(B)(1)(a)(5).

[23] Okla. Stat. Ann. tit. 63, § 1-738.2(B)(2)(c)(3).

[24] Okla. Stat. Ann. tit. 63, § 1-738.2(B)(1)(a).

[25] Mandatory delays disregard a fundamental principle of quality care articulated by the National Academy of Medicine: care should be timely, reduce waits and delays, and be provided according to medical need and the patient's best interests. Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (pp. 2–3). Retrieved 16 January 2019, 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.

[26] See Guttmacher Institute. (2018, July). *Waiting Periods for Abortion*. Retrieved 16 January 2019, from https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion

[27] Brief for the Petitioner at 19, Nova Health Sys. v. Pruitt, No. CV-2015-1838, slip op. (Okla. Cty. Dist. Ct. 2015), 2015 Okla. Dist. LEXIS 1045 ("Because the risks of abortion, while extremely low, increase as the pregnancy advances, the 72-hour mandatory delay will increase the risk of complications for women seeking abortion. Women who are close to the cutoff for medication abortion (which is 63 days LMP at the Clinic), may be forced to have a surgical abortion instead, even if a medication abortion would be a more appropriate option. For patients who are close to 12 weeks LMP, the 72-hour delay may push them from a first-trimester surgical procedure to second-trimester procedure, which carries additional health risks for women,

costs more than first-trimester procedure, and is almost always is a two-day procedure. If the Clinic is still able to perform D & E procedures up to 17 weeks LMP, the mandatory delay law may push some women beyond the gestational limit for when abortions are available at the Clinic and therefore in the state, forcing them to turn to out-of-state providers.").

[28] See, e.g., note 26; 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 16 January 2019, from https://www.guttmacher.org/sites/default/files/report_pdf/mandatorycounseling.pdf (noting that while mandatory delay and counseling laws affect women across economic and age spectrums, women who have resources – that is older, more educated and non-poor women – are better able to access services despite the restrictions); Texas Policy Evaluation Project. (2013, April). *Research Brief: Impact of Abortion Restrictions in Texas* (p. 1). Retrieved 16 January 2019, from http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf ("These laws have had the greatest impact on low-income women and women in rural counties."); American Civil Liberties Union. (n.d.). *Government-Mandated Delays Before Abortion*. Retrieved 16 January 2019, from https://www.aclu.org/other/government-mandated-delays-abortion

[29] Okla. Stat. Ann. tit. 63, § 1-729.1 ("When RU-486 (mifepristone) or any other drug or chemical is used for the purpose of performing or inducing an abortion, the physician who is prescribing, dispensing, or otherwise providing the drug or chemical shall be physically present, in person, in the same room as the patient when the drug or chemical is first provided to the patient.").

[30] See Boonstra, H. D. (2013). Medication abortion restrictions burden women and providers – and threaten U.S. trend toward very early abortion (p. 20). *Guttmacher Policy Review, 16*(1), 18–23. Retrieved 16 January 2019, from http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf

[31] 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.

[32] 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).

[33] See note 4, p. 2-11.

[34] 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 16 January 2019, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20180122T0424256502; Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, February; reaffirmed 2018). Committee Opinion No. 586, *Health Disparities in Rural Women* (p. 2). Retrieved 17 January 2019, from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20190117T1247072998

[35] Institute for Women's Policy Research & National Partnership for Women & Families. (2015, May). *Workers' Access to Paid Sick Days in the States.* Retrieved 16 January 2019, from http://www.nationalpartnership.org/research-library/work-family/psd/workers-access-to-paid-sick-days-in-the-states.pdf

[36] See Okla. Admin. Code § 310:600-11-1, 2.

[37] 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).

[38] See note 3, p. 2315.

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

[40] 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.

[41] See note 3, p. 2315.

[42] Ibid.

[43] Burns v. Cline, 387 P.3d 348, 356 (Okla. 2016).

[44] Okla. Stat. Ann. tit. 63, § 1-748(B).

[45] See note 37, pp. 16-17.

[46] Ibid, p. 16.

[47] Ibid.

[48] *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).

[49] See generally Catholics for Choice. (2011, April). *The Ethical and Religious Directives for Catholic Health Care Services* [Memorandum]. Retrieved 16 January 2019, from http://www.catholicsforchoice.org/wp-content/uploads/2014/01CFCMemoontheDirectivesweb.pdf

[50] 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.).

[51] See note 37, pp. 18–19.

[52] See note 43, pp. 352–54.

[53] See note 3, pp. 2310–14.

[54] Okla. Stat. Ann. tit. 63, § 1-731(A).

[55] 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 17 January 2019, 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 17 January 2019, 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 17 January 2019, from https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/

[56] See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 17 January 2019, 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

[57] See note 34, *Committee Opinion No. 613* (p.1); see also note 4, pp. 3-7 to 3-9.

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

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