# BAD MEDICINE

## How a Political Agenda is Undermining Women's Health Care

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**About the National Partnership for Women & Families**

At the National Partnership for Women & Families, we believe that actions speak louder than words, and for four decades we have fought for every major policy advance that has helped women and families.

Today, we promote reproductive health and rights, access to quality, affordable health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. Our goal is to create a society that is free, fair and just, where nobody has to experience discrimination, all workplaces are family friendly and no family is without quality, affordable health care and real economic security.

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.



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# BAD MEDICINE

## How a Political Agenda is Undermining Women's Health Care

States across the country are increasingly enacting laws mandating how health care providers must practice medicine, regardless of the provider's professional judgment and 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. They are political infringement on the provision of health care – they are ***Bad Medicine***.

States have an important role to play in regulating the medical profession,[1] but when those regulations do not comport with medical standards or when they directly interfere in the relationship between patients and their health care providers, lawmakers have abused their authority. Examples of laws or regulations that undermine health care include:

- Requiring a health care provider to give – and a patient to receive – tests or procedures that are not supported by evidence, the provider's medical judgment or the patient's wishes.
- Dictating the information that a health care provider must or must not give to a patient, including requirements to provide biased or medically inaccurate information.
- Forcing a health care provider to delay time-sensitive care regardless of the provider's medical judgment or the patient's needs.
- Prohibiting a health care provider from prescribing medication using the best and most current evidence, medical protocols and methods.

**"[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 in the *New England Journal of Medicine*, Oct. 2012**

This report focuses on women's health and, specifically, on the provision of abortion care. However, the growing trend of imposing ideology on medical care has far broader implications. Similar restrictions impair health care providers' ability to counsel patients on gun safety or environmental risk factors, among other health and safety concerns. Major medical organizations from the American Medical Association (AMA),[2] to the American College of Physicians (ACP),[3] to the American College of Obstetricians and Gynecologists (ACOG),[4] have all recognized that this trend of political interference in medical decision-making is detrimental to patient care.

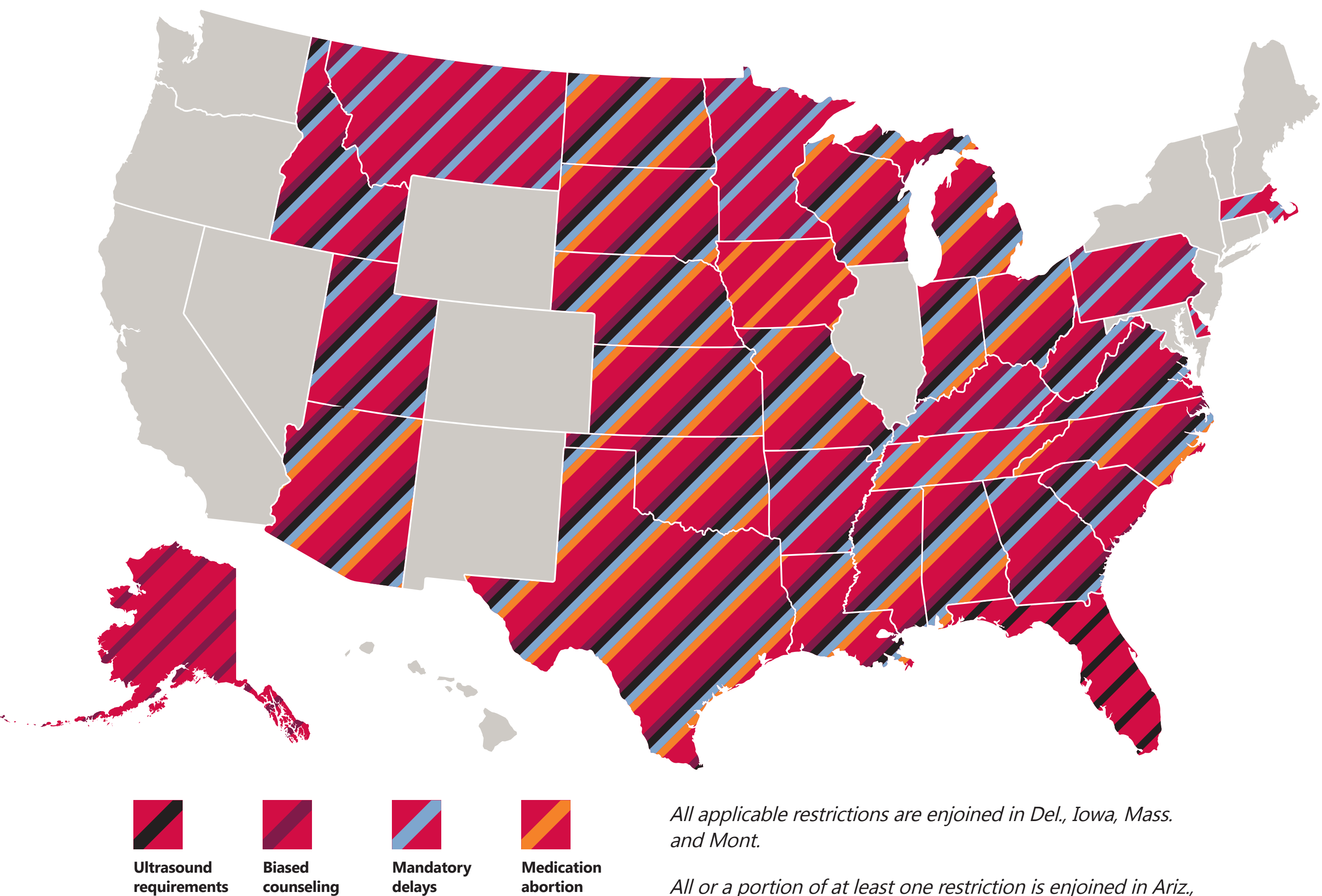
All patients deserve accurate information, high-quality care and the treatment options that best meet their needs. Health care providers should not be forced to choose between adhering to their ethical and professional obligations to provide the highest standard of care and following legal restrictions enacted in pursuit of a political agenda.

The abortion restrictions covered in this report include:[*]

- Ultrasound Requirements
- Biased Counseling
- Mandatory Delays
- Medication Abortion Restrictions

Thirty-three states have restrictions that fit into at least one of these categories; 16 states have all four types.[5†] Several laws have been enjoined through court challenges, but 29 states have at least one restriction in force, and all four types are in force in 15 states.

## Bad Medicine Overview




[*] This list is not meant to be comprehensive, but instead demonstrates how abortion restrictions can directly contradict medical judgment, interfere in the patient-provider relationship and undermine health care providers' ability to provide 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.

[†] As of June 1, 2014. The specific requirements of each law vary from state to state, and some restrictions may be modified in limited circumstances. All applicable restrictions are enjoined in Delaware, Iowa, Massachusetts and Montana. All or a portion of at least one restriction is enjoined in Arizona, North Carolina, North Dakota, Oklahoma and Tennessee.

# What Is Quality Health Care?

According to the Institute of Medicine – an independent, nonprofit organization that serves as the health arm of the National Academy of Sciences – quality care is care that meets the patient's needs and is based on the best scientific knowledge.[6] It is the *right care* at the *right time* in the *right setting* for the individual patient.[7] There is a strong national consensus that quality care should be evidence-based and patient-centered, and should improve health outcomes. Health care providers, the federal government, state and local governments and patient advocates across the country are all investing significant resources in promoting high-quality care.[8]

**"When the legislature dictates medicine the quality of care suffers."**

**— Dr. Douglas Laube, Past President, American College of Obstetricians and Gynecologists, regarding Wisconsin's restrictions on medication abortion, Dec. 2012**

When it comes to regulation of abortion care, however, things are moving in the opposite direction. States are enacting restrictions that try to undermine health care providers' ability to give the best possible care. The laws described in this report put providers in the position of having to choose between adhering to their ethical and professional obligations to provide patient-centered, evidence-based care and following legislative restrictions that are not based on medical standards or patient needs.

This report details how laws imposing ideology on health care hinder providers' efforts to give the highest quality care, individualized for each patient.

**"Prior to the passage of these onerous legislative restrictions, our only focus was to treat patients with dignity and respect, with the first priority being a focus on providing the highest quality medical services with compassion and attention to patient needs. Unfortunately the passage of these laws means that our focus has had to be distracted. While we continue to strive for patient-centered experiences, we struggle to do this while at the same time abiding by the laws in our state."**

**— Brooke Bailey, Clinic Counselor, Florida**

# Ultrasound Requirements

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

**"Mandated care may also interfere with the patient-physician relationship and divert clinical time from more immediate clinical concerns."**

**— American College of Physicians, Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship, July 2012**

While ultrasound is frequently used as a standard part of abortion care, best practices and medical ethics dictate that it should be administered only when the health care provider believes it is necessary for medical purposes or the patient requests it.[9] Laws requiring a provider to administer an ultrasound, along with other state-directed mandates such as forcing a provider to display the image and describe it, even when a woman objects, undermine quality health care. It is a violation of medical standards to use a procedure to influence, shame or demean a patient.[10]

Quality care is based on evidence and medical need in the context of each patient's individual circumstances. Yet some states force providers to place the ultrasound image in the patient's view and then give a detailed, pre-scripted description of that image. 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.[11] These laws usurp the medical judgment of health care providers and ignore the needs and best interests of women. Additional mandates such as a delay after the ultrasound or a requirement that the ultrasound and the abortion be performed by the same provider cause unnecessary delays and directly undermine the provider's ability to make health care decisions with the patient based on what is medically appropriate in her particular circumstance.[12]

## Mapping Ultrasound Requirements

Twenty-four states regulate the provision of ultrasound by abortion providers.[13] 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; or requiring a provider to offer specific information if an ultrasound is already included in the patient's care.[14]

**"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**

Of the 24 states regulating ultrasound by abortion providers, 13 have passed laws **mandating** an ultrasound before an abortion,[15] and of those, **five include a requirement that the provider display and describe the image, forcing the provider to give, and the patient to receive, information she may not want or need**.[16‡] The other states that mandate an ultrasound require that the provider offer the patient the opportunity to see the image.

‡ Enforcement is enjoined in North Carolina and Oklahoma. In addition to the enjoined law, North Carolina regulations mandate an ultrasound and require that the provider offer the patient the opportunity to see the image; this regulation remains in place and enforceable. In Oklahoma, the 2010 law is permanently enjoined; in May 2014, the governor signed a law directing the state Board of Health to implement additional abortion regulations, including ultrasound for all abortion patients. The 2014 law is set to go into effect on November 1, 2014.

Transvaginal ultrasound may be necessary to meet the requirements of many of these laws early in pregnancy.[17]

In addition to the laws mandating ultrasound, 18 states have laws regulating pre-abortion ultrasound in other ways. In four states, the provider is required to offer an ultrasound.[18] In nine states, a patient must be explicitly offered the opportunity to view the ultrasound image if the provider performs one.[19] Twelve states also require that the woman be given or offered information on how to access ultrasound services.[20]

In five states, the ultrasound must take place 24 hours before the abortion procedure for most women,[21] thus creating **a mandatory delay of a time-sensitive procedure** without regard to the wishes of the patient and without any medical rationale. (See section on Mandatory Delays below for more information.)

> **"The sanctity of the patient-physician relationship is the foundation of health care in America, and it must be preserved to assure candid communication and allow patients to evaluate their care options. The Legislature's role should not be to dictate how physicians and patients communicate with one another or what procedures and diagnostic tests must be performed on a given patient."**
>
> **— Texas Medical Association letter to Texas State Sen. Robert Duncan, regarding legislation imposing an ultrasound requirement, Feb. 2011**

# Ultrasound Requirements

**Provider must perform ultrasound, display image and describe fetal characteristics**

**Provider must perform ultrasound and offer opportunity to view image**

**Provider must offer opportunity to view ultrasound image if performing procedure**

**Provider must offer ultrasound procedure**

**Provider must offer or give patient information about obtaining an ultrasound**

*Laws requiring providers to perform ultrasound, display image and describe fetal characteristics are enjoined in N.C. and Okla. In addition to the enjoined law, N.C. regulations mandate an ultrasound and require that providers offer patients the opportunity to see the image – this regulation remains in place and enforceable. In Okla., the 2010 law is permanently enjoined; in May 2014, the governor signed a law directing the state Board of Health to implement additional abortion regulations, including ultrasounds for all abortion patients. The 2014 law is set to go into effect on November 1, 2014.*

# Biased Counseling

**Bad medicine is dictating the content of a 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 both a fundamental requirement for medical practice in every state and the foundation of the patient-provider relationship.[22] Laws mandating the provision of information that is inaccurate, biased, irrelevant or otherwise outside the medical profession's evidence-based standards of care undermine true informed consent.[23]

The medical community has well-established standards for informed consent for an abortion that health care providers have a professional and ethical obligation to follow.[24] 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 own care and to make the best decisions for herself and her family. True informed consent requires providing medically accurate information that is tailored to the patient's individual circumstances.

**"Seeking informed consent expresses respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity."**

**— American College of Obstetricians and Gynecologists, Committee Opinion Number 439, Aug. 2009 (reaffirmed 2012)**

According to ACOG, "A pregnant woman should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. The professional should make every effort to avoid introducing personal bias."[25] In addition to ensuring that patients receive only scientifically accurate and up-to-date information, medical standards dictate that "[t]he quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients."[26]

Patients rely on their health care providers to give them accurate information based on medical evidence, not on the government's ideology. When laws require 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, undermines the trust that is essential to the patient-provider relationship. On the importance of trust, the AMA explains in its Code of Medical Ethics that "[t]he relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."[27]

## Mapping Biased Counseling

Twenty-eight states have measures that require health care providers to give or offer the patient abortion-specific, state-developed written materials.[28§] These requirements apply a one-size-fits-all approach and force women seeking abortion to receive information unrelated to their individual circumstances.

§ Enforcement is enjoined in Montana.

Nineteen states require providers to give, or require providers to offer, information – verbally or in writing – that is medically inaccurate or biased.[29] For example:

- Twelve states[30] include **unfounded information that fetuses can feel pain**, despite the lack of scientific evidence.[31]
- Eight states[32] include information that describes **only negative emotional responses to abortion**.[33]
- Five states[34] include **erroneous information about the impact of abortion on future fertility**.[35]
- Five states[36] include information about a **false link between abortion and breast cancer**.[37]
- Five states[38] include the assertion that **personhood begins at conception**.
  - Women in Kansas receive information including *all five of the above inaccurate assertions*.
- Two states[39] include **inaccurate information linking abortion to an increased risk of suicide**, even though there is no such connection.[40]

Twenty-four states require providers to give or offer patients descriptions of all common abortion procedures.[41**] As procedures vary greatly depending on the stage of gestation, the information presented may be entirely inapplicable to the patient. Twenty-eight states require abortion providers to give or offer patients descriptions of fetal development throughout pregnancy, rather than information only about the gestational age relevant to the woman's pregnancy.[42††]

** Enforcement is enjoined in Montana.

†† Enforcement is enjoined in Montana.

# Biased Counseling

**Provider must give or offer specific state-mandated information, regardless of whether it is medically appropriate**

**Provider must give or offer medically inaccurate or biased information:**

**Unfounded information regarding fetal pain**

**Description of only negative emotional responses following abortion**

**Erroneous impact of abortion on future fertility**

**False link between abortion and breast cancer**

**Assertion that personhood begins at conception**

**False link between abortion and suicide**

*Law requiring providers to offer state-mandated materials to patients is enjoined in Mont.*

# Mandatory Delays

**Bad medicine is forcing a 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 hours or days before being able to obtain abortion care. These policies take decision-making away from the health care provider and patient, disregarding the fundamental principle of providing the right care at the right time according to medical need and the patient's best interests.[43] Mandatory delay laws require providers to withhold care, even if doing so violates their medical judgment.

> **"[M]andatory delays create obstacles for women, including family problems, increased expense, and travel difficulties. These restrictions may disproportionately affect low-income women, particularly those in rural settings."**
>
> **— American College of Obstetricians and Gynecologists, Committee Opinion Number 424, Jan. 2009**

Mandatory delays are often linked to other state interference in health care, such as mandating that women receive specific information or an ultrasound before a delay period begins. In many states, this necessitates at least one extra trip to the clinic for no medical reason.[44] By contrast, quality health care includes reducing unnecessary medical visits for the patient.[45]

According to the World Health Organization:
"Information, counseling 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."[46] In other words, it is the patient, in consultation with her health care provider, who must make decisions about timing – not the state.

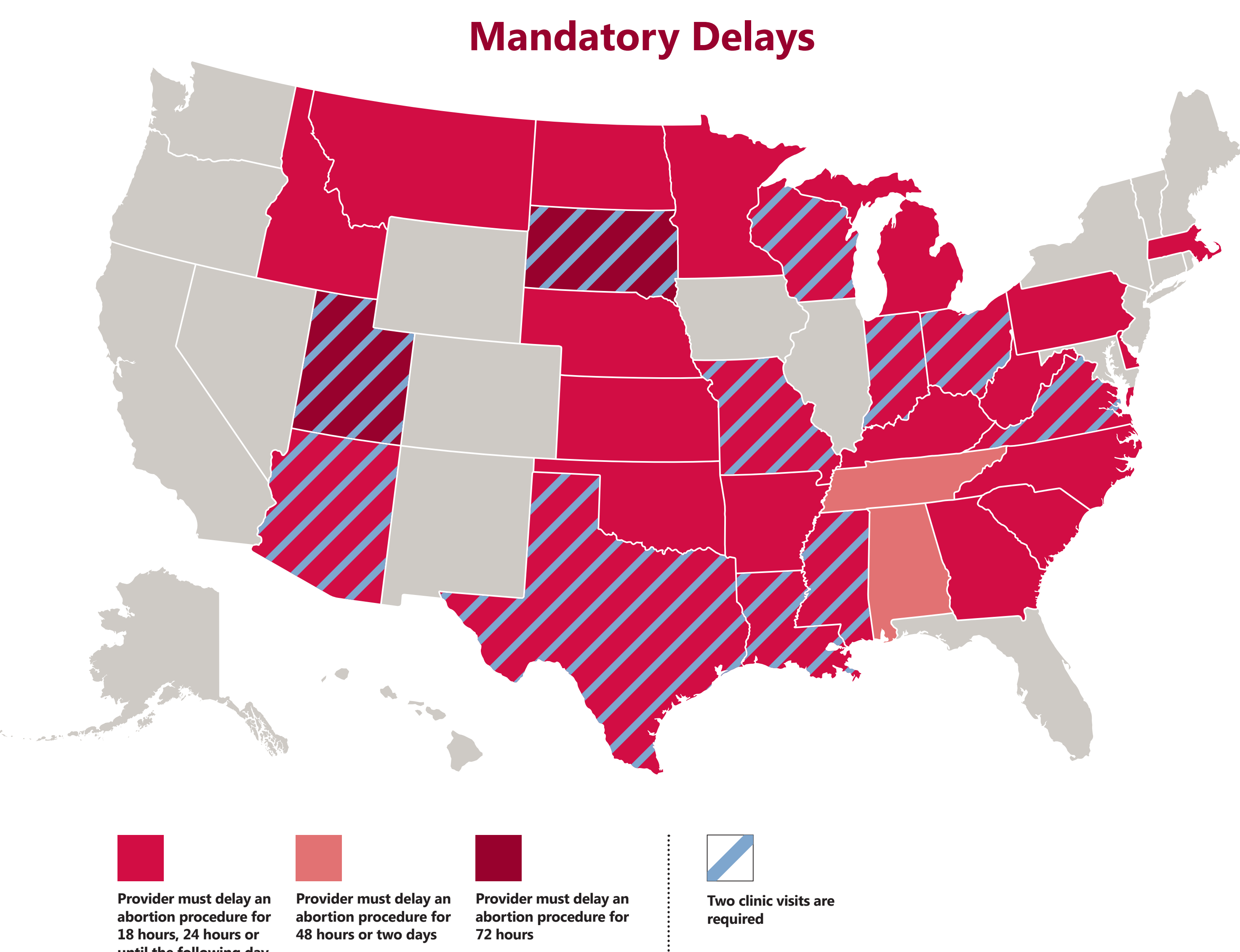
The impact of mandatory delays is exacerbated by the national shortage of abortion providers and can result in waits of greater duration than the state-mandated period. Eighty-nine percent of counties in the United States do not have a single abortion provider.[47] Even for those counties that do have one or more providers, abortion services might be available only on certain days. Several states have only one clinic that offers surgical abortions,[48] and some clinics rely on doctors to fly in from out of state.

> **"I recently had a patient who was diagnosed with an aggressive form of breast cancer. She needed to terminate the pregnancy immediately to start chemotherapy. Due to a mandatory waiting period, she was forced to wait before I could perform her abortion. It's cruel that our state law forced her to wait to start life-saving treatment, especially since every day with her family is precious."**
>
> **— Dr. Elizabeth Schmidt, Missouri**

Given the shortage, many women must travel long distances to reach abortion clinics. Most patients seeking abortions already have children[49] and thus need to secure child care, as well as transportation and time off of work. In states that require two trips to the clinic, women may have to do each of those things twice. Unnecessary delay requirements create the heaviest burden on rural, young and low-income women, exacerbating health disparities.[50]

## Mapping Mandatory Delays

Thirty states have passed laws imposing a mandatory delay before a woman can have an abortion.[51‡‡] Eleven of these states also require that a woman receive state-mandated counseling in person, necessitating at least two trips to the clinic.[52] In most states the waiting period is **24 hours**; under the Utah and South Dakota laws, a patient must wait **72 hours** before obtaining an abortion and must make two trips to the clinic. South Dakota excludes weekends and state holidays from the 72-hour waiting period,[53] forcing a patient to wait as long as six days if there is a long weekend following her first appointment.




*Laws requiring providers to delay the procedure are enjoined in Del., Mass., Mont. and Tenn.*

‡‡ Enforcement is enjoined in Delaware, Massachusetts, Montana and Tennessee.

# Medication Abortion Restrictions

**Bad medicine is prohibiting a provider from using evidence-based standards to administer medication, or banning the use of technology to provide the most appropriate care.**

A growing number of states have passed restrictions on how medication abortion must be provided that have no basis in, or are contrary to, medical evidence. Laws that restrict a patient's ability to access appropriate, evidence-based care in a timely manner and in the most appropriate setting undermine quality care.

Medication abortion is a safe, non-surgical abortion method in which medications are used to end a pregnancy.[54] The necessary medications are dispensed by a trained health care provider, and the patient takes the two types of drugs a few days apart according to her provider's written and verbal guidelines.[55] Medical support is available at all times throughout the process.[56] This method is medically indicated for certain women, and others may choose it because it provides them more control and it is more private. This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure.

Two common restrictions on medication abortion are:

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

## Prohibitions on the Use of Evidence-Based Standards

Several states have prohibited the use of evidence-based prescribing when it comes to medication abortion. These states require providers to adhere to an outdated protocol that is found on the label for the medication abortion drug, as initially approved by the FDA in 2000, rather than allowing providers to administer it according to the most up-to-date research.

Years of use in the field, as well as additional research and clinical studies, allow doctors to learn much more about a drug and adjust the standard of practice based on the most current scientific evidence.[57] The best practices for care consistently evolve as new evidence is collected, while an FDA label will typically not be updated unless the manufacturer wants to advertise the drug for a new purpose and, even then, only when the manufacturer has gone through a complicated and expensive updating process.[58] It is common practice – and often representative of the best quality care – for providers to follow the medical community's evidence-based regimen in lieu of the protocol found on a medication's label. These adjusted regimens are commonly known as "evidence-based" or "off-label."

**"Not only is it costly, because the patient must take three mifepristone pills instead of one, but it also requires patients to come to the clinic for four appointments. This law does nothing to make abortion safer – all it does is limit access."**

**— Dr. Lisa Perriera, Ohio**

The 2000 FDA protocol limited medication abortion to seven weeks of pregnancy, included specific dosages of the medication and required the second pill to be taken in the presence of a health care provider. Since then, evidence has shown that medication abortion is safe and effective through at least nine weeks of pregnancy, the first pill can be taken at a much lower dosage and the second pill can be taken in the privacy of one's home.[59]

The AMA has voiced its "strong support for the autonomous clinical decision-making authority of a physician and that

a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion."[60] Nonetheless, some laws restricting medication abortion make it a crime for a health care provider to follow the most up-to-date standard of care.

When providers are forced to follow an outdated label, they are prevented from employing best practices and delivering evidence-based care to their patients. Major medical organizations across the United States and the world have endorsed the more recently developed, evidence-based regimen for medication abortion.[61] As ACOG and the AMA jointly stated, "evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA over 13 years ago."[62] They note that these evidence-based regimens are "superior" to the FDA protocol.[63] Importantly, unlike the FDA label protocol, the evidence-based regimen eliminates the need for a medically unnecessary trip to the clinic, as it permits taking the second dose of medication at home.[64]

## Prohibitions Against Telemedicine

Telemedicine is a safe way to make health care more accessible, especially to women in underserved areas – yet states continue their efforts to prohibit providers from using it to administer medication abortion.

Telemedicine is the delivery of any health care service or the transmission of health information using telecommunications technology. Consultation through video conferencing, where a patient interacts with a remote provider, is a common and growing method of providing care.[65] When medication abortion is administered via telemedicine, a woman first has a face-to-face meeting with a trained medical professional at a health care clinic where she receives information about the medication and the process. The woman then meets with a physician via a video conference system to review her medical records and ask questions. Once the medical visit is completed, the physician authorizes the clinic to administer the medication.[66]

**"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, Vice President for Research, Ibis Reproductive Health, July 2011**

Telemedicine can improve the quality, safety and efficiency of our health care system. For example, telemedicine is regularly used to expand access to wound care, radiology, obstetric and gynecological care, as well as primary care.[67] It can be particularly important for rural women, who experience a significant shortage of reproductive health providers.[68]

Studies and practice have shown that care delivered via telemedicine is not only safe and effective, but can actually *increase* the safety and effectiveness of care. For example, a study by the University of Missouri found that telemedicine allowed for earlier detection of key warning signs in patients and more timely interventions by providers.[69] According to the same study, telemedicine patients also experienced fewer hospital readmissions.[70] Another study comparing patients with chronic illnesses receiving care through in-person visits and telemedicine found no significant differences between quality of care indicators such as patients' self-management and medication use, or patient satisfaction.[71] Importantly, telemedicine can increase the timeliness of care delivered. According to one study, telemedicine reduced the delay between the request for a wound care consultation and its completion, and the telemedicine consultations were "comparable to traditional face-to-face consultations."[72]

The same is true for providing medication abortion via telemedicine. ACOG has determined that medication abortion "can be provided safely and effectively via telemedicine with a high level of patient satisfaction," and that laws banning telemedicine are contrary to medical evidence.[73] Studies comparing face-to-face medication abortion provision with medication abortion via telemedicine show equivalent effectiveness and rates of positive patient experience.[74] Telemedicine patients particularly valued being able to receive abortion care at clinics closer to their homes and reported that they would recommend telemedicine to their friends at high rates.[75]

## Mapping Medication Abortion Restrictions

Eighteen states have passed medically unnecessary restrictions on how providers can administer medication abortion.[76§§] Five of these 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.[77***] Seventeen of these states have passed measures prohibiting providers from administering medication abortion via telemedicine.[78†††] Four states have passed both of these restrictions.[79‡‡‡]

§§ Enforcement of at least one medication abortion restriction is enjoined in Arizona, Iowa, North Dakota and Oklahoma.

*** Enforcement is enjoined in Arizona and North Dakota. In Oklahoma, the law passed in 2011 is permanently enjoined; a similar law was passed in 2014 and signed into law on April 22. The 2014 restriction is set to go into effect on November 1, 2014.

††† Enforcement is enjoined in Iowa and North Dakota.

‡‡‡ Enforcement of at least one medication abortion restriction is enjoined in Arizona, North Dakota and Oklahoma.

# Medication Abortion Restrictions

**Provider is prohibited from administering medication abortion according to the most current standards**

**Provider is banned from administering medication abortion via telemedicine**

*Laws prohibiting providers from administering medication abortion according to the most current standards are enjoined in Ariz. and N.D. In Okla., the prohibition passed in 2011 is permanently enjoined; a similar law was passed in 2014 and is set to go into effect on November 1, 2014.*

*Laws banning providers from administering medication abortion via telemedicine are enjoined in Iowa and N.D.*

# Recommendations

States have an appropriate role to play in regulating the medical profession, but stepping into the exam room with an ideological agenda, overriding providers' medical judgment and ignoring patients' needs is an unacceptable overreach. Instead, states should acknowledge and support health care providers' ethical and professional obligation to put their patients first, and should strive to improve the quality of care – not undermine it.

- Legislators and policymakers, as well as the medical community, patient advocates and others, should reject government regulations or actions that inappropriately infringe on the relationship between patients and their health care providers, or that require providers to violate accepted, evidence-based medical practices and ethical standards.
- Accordingly, laws that are based on ideology and not sound medical evidence, such as ultrasound requirements, biased counseling, mandatory delays and restrictions on medication abortion, should be repealed.
- Lawmakers should take steps to protect the patient-provider relationship and affirm the importance of individualized care and providers' ability to further the best interests of their patients.

# Conclusion

While in many areas we have seen advances in making care more accessible and centered on the needs of the patient, state restrictions have moved abortion care in the opposite direction. Women seeking abortion services deserve truthful information, quality care and treatment options that are appropriate for their individual circumstances. They should not face laws that force them to experience unnecessary delays or medical procedures, deny them safe and timely abortion options or force them to receive unnecessary and often inaccurate information. By the same token, health care providers should be able to prioritize their obligations to their patients.

It is time to take politics out of the exam room and return abortion care to women and their health care providers. Politicians' personal beliefs about abortion must not trump women's health or the weight of medical evidence. States should act to ensure that laws involving women's reproductive health care promote access to quality care without bias, ideology or unnecessary barriers.

**"By reducing health care decisions to a series of mandates, lawmakers devalue the patient–physician relationship. Legislators, regrettably, often propose new laws or regulations for political or other reasons unrelated to the scientific evidence and counter to the health care needs of patients."**

**— 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 in the *New England Journal of Medicine*, Oct. 2012**

# Endnotes

[1] American College of Physicians. (2012, July). *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* (p. 2) ("The many appropriate roles of government include licensing, protecting and improving public health, determining the safety and effectiveness of drugs and medical devices, and supporting medical education, training, and research, among others.").

[2] House of Delegates, American Medical Association. (2013). *Resolution 717, Government Interference in the Patient-Physician Relationship*.

[3] See note 1.

[4] Executive Board, American College of Obstetricians and Gynecologists & American Congress of Obstetricians and Gynecologists. (2013). *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*. Retrieved from http://www.acog.org/~/media/Statements%20of%20Policy/Public/2013LegislativeInterference.pdf.

[5] The 33 states are Alabama, Alaska, 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. The 16 states are Alabama, Arizona, Indiana, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Texas and Wisconsin.

[6] Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p. 1). Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. Clancy, C. (2009, March 18). Testimony before the Senate Committee on Finance Subcommittee on Health Care. Washington, D.C. Retrieved from http://www.hhs.gov/asl/testify/2009/03/t20090318b.html.

[7] See Clancy, note 6 and Institute of Medicine, note 6.

[8] National Committee for Quality Assurance. (2007). *The Essential Guide to Health Care Quality* (p. 7). Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf ("Virtually every part of the health care industry – hospitals, health plans, physicians, nursing homes, home health providers and others – is working to improve health care quality. The federal government, states, employers and consumer advocates are also focused on improving care.").

[9] Minkoff, H. & Ecker, J. (2012, September). When legislators play doctor – The ethics of mandatory preabortion ultrasound examinations. *Obstetrics & Gynecology*, 120(3), 647–649 (pp. 647, 649) ("Ultrasonography 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."). 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 from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co390.pdf?dmc=1&ts=20120305T0654106237 [hereinafter ACOG Opinion 390] ("A patient's right to make her own decisions about medical issues extends to the right to refuse . . . medical treatment."). Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2012). *Committee Opinion No. 439, Informed Consent* (p. 7). Retrieved from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20130415T1047469933 [hereinafter ACOG Opinion 439] (advising that refusing information can "be itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy").

[10] See ACOG Opinion 439, note 9, p. 3 ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."). American Medical Association. (2001). *AMA Code of Medical Ethics, Principles of Medical Ethics*. Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."). American Medical Association. (2008). *Model Medical Staff Code of Conduct* ("Inappropriate Behavior [includes] . . . Belittling or berating statements . . . Intentionally degrading or demeaning comments regarding patients and their families . . ."). American College of Physicians. *ACP Ethics Manual* (6th Ed.) Retrieved 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.").

[11] See Minkoff & Ecker, note 9, p. 647–648 ("There are no circumstances in which a patient's viewing of the fetus is medically necessary.") ("[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."). Stuart v. Loomis, No. 1:11-cv-804 at 20 (M.D.N.C. Jan. 17, 2014) (noting the state's acknowledgment that one of the purposes of the ultrasound law in question is to dissuade women from terminating a pregnancy).

[12] The Texas Policy Evaluation Project. (2013, April). *Research Brief, Impact of Abortion Restrictions in Texas* (p. 1). Retrieved from http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf (finding that almost a third of women "reported that the waiting period had a negative impact on their emotional well-being").

[13] Guttmacher Institute. (2014, June 1). *State Policies in Brief: Requirements for Ultrasound*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin).

[14] Ibid.

[15] Ibid. (Alabama, Arizona, Florida, Indiana, Kansas, Louisiana, Mississippi, North Carolina, 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).

[16] Ibid. (Louisiana, North Carolina, Oklahoma, Texas and Wisconsin).

[17] Kaur, A. & Kaur, A. (2011, July). Transvaginal ultrasonography in first trimester of pregnancy and its comparison with transabdominal ultrasonography. *Journal of Pharmacy and Bioallied Sciences*, 3(3), 329–338. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178938 (concluding that transvaginal ultrasonography accurately reflects pregnancy and developmental markers at an earlier stage in pregnancy than transabdominal ultrasonography). Eckholm, E. & Severson, K. (2012, February 28). Virginia senate passes

ultrasound bill as other states take notice. *New York Times*. Retrieved from http://www.nytimes.com/2012/02/29/us/virginia-senate-passes-revised-ultrasound-bill.html?pagewanted=all&_r=0 ("Through most of the first 12 weeks of pregnancy, medical experts say, only the [vaginal ultrasound] procedure can provide a clear image of the tiny fetus or an audible record of the heartbeat, and most abortions occur within this period."). Guttmacher Institute. (2014 February). *Fact Sheet, Induced Abortion in the United States*. Retrieved from http://www.guttmacher.org/pubs/fb_induced_abortion.html (noting that the vast majority of abortions occur during the first trimester).

[18] See note 13 (Missouri, North Dakota, South Dakota and Utah; this count does not include Indiana, which has an offer requirement, because that state also has a mandatory ultrasound requirement).

[19] Ibid. (Arkansas, Georgia, Idaho, Michigan, Nebraska, Ohio, South Carolina, Utah and West Virginia).

[20] Ibid. (Georgia, Indiana, Kansas, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, Utah, Virginia and Wisconsin; Michigan includes this information in its state-drafted written materials but it is not mandated by state law).

[21] Ibid. (Arizona, Louisiana, North Dakota, Texas and Virginia).

[22] Vandewalker, I. (2012). Abortion and informed consent: How biased counseling laws mandate violations of medical ethics. *Michigan Journal of Gender and Law*, 19(1). Retrieved from http://repository.law.umich.edu/cgi/viewcontent.cgi?article=1020&context=mjgl.

[23] American Medical Association. (2006). *AMA Code of Medical Ethics, Opinion 8.08 – Informed Consent*. Retrieved from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page ("The physician's obligation is to present the medical facts accurately to the patient . . . .") ("Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.").

[24] College Executive Board, American College of Obstetricians and Gynecologists. (reaffirmed 2011). *College Statement of Policy, Abortion Policy*. See ACOG Opinion 439, note 9.

[25] See College Executive Board, note 24, p. 2.

[26] See note 23.

[27] American Medical Association. (2001). *AMA Code of Medical Ethics, Opinion 10.015 – The Patient-Physician Relationship*. Retrieved from http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page.

[28] Guttmacher Institute. (2014, June 1). *State Policies in Brief: Counseling and Waiting Periods for Abortion*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf; and Mont. Code Ann., § 50-20-104. (Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, 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.

[29] See Guttmacher Institute, note 28 (Alaska, Arizona, Arkansas, Georgia, Indiana, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah and West Virginia).

[30] Ibid. (Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma and Utah; Alaska, South Dakota and Texas include this information in their state-drafted written materials but it is not mandated by state law).

[31] Royal College of Obstetricians and Gynaecologists. (2010, March). *Report of Working Party, Fetal Awareness: Review of Research and Recommendations for Practice* (pp. viii, 11). Retrieved from http://www.rcog.org.uk/files/rcog-corp/RCOGFetalAwarenessWPR0610.pdf (concluding that anatomical and physiological connections required to experience pain are not intact before 24 weeks gestation thus "the fetus cannot experience pain in any sense prior to this gestation."). Lee, S., Ralston, H., Drey, E., Partridge, J., & Rosen, M. (2005, August). Fetal pain: A systematic multidisciplinary review of the evidence. *Journal of the American Medical Association*, 294(8), 947–954.

[32] See Guttmacher Institute, note 28 (Kansas, Michigan, Nebraska, North Carolina, Utah and West Virginia; South Dakota and Texas include this information in their state-drafted written materials but it is not mandated by state law).

[33] Rocca, C., Kimport, K., Gould, H., & Foster, D. (2013, September). 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 (p. 126). Retrieved from http://bixbycenter.ucsf.edu/publications/files/Rocca%20et%20al%20TA%20emotions%20PSRH%202013.pdf. Task Force on Mental Health and Abortion, American Psychological Association. (2008). *Task Force Report* (p. 92). Retrieved 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.").

[34] See Guttmacher Institute, note 28 (Arizona, Texas and West Virginia; Kansas and South Dakota include this information in their state-drafted written materials but it is not mandated by state law).

[35] See Guttmacher Institute, note 17.

[36] See Guttmacher Institute, note 28 (Kansas and Texas; Alaska, Mississippi and Oklahoma include this information in their state-drafted written materials but it is not mandated by state law).

[37] Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. (2009, Reaffirmed 2013). *Committee Opinion No. 434, Induced Abortion and Breast Cancer Risk*. Retrieved from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co434.pdf?dmc=1&ts=20140618T1023081652. American Cancer Society. (2013, February). *Is Abortion Linked to Breast Cancer?* Retrieved 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.").

[38] See Guttmacher Institute, note 28 (Indiana, Kansas, Missouri, North Dakota and South Dakota).

[39] S.D. Codified Laws § 34-23A-10.1. West Virginia Department of Health and Human Services. *Information on Fetal Development, Abortion and Adoption* (p. 15). Retrieved from http://www.wvdhhr.org/wrtk/wrtkbooklet.pdf. (South Dakota and West Virginia).

[40] Bassett, L. (2012, July 24). South Dakota law linking abortion, suicide upheld in court. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/2012/07/24/south-dakota-abortion-suidice-law-appeals-court_n_1699615.html ("A 2008 Johns Hopkins review of various studies on the link between abortion and suicide concluded that the highest quality studies showed few, if any, differences between the mental health of women who'd had abortions and women who hadn't." (citing Charles, V., Polis, C., Sridhara, S., & Blum, R. (2008, December). Abortion and long-term mental health outcomes: A systemic review of the evidence. *Contraception,* 78(6), 436–450)).

[41] See Guttmacher Institute, note 28; and Mont. Code Ann., § 50-20-304. (Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Louisiana, Minnesota, Missouri,

Montana, Nebraska, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, West Virginia and Wisconsin; Texas includes this information in its state-drafted written materials but it is not mandated by state law).

[42] See Guttmacher Institute, note 28; and Mont. Code Ann., § 50-20-304. (Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia and Wisconsin).

[43] See Institute of Medicine, note 6.

[44] See Guttmacher Institute, note 28 (Arizona, Indiana, Louisiana, Mississippi, Missouri, Ohio, South Dakota, Texas, Utah, Virginia and Wisconsin).

[45] Burns, M., Dyer, M., & Bailit, M. (2014, January). *Reducing Overuse and Misuse – State Strategies to Improve Quality and Cost of Health Care*. Robert Wood Johnson Foundation Publication. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409990. See note 12, p. 1 (finding that almost a third of women reported that a forced waiting period had a negative impact on their emotional well-being).

[46] World Health Organization. (2nd. ed. 2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (p. 36). Retrieved from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf.

[47] See Guttmacher Institute, note 17.

[48] MSNBC. (2014, May 23). *All in with Chris Hayes: Fighting for the right to choose* [Television broadcast]. Retrieved from http://www.msnbc.com/all-in/watch/fighting-for-the-right-to-choose-264613955629.

[49] See Guttmacher Institute, note 17.

[50] 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 from http://www.guttmacher.org/pubs/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). Henshaw, S. & Finer, L. (2003, February). The accessibility of abortion services in the United States, 2001. *Perspectives on Sexual and Reproductive Health,* 35(1), 16–24 (p. 19). Retrieved from https://www.guttmacher.org/pubs/journals/3501603.pdf ("Traveling a long distance to a provider can be difficult for women who need to make two or more trips to the abortion facility."). See note 12, p. 1 ("These laws have had the greatest impact on low-income women and women in rural counties.").

[51] See Guttmacher Institute, note 28 (Alabama, Arizona, Arkansas, Delaware, Georgia, Idaho, Indiana, 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).

[52] Ibid. (Arizona, Indiana, Louisiana, Mississippi, Missouri, Ohio, South Dakota, Texas, Utah, Virginia and Wisconsin).

[53] Ibid.

[54] 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 (p. 18). Retrieved from http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf.

[55] Ibid. National Abortion Federation. (2013). *Clinical Policy Guidelines* (pp. 1, 13). Retrieved from https://www.prochoice.org/pubs_research/publications/documents/2013NAFCPGsforweb.pdf.

[56] See National Abortion Federation, note 55, p. 13.

[57] National Abortion Federation. (2008, January). *Early Options: Frequently Asked Questions about Mifepristone*. Retrieved from http://www.prochoice.org/pubs_research/publications/downloads/professional_education/medical_abortion/faq_about_mifepristone.pdf. Reproductive Health Access Project. (2012, June 14). *Mifepristone/Misoprostol Abortion Protocol*. Retrieved from http://www.reproductiveaccess.org/med_ab/downloads/MifepristoneProtocol.pdf.

[58] Planned Parenthood of AZ v. Humble, No. 14-15624 at 8–9 (9th Cir. June 3, 2014).

[59] American College of Obstetricians and Gynecologists. (2014, March). *Practice Bulletin No. 143, Medical Management of First-Trimester Abortion*. Retrieved from http://www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb143.pdf?dmc=1&ts=20140618T1452186427.

[60] American Medical Association. *Policy H-120.988, Patient Access to Treatments Prescribed by Their Physicians*. Retrieved from https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-120.988.HTM.

[61] See note 59; note 46, pp. 3–4; and note 54, p. 19.

[62] Brief for American College of Obstetricians and Gynecologists and American Medical Association as Amici Curiae Supporting Plaintiffs-Appellees, p. 13, Planned Parenthood of Greater TX Surgical Health Services v. Abbott, No. 13-51008 (5th Cir. March 28, 2014). See note 59. Studies examining the efficacy and safety of varied dosing and administration methods indicate that many alternative regimens are as safe and effective, if not more effective, than the FDA protocol. See National Abortion Federation, note 57. El-Refaey, H., Rajasekar, D., Abdalla, M., Calder, L., & Templeton, A. (1995, April). Induction of abortion with mifepristone (RU 486) and oral or vaginal misoprostol. *New England Journal of Medicine*, 332(15), 983–987 (p. 985–986) (finding that vaginal administration of misoprostol "is more effective and better tolerated" than oral administration for inducing first trimester abortion within the first 63 days of pregnancy). Schaff, E., Fielding, S., Eisinger, S., Stadalius, L., & Fuller, L. (2000, January). Low-dose mifepristone followed by vaginal misoprostol at 48 hours for abortion up to 63 days. *Contraception,* 61(1), 41–46 (abstract) (concluding that 200 mg mifepristone in conjunction with home-administered 800 μg misoprostol was a highly effective method of medication abortion within the first 63 days of pregnancy). Schaff, E.. Fielding, S., & Westhoff, C. (2001, August). Randomized trial of oral versus vaginal misoprostol at one day after mifepristone for early medical abortion. *Contraception,* 64(2), 81–85 (p. 81) (concluding that two doses of misoprostol, administered in a shorter interval than in the FDA protocol, is safe and effective within the first 63 days of pregnancy and that women may prefer this method). Schaff, E., Fielding, S., Westhoff, C., Ellertson, C., Eisinger, S., Stadalius, L., & Fuller, L. (2000, October). Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: a randomized trial. *Journal of the American Medical Association,* 284(15), 1948–1953 (p. 1948) (concluding that 200 mg of mifepristone followed by 800 μg misoprostol, administered vaginally and at home, at a 1–3 interval is safe and effective within the first 56 days of pregnancy). World Health Organization Task Force on Post-Ovulatory Methods of Fertility Regulation. (2000, April). Comparison of two doses of mifepristone in combination with misoprostol for early medical abortion: a randomized trial. *British Journal of Obstetrics and Gynaecology*, 107, 527–530 (p. 524) (finding that lower doses of mifepristone (200 mg versus 600 mg) are comparably effective).

[63] See Brief for American College of Obstetricians and Gynecologists and American Medical Association, note 62, p. 17.

[64] Ibid., pp. 14–16. See note 54, p. 19.

[65] Institute of Medicine. (2012). *The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary*. Retrieved from http://www.iom.edu/Reports/2012/The-Role-of-Telehealth-in-an-Evolving-Health-Care-Environment.aspx (noting that telemedicine via interactive video is used, for example, in ICU care, infectious disease treatment and stroke care).

[66] See note 54, p. 20.

[67] National Partnership for Women & Families. (2012, July). *Fact Sheet, Telemedicine: Improving Women's Access to Health Care Through Innovation*. Retrieved from http://www.nationalpartnership.org/research-library/health-care/HIT/telemedicine-improving.pdf.

[68] Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, February). *Committee Opinion No. 586, Health Disparities in Rural Women* (p. 3). Retrieved from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co586.pdf?dmc=1&ts=20140422T1410168732.

[69] University of Missouri. (2008, May 7). *Patients with Chronic Illness Benefit from Telehealth Intervention* [Press Release]. Retrieved from http://munews.missouri.edu/news-releases/2008/0507-telehealth-intervention-wakefield.php.

[70] Ibid.

[71] Eron, L. (2010). Telemedicine: The future of outpatient therapy? *Clinical Infectious Diseases,* 51(Suppl. 2), S224–S230 (p. S225). Retrieved from http://cid.oxfordjournals.org/content/51/Supplement_2/S224.full.pdf+html.

[72] Clegg, A., Brown, T., Engels, D., Griffin, P., & Simonds, D. (2011, June). Challenges in practice: Telemedicine in a rural community hospital for remote wound care consultations. *Journal of Wound, Ostomy and Continence Nursing*, 38(3), 301–304 (p. 301). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21566491.

[73] See note 59, p. 11.

[74] 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 (p. 302).

[75] Ibid.

[76] Guttmacher Institute. (2014, June 1). *State Policies in Brief: Medication Abortion*. Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (Alabama, Arizona, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Tennessee, Texas and Wisconsin).

[77] Ibid. (Arizona, North Dakota, Ohio, Oklahoma and Texas). Texas law requires providers to adhere to much of the outdated FDA protocol, but sets out different requirements for dosage.

[78] Ibid. (Alabama, Arizona, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas and Wisconsin).

[79] Ibid. (Arizona, North Dakota, Oklahoma and Texas).

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