

# **POLITICS IN THE EXAM ROOM**

## A Growing Threat

National Partnership for Women & Families

National Physicians Alliance

Natural Resources Defense Council

Law Center to Prevent Gun Violence

The following organizations contributed to this report: National Partnership for Women & Families, National Physicians Alliance, Natural Resources Defense Council, and Law Center to Prevent Gun Violence. Each organization authored the section related to their subject matter expertise and is responsible solely for that section.

#### **National Partnership for Women & Families**

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 [www.NationalPartnership.org](http://www.NationalPartnership.org).

#### **National Physicians Alliance**

Uniting physicians across medical specialties, the National Physicians Alliance (NPA) creates research and education programs that promote health and foster active engagement of health care providers with their communities to achieve high quality, affordable health care for all. The NPA provides an organizational base for physicians who share a commitment to professional integrity and health justice. Learn more at [www.npalliance.org](http://www.npalliance.org).

#### **Natural Resources Defense Council**

The Natural Resources Defense Council (NRDC) is an international nonprofit environmental organization with more than 2 million members and online activists. Since 1970, our lawyers, scientists, and other environmental specialists have worked to protect the world's natural resources, public health, and the environment. NRDC has offices in New York City, Washington, D.C., Los Angeles, San Francisco, Chicago, Bozeman, MT, and Beijing. Visit us at [www.nrdc.org](http://www.nrdc.org) and follow us on Twitter @NRDC.

#### **Law Center to Prevent Gun Violence**

The Law Center to Prevent Gun Violence is a national law center focused on providing comprehensive legal expertise in support of gun violence prevention and the promotion of smart gun laws that save lives. As a non-profit organization founded by attorneys, we remain dedicated to preventing the loss of lives caused by gun violence by providing trusted, in-depth legal expertise and information on America's gun laws. Learn more at [www.smartgunlaws.org](http://www.smartgunlaws.org) and follow us on Twitter @smartgunlaws.

# Introduction

Across the country, politicians are playing doctor – pushing for laws that intrude into exam rooms and conflict with professional and ethical standards of medical care. But this is no game. The laws they are passing put politicians’ words into the mouths of health care providers, prohibit providers from communicating important health information, mandate medically unnecessary procedures or outdated modes of care and much more. No matter what form these laws take, the result is the same: state lawmakers are undermining quality care by interfering in the patient-provider relationship – a relationship that should be grounded in trust and driven by medical knowledge and evidence.

This report highlights three areas where political agendas have intruded into exam rooms in harmful ways: the clinical management of toxic exposures, reproductive health, and gun safety. The impact of these laws could not be more serious: Health care providers who violate them may be subject to professional sanctions, civil liability, or even criminal penalties.

Some state-imposed restrictions take the form of “gag rules,” for example, imposing limits on providers’ ability to counsel patients about gun safety – a standard practice for pediatricians and family physicians.<sup>2</sup> In another example, health care providers treating patients for toxic chemical exposure resulting from hydraulic fracturing (fracking), an oil and gas extraction technique, face gag clauses that can undermine their ability to share information about chemicals to which their patients have been exposed.

Reproductive health care providers are increasingly subject to harmful restrictions and mandates on the provision of abortion care. Some states require providers to recite or distribute scripts to their patients that contain information that may be inaccurate, irrelevant or biased; prohibit clinicians from providing timely care; and/or mandate the provision of care that is not based in – or even contradicts – medical evidence.

Whether by dictating the content of provider communications or obstructing clinicians’ ability to determine the timing and process of care, politicians are taking medical decision-making out of the hands of patients and their health care providers. Some of these laws have been challenged in court, but the outcomes have been mixed. Litigation is likely to continue and the U.S. Supreme Court may ultimately decide which, if any, of these laws will stand.

---

**[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 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*<sup>1</sup>

---

The impact of this interference in the patient-provider relationship is far-reaching:

- ▶ More than 15 million people in the United States live within a mile of a recently-drilled fracking well.<sup>3</sup>
- ▶ Thirty percent of U.S. women will have an abortion by age 45,<sup>4</sup> and roughly 40 million women of reproductive age live in a state that has at least one of the reproductive health restrictions discussed in detail below.<sup>5</sup>
- ▶ More than 100,000 people in the United States suffer gunshot wounds each year,<sup>6</sup> and approximately 1.7 million children live in homes with unsafe gun practices.<sup>7</sup>

As state restrictions proliferate, so will the number of people affected.

Health care providers have professional and ethical obligations to provide patient-centered, evidence-based care. Yet states are passing laws that place providers in the untenable position of having to choose between adhering to their professional and ethical standards or abiding by these politically-motivated restrictions. The government has an important role to play in regulating the medical profession,<sup>8</sup> but when those regulations do not comport with medical standards and/or when they directly interfere in the patient-provider relationship and undermine patient-centered care, lawmakers have abused their authority.

# Politics in the Exam Room: Toxic Exposures

Over the past decade, the advent of high-volume fracking has spurred dramatic increases in the level of oil and gas drilling in the United States. Tens of thousands of new well sites have sprung up around the country. More than 15 million people in the United States now live within a mile of a well that was recently drilled.<sup>9</sup> As this heavy industrial process increasingly moves into agricultural and residential areas, it has sparked controversy and raised health concerns.<sup>10</sup> Many states have put in place laws specifically regulating fracking, but with the exception of New York (which banned it recently<sup>11</sup>), states are generally allowing the practice.

In many states, fracking companies have influenced the passage of legislation that interferes with the identification and treatment of associated health problems. These laws provide trade secret protections for fracking chemicals and mandatory non-disclosure agreements that prevent health care providers from sharing information about their patients' chemical exposures.

## Fracking Chemicals Pose Hazards

A large number of the chemicals used in fracking present significant environmental and human health risks. Many are toxic.<sup>12</sup> A number are classified as known or probable carcinogens.<sup>13</sup> These chemicals may be released into the environment in multiple ways. Fracking fluids have spilled, contaminating soil and water bodies.<sup>14</sup> Equipment failures and other problems have led to well blowouts during fracking, spraying fracking fluids into the air and onto surrounding lands.<sup>15</sup> Fracking also has the potential to cause groundwater contamination and air pollution.<sup>16</sup>

Transport and storage of hazardous fracking chemicals also poses risks. The tens or hundreds of thousands of gallons of chemicals used for a high-volume fracking treatment must be trucked through communities to the well site and stored there. Accidents, fires or explosions at a well site may cause the release of chemicals even before fracking commences. After fracking, wastewater containing the chemicals that were injected into the well, termed "flowback," resurfaces and may be stored and/or disposed of onsite or transported to a disposal facility. Accidental chemical releases may occur at any of these stages of the fracking process.

## The Need for Fracking Chemical Information

In 2008, an emergency room nurse named Cathy Behr became critically ill and suffered multiple organ failure after being exposed to fracking chemicals, according to an article in the *Denver Post*.<sup>17</sup> Behr had helped treat an injured oilfield worker when he arrived in the emergency room after an accident at a well site left him covered in fracking fluid. Behr reported that she breathed in chemical fumes as she helped the worker remove his boots and shower. Later, her vision blurred, her skin turned yellow, she began vomiting and her lungs filled with fluid. For days, the fracking company refused to tell her doctors what chemicals

were in the fluid, claiming the information was a confidential “trade secret,” even though her life was in jeopardy. Fortunately, Behr eventually recovered – even though her doctors never got the information they sought.

Because of stories like Cathy Behr’s, a number of states developed rules meant to ensure that doctors and other health care providers can obtain information on all the chemicals in fracking fluids, even if companies claim such information is confidential. At least 13 states now require provision of trade secret-protected information concerning fracking chemicals to health professionals or emergency responders or both.<sup>18</sup>

Unfortunately, many of these states have prioritized corporate secrecy over proper medical treatment by prohibiting health care providers and emergency responders from sharing the information with anyone else, including patients. Such rules fail to account for the fact that sharing information about the cause of a patient’s condition with the patient or consulting health professionals and public health agencies may be professionally and ethically necessary.

Numerous situations necessitate sharing of information about disclosed fracking chemicals. Professional and ethical obligations will generally require health care providers to inform patients about chemicals to which they have been exposed.<sup>19</sup> Where patients are not able to direct their own care, family members or surrogates may need this information – and even when patients are fully aware and competent, it may well be a significant strain on the patient-provider relationship and potentially on the patients themselves if health care providers cannot freely discuss the cause of an illness in the presence of family members.<sup>20</sup>

It is likely that treating health professionals may also need to share information with consulting professionals. Diagnosis and treatment of environmental exposures are often difficult and complex matters and will likely require expertise beyond that of a single health professional. In these cases, health professionals may need to consult with toxicologists, epidemiologists, or other environmental health specialists in order to develop an accurate diagnosis and deliver quality care. Health care providers may also have an ethical, professional and legal duty to warn members of the patient’s family, neighbors or other members of the public when they are aware of potential harm that may arise because of an exposure.<sup>21</sup>

Any time a health professional is in violation of a professional duty of this nature, there is a risk of public sanctions or private lawsuits. Thus, the confidentiality obligations imposed in these situations may place health professionals in an untenable position: ignore professional or ethical duties to share information and report public health threats, or violate the law.<sup>22</sup>

## **Restrictions on Sharing Fracking Chemical Information**

Strikingly, a number of states allow companies that claim trade secret protection for fracking chemicals to define the scope of a health professional’s duty of confidentiality. Only three states have established a process for reviewing and approving or denying claims that information is legally entitled to trade secret protection; in the remaining states, company claims are not necessarily evaluated by any state official to determine their legitimacy.<sup>23</sup>

Pennsylvania’s provision<sup>24</sup> is typical of this approach. The state requires a company to provide a health professional with chemical information that the company claims as confidential only if the health professional provides a written statement of need for the information and executes a confidentiality agreement. However, because the state does not limit what may be included in the confidentiality agreement, it might well prohibit disclosures that are professionally or ethically necessary. In such a situation, a health professional could be forced to choose between (1) violating the confidentiality agreement and facing legal claims brought by the company, and (2) violating duties to the patient that exposes him or her to medical malpractice and other tort claims.<sup>25</sup> Corporate entities have a primary interest in guarding competitive information and therefore should not be allowed to define confidentiality obligations for health care providers. Yet this is precisely the situation in Pennsylvania, Montana, North Carolina and Tennessee.<sup>26</sup>

Other states, including Colorado and Kansas, require a confidentiality agreement but provide a government form for that purpose rather than leaving the content of the agreement up to companies.<sup>27</sup> Unfortunately, these forms are not always drafted to alleviate conflicts with health providers’ other obligations. Colorado’s form, for instance, states that by signing, the health professional “agrees to hold confidential all Trade Secret Information provided by the Custodian and not to make use of it for purposes other than medical diagnosis, treatment, or other health needs asserted in the statement of need.”<sup>29</sup>

The form goes on to state that it shall not prohibit disclosure when a health care provider “is required by law to disclose such information pursuant to a court order or government agency order.”<sup>30</sup> This provision implies that any disclosure that is not legally required under order of a court or government agency is prohibited. At best, this wording leaves ambiguous whether the health care provider can disclose the information in other, less well-defined situations if such disclosure may be ethically or professionally required – for instance, to a public health agency when there is reason to believe that a larger portion of the public may have been affected by the chemical release. Certainly, the wording of the agreement may raise concern for health care providers that sharing this information may violate the agreement and subject them to legal claims brought by the company, including breach of contract and misappropriation of trade secrets.

---

**Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information (including proprietary information on exposure to potentially dangerous chemicals or biological agents) to the patient, which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient. Rules limiting what may or may not be discussed, or the information that may be disclosed, during healthcare encounters undermine the patient-physician relationship and can inappropriately affect patient health. The patient and his or her physician are best positioned to determine what topics to discuss.**

— American College of Physicians, *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship*<sup>28</sup>

---

The ambiguity of Colorado’s confidentiality form exemplifies a significant problem that plagues almost all state provisions of this type. The disclosure rules, and confidentiality agreements developed pursuant to them, are often vague and subject to interpretation. The resulting uncertainty may produce a chilling effect, preventing health professionals from disclosing information due to concerns about potential lawsuits or even criminal liability. And if frontline health professionals believe it will be difficult or impossible to navigate their confidentiality obligations without facing serious consequences, they may be discouraged from treating patients with potential exposures at all.

State rules often emphasize the consequences of unauthorized disclosure of trade secret-protected information about fracking chemicals despite the lack of clear rules clarifying when disclosures are allowed. North Carolina’s law, for instance, makes disclosure to an unauthorized person a Class 1 misdemeanor.<sup>31</sup> West Virginia’s rules state that companies “may provide notice to the health care professional at the time of release of the information that the information provided is solely for diagnosis or treatment of the individual, that the information may be a trade secret, and disclosure to others for any other purpose may subject that health care professional to a legal action by the operator or service provider for violating its trade secret.”<sup>32</sup>

## **Safe Harbor Provisions: General and Specific**

Ohio attempted to deal with concerns from health care providers by inserting a provision in its law that states that the statute does not “preclude a medical professional from making any report required by law or professional ethical standards.”<sup>33</sup> While this is an improvement over rules with no provision for ethical duties, health care providers may remain unclear as to when disclosure is *required* by law or professional standards. Such a standard is inherently situation-specific and often open to interpretation. Providers should not have to guess whether disclosure is permissible in a situation or whether it will be challenged by a zealous company that disagrees with a reasonable judgment as to what is required by professional ethics and duties.

Some states have explicitly laid out the allowable disclosures in an attempt to ensure that health care providers can comply with their professional and legal duties. Illinois, for instance, explicitly allows health care providers to share the information with the affected patient, the patient’s family members if the patient is unable to make medical decisions, and public health agencies.<sup>34</sup> However, there will remain situations in which health care providers may believe they have a duty that conflicts with their confidentiality obligations. For instance, an Illinois health care provider could feel a duty to warn those using a particular drinking water source about the presence of a dangerous chemical.

Since it is nearly impossible to draft a disclosure provision or confidentiality agreement that removes all doubt about when disclosure is allowed, trade secret protections for chemicals used in fracking should be eliminated. California law, for instance, requires disclosure of all chemicals used in fracking and prohibits companies from keeping the identities of individual chemicals confidential.<sup>35</sup>

## Looking Ahead: Legal Challenges Likely

Despite the demonstrated need to eliminate trade secret protections for fracking chemicals, legal challenges to current laws have thus far been unsuccessful. Health care providers attempted to challenge Pennsylvania's chemical disclosure laws in two separate lawsuits. In the first case, a federal district court found that a nephrologist did not have legal standing to maintain a case because he had not been required to sign a confidentiality agreement, nor was there evidence that he had requested information from a company since enactment of the law.<sup>36</sup> The decision not to let the nephrologist's challenge go forward was upheld by the U.S. Court of Appeals for the Third Circuit.<sup>37</sup> In the second case, the state Commonwealth Court rejected a physician's claims that the law violated two separate sections of the Pennsylvania Constitution.<sup>38</sup> While these particular challenges have been unsuccessful, it is likely that additional claims will be brought in the days ahead, as health care providers grapple with the sometimes impossible conundrum of complying with disclosure laws and their professional and ethical obligations.

# Politics in the Exam Room: Reproductive Health

A record number of abortion restrictions have been passed in the last several years, interfering in the relationship between women and their health care providers and inhibiting women's ability to make personal medical decisions. Since 2010, states have enacted more than 280 abortion restrictions<sup>39</sup> – more restrictions than were enacted in the entire preceding decade,<sup>40</sup> and a prime example of the growing boldness with which states are now regulating the patient-provider relationship. These laws are not evidence-based, and they disregard both patients' needs and health care providers' professional judgment and ethical obligations. Restrictions discussed in this report include: requiring abortion providers to give patients misinformation about health risks; mandating that providers perform ultrasounds and describe and display the images; forcing providers to delay time-sensitive care; and banning the use of the prevailing evidence-based regimen for medication abortion and the provision of medication abortion via telemedicine.

These are but several examples of a pervasive trend. Increasingly, states are demanding that abortion providers acquire medically unnecessary admitting privileges at local hospitals – a requirement the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) have described as “incongruous with modern medical practice.”<sup>41</sup> Other restrictions require abortion clinics to conform to onerous licensing standards such as those required for ambulatory surgical centers even though the AMA and ACOG agree there is “no medical basis” for these requirements.<sup>42</sup> Each year, new measures are introduced that further intrude in the exam room and undermine women's health care.<sup>43</sup>

## Subverting Informed Consent: Biased Counseling and Mandatory Ultrasound Laws

Informed consent is a fundamental requirement of medical practice in every state, and is foundational to the patient-provider relationship.<sup>44</sup> Patients rely on their health care providers to give them relevant and accurate information based on medical evidence. Yet many states invade that relationship when it comes to abortion care and dictate the content of communications between health care providers and their patients. These laws mandate the provision of information that is inaccurate, biased, irrelevant or otherwise outside the medical profession's standards of care,<sup>45</sup> and therefore undermine true informed consent.<sup>46</sup>

The medical community has well-established standards for informed consent that health care providers have a professional and ethical obligation to follow. Informed consent must be based on an open and honest conversation between a patient and her health care provider. It allows a patient to actively engage in her own care and make her own decisions and judgments, and it requires the communication of information that is personalized to the patient's individual circumstances. In addition to ensuring that patients receive only scientifically accurate and

up-to-date information, medical standards provide that “[t]he quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.”<sup>47</sup>

However, a number of states mandate that abortion providers give or offer patients verbal or written statements that are biased, irrelevant or simply false,<sup>48</sup> including:

- ▶ In 12 states,<sup>49</sup> an unfounded assertion that fetuses can feel pain, despite the lack of scientific evidence.<sup>50</sup>
- ▶ In nine states,<sup>51</sup> content emphasizing negative emotional responses to abortion.<sup>52</sup>
- ▶ In four states,<sup>53</sup> erroneous statements about the impact of abortion on future fertility.<sup>54</sup>
- ▶ In five states,<sup>55</sup> false links between abortion and breast cancer.<sup>56</sup>
- ▶ In six states,<sup>57</sup> assertions that personhood begins at conception.
- ▶ In two states,<sup>58</sup> the claim that medication abortion is “reversible,” which medical experts have deemed unsubstantiated, inappropriate and non-scientific.<sup>59</sup>

Forcing providers to give false or irrelevant information to their patients undermines the trust that is essential to the patient-provider relationship.

A growing number of states also impose mandatory ultrasound laws that force health care providers to deliver politicians’ biased message in lieu of providers’ professional judgment. These laws require providers to administer an ultrasound, and some require them to display the image and give a pre-scripted description of it – even when a woman objects. These mandates flout foundational principles 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.”<sup>60</sup> One health care provider aptly described the ethical conflict ultrasound mandates create in practice:

“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.”<sup>61</sup>

In an opinion rejecting an ultrasound mandate in North Carolina, the U.S. Court of Appeals for the Fourth Circuit explained that these laws “look nothing like traditional informed consent” and “markedly depart from sound medical practice.”<sup>63</sup> Indeed, they are “antithetical to the very communication that lies at the heart of the informed consent process.”<sup>64</sup>

---

**[I]mposing medically unjustified requirements on physicians providing abortion care... compels physicians to compromise their medical judgment, their ethical obligations, and the integrity of the physician-patient relationship.**

— American Public Health Association, Amicus Curiae Brief in *Stuart v. Camnitz*<sup>62</sup>

---

The court wrote:

The patient seeks in a physician a medical professional with the capacity for independent medical judgment that professional status implies. The rupture of trust comes with replacing what the doctor's medical judgment would counsel in a communication with what the state wishes told. It subverts the patient's expectations when the physician is compelled to deliver a state message bearing little connection to the search for professional services that led the patient to the doctor's door.<sup>65</sup>

However, the U.S. Court of Appeals for the Fifth Circuit reached a different conclusion and permitted a similar law to stand in Texas.<sup>66</sup> Despite this split, in June 2015 the U.S. Supreme Court declined to hear an appeal in the North Carolina case, leaving the Fourth Circuit's important opinion in place.<sup>67</sup>

## **Forcing Providers to Delay Care**

Many states have mandatory delay laws for abortion that force providers to withhold care even when doing so contradicts their medical judgment. These laws require that patients wait a specified number of days before being able to obtain abortion care, despite the fact that such delays serve no medical purpose and actually undermine the provision of care. Such laws take decision-making away from health care providers and patients, and disregard the fundamental principle of quality care articulated by the Institute of Medicine: Care should be given at the right time, according to medical need and the patient's best interests.<sup>68</sup>

Mandatory delay laws vary in duration from one to several days, and some states also require that a woman receive state-mandated information in person prior to the delay, necessitating multiple trips to a clinic. South Dakota even excludes weekends and state holidays from its 72-hour waiting period, forcing a patient to wait as long as six days if a long weekend follows her first appointment.<sup>69</sup> Increasingly, states are extending the length of delays previously in place.<sup>70</sup> Delays can be longer still when compounded by other abortion restrictions that impede access to health care providers and clinics.<sup>71</sup> As a result, unnecessary delay requirements place the heaviest burden on rural, young and low-income women, exacerbating health disparities.<sup>72</sup>

## **Restrictions on the Provision of Medication Abortion**

Medication abortion is a safe, non-surgical abortion method in which medications are used to end a pregnancy.<sup>73</sup> The medications are dispensed by a trained health care provider, and the patient takes two types of drug, one or more days apart, according to her provider's written and verbal guidelines.<sup>74</sup> This method is medically indicated for certain women, and others may choose it because it provides more control and privacy. This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure.

Despite these benefits, a number of states have passed laws that prohibit providers from administering medication abortion according to the most current medical standards, or prevent them from using advances in medical technology. These laws restrict a patient's ability to access appropriate, evidence-based care in a timely manner and in the most

appropriate setting. They also interfere with providers' ethical duties: AMA policy provides that "[w]ithin the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount."<sup>75</sup>

Several states require providers to administer medication abortion based on an outdated protocol found on the medication abortion drug's label as initially approved by the FDA in 2000, rather than according to current research and evidence-based standards. The 2000 protocol limited medication abortion to the first 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, clinical studies and research have shown that medication abortion is safe and effective up to at least ten weeks of pregnancy,<sup>77</sup> that the first pill can be taken at a much lower dosage, and that the second pill can be taken in the privacy of one's own home.<sup>78</sup> As ACOG and the AMA have explained, "evidence-based regimens have emerged that make medica[tion] abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA [15] years ago."<sup>79</sup> They note these regimens are "superior"<sup>80</sup> to the outdated FDA label protocol because they reflect "the most current, well-researched, safe, evidence-based, and proven protocols."<sup>81</sup> Nonetheless, laws restricting medication abortion make it illegal for a health care provider to follow the most up-to-date standard of care. These laws not only undermine women's access to a safe option for abortion care, they also threaten a central tenet of the practice of medicine – that evidence and research inform improved treatment and regimens for patients.

A number of states have prohibited the provision of medication abortion via telemedicine. Telemedicine is the delivery of health care services using telecommunications technology. It is a safe way to make health care more accessible, especially to individuals in rural or underserved areas. 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 a video conference system with a physician who has reviewed her medical records and the results of her in-person examination. Once the medical visit is completed, the medication is dispensed to the patient.<sup>82</sup>

Studies comparing in-person medication abortion with telemedicine medication abortion show equivalent effectiveness and rates of positive patient experience;<sup>83</sup> as ACOG has noted, the two types of visits are "medically identical."<sup>84</sup> And yet, state restrictions interfere with the patient-provider relationship by banning this innovative and effective method of service delivery for abortion care. The Iowa Supreme Court recently acknowledged this interference

---

**Laws that mandate a medica[tion] abortion treatment protocol that goes against best medical practice guidelines are dangerous to patient health. Even laws that mandate a protocol that is valid at the time of the law's enactment are ill-advised because medical knowledge is not static. As knowledge advances, medical treatments enshrined within such laws become outdated, denying patients the best evidence-based care.**

— American College of Obstetricians and Gynecologists and American Medical Association, *Amici Curiae Brief in Planned Parenthood v. Abbott*<sup>76</sup>

---

when it struck down a ban on telemedicine abortion, noting that there was no medical justification for the ban and that it was indeed contrary to the standard of care.<sup>85</sup> The court further noted that the state was singling out abortion care with this ban, while promoting the use of telemedicine to expand access to other types of health care.<sup>86</sup>

## **Looking Ahead: Reproductive Health Care at Risk**

While there have been some notable court victories, abortion restrictions that interfere with the relationship between a patient and health care provider are in litigation across the country and remain in effect in many places. Meanwhile, politicians continue to push harmful legislation: More than 300 abortion restrictions were introduced in just the first three months of 2015.<sup>87</sup> These ongoing efforts to impose politics on the practice of medicine undermine patients' rights and providers' ability to fulfill their professional and ethical obligations.

# Politics in the Exam Room: Gun Safety

Each year in the United States, more than 100,000 people are victims of gunshot wounds<sup>88</sup> and more than 30,000 of those victims lose their lives.<sup>89</sup> Having a gun in the home is strongly correlated with three main risks: 1) accidental shootings, particularly among children; 2) suicide; and 3) fatal intimate partner violence.

Because of the impact of guns on public health and safety, there is a compelling need for medical professionals to be able to inform patients about the particular risks guns pose to children, people with mental illness, and survivors of intimate partner violence, and to educate patients about safe storage practices. Clinical guidance about guns is a proven life-saving preventive health approach. Yet a growing number of gag laws threaten to ban such informational conversations in the exam room.

## Importance of Gun Safety and Preventive Care

Extensive research has shown that guns in a home that are not properly secured pose significant risks. A national study of people who died from accidental shootings showed that victims were three times more likely to have had a gun in their home.<sup>90</sup> States with the most guns have, on average, nine times the rate of unintentional firearm deaths than states with the fewest guns.<sup>91</sup> Homes with children are at a particularly high risk for unintentional shootings: 89 percent of unintentional shooting deaths of children occur in the home – and most of these deaths occur when children are playing with a loaded gun in their parents' absence.<sup>92</sup> Safe storage practices are therefore necessary to restrict access to guns by unauthorized users (such as children). Health care providers, in particular pediatricians, are often well positioned to discuss such storage practices with parents or guardians of their patients.

The presence of a gun in the home is also a risk factor for suicide. According to one study, homes in which a suicide occurred were 4.8 times more likely to contain a firearm than similarly situated homes that had not experienced a suicide.<sup>94</sup> In states with a higher rate of household firearm ownership, there is a higher average suicide rate, even after controlling for differences relating to poverty, urbanization, unemployment, mental illness, and alcohol or drug use.<sup>95</sup>

A person who attempts suicide by a method other than a firearm is more likely to survive than a person who uses a firearm: suicide attempts with a firearm have a fatality rate of more than 90 percent, far exceeding fatality rates of suicide attempts by jumping (34 percent) and

---

**Pediatricians and other child health care professionals are urged to counsel parents about the dangers of allowing children and adolescents to have access to guns inside and outside the home. The AAP recommends that pediatricians incorporate questions about the presence and availability of firearms into their patient history taking and urge parents who possess guns to prevent access to these guns by children.**

— American Academy of Pediatrics, Policy Statement: Firearm Related Injuries Affecting the Pediatric Population<sup>93</sup>

---

drug poisoning (two percent).<sup>96</sup> About 90 percent of people who attempt suicide and survive do not go on to die by suicide later.<sup>97</sup> Because suicide is often an impulsive decision,<sup>98</sup> restricting gun access could allow time for the suicidal impulse to pass or diminish.

Firearms in the home pose a special risk for survivors of intimate partner violence. Women in abusive relationships are eight times more likely to be killed by their abusive partners if the partners have access to guns.<sup>99</sup> Domestic violence incidents involving firearms are 12 times more likely to result in homicide than abuse incidents not involving firearms.<sup>100</sup> Screening for intimate partner violence is an integral part of preventive care. Indeed, medical organizations such as the American Academy of Pediatrics (AAP) and ACOG have issued guidelines and screening tools for health care providers to identify patients who are at risk for intimate partner violence.<sup>101</sup> Restricting dialogue on gun access in the home limits the opportunities for providers to fully assess patients' level of risk and provide meaningful support. Medical gag rules inhibit providers' ability to fulfill their professional and ethical obligations to provide their patients with preventive care.

## **The Role of Health Care Providers in Reducing Gun Violence**

Physicians and other health care providers play a critical role in gun violence prevention by educating their patients about the risks of firearm ownership and advising them about safer behaviors and practices. Patients frequently heed advice from health care providers regarding the proper storage of firearms and ammunition. One study found that 64 percent of individuals who received verbal firearm storage safety counseling from their doctors improved their gun storage practices.<sup>102</sup> Leading medical societies, including the AMA, AAP, American Academy of Family Physicians (AAFP) and American College of Physicians (ACP), attest that gun violence can be reduced by providing patients and parents with information about gun safety.<sup>103</sup> The AAP recommends that conversations about guns and gun safety start during a prenatal visit and be repeated regularly as part of anticipatory guidance.<sup>104</sup>

Given the implication of guns in suicide, intimate partner homicide, and unintentional child deaths, health care provider counseling about guns is essential to helping address these grave public health threats. A 2012 report by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention recommends that suicide risk assessment be an integral part of primary care.<sup>105</sup> Clinicians are advised to document suicide-related information, such as alcohol and drug use, and "routinely assess for access to lethal means."<sup>106</sup> According to one study, an estimated 45 percent of patients who died by suicide saw their primary care physician in the month before their death,<sup>107</sup> which means their primary care physicians had an opportunity to identify patients at risk for suicide and provide life-saving preventive care. It is crucial that health care providers be permitted to engage in unfettered conversations with their patients so they can accurately assess risk and determine appropriate care.

Health care providers routinely counsel their patients about a variety of hazards, including backyard swimming pools, tobacco, household cleaners and other toxins and sexually transmitted infections. Guns should be no different. Providers have an obligation to educate patients about the risks of keeping a gun in the home, safe storage practices and the importance of considering certain risk factors, such as mental health and domestic violence,

before deciding to bring a gun into the home. It is critical that this aspect of the patient-provider relationship be protected, and that politicians stay out of this conversation so health care providers can give the preventive care necessary to reduce injuries and death from gun violence.

## **Medical Gag Laws and Legislative Infringement on the Patient-Provider Relationship**

Despite overwhelming evidence demonstrating that safe gun storage counseling is a key part of preventive care, state legislators have begun to suppress open dialogue between patients and health care providers on this topic.

In 2011, Florida Representative Jason Brodeur introduced a bill sponsored by the National Rifle Association (NRA) that subjected health care practitioners to disciplinary action for inquiring into patients' gun ownership. The bill, dubbed the "gag rule," prevents providers from even asking patients about gun ownership as part of routine preventive care. Governor Rick Scott signed the bill and the law took effect on June 2, 2011.<sup>108</sup>

Soon after the bill was signed into law, it was challenged in federal court. The challengers included six individual physicians and the Florida chapters of the AAP, AAFP and ACP.<sup>109</sup> The District Court struck down the law, finding that it "chills practitioners' speech in a way that impairs the provision of medical care and may ultimately harm the patient."<sup>110</sup>

In July 2014, however, a three-judge panel of the U.S. Court of Appeals for the Eleventh Circuit reversed the District Court's ruling and upheld the gag rule. The court determined that doctors must decide on a "case-by-case basis" whether a conversation about gun safety is relevant to a patient's medical care.

Under this vague framework, a doctor who believes, consistent with medical guidelines,<sup>112</sup> that discussions about the presence of firearms in the home are always relevant to preventive health care may find herself subject to disciplinary action.

In his powerful dissenting opinion, Judge Charles Wilson highlighted the chilling effect the gag rule would have on health care providers, noting that "[a]s a result of the Act, there is no doubt that many doctors in Florida will significantly curtail, if not altogether cease, discussions with patients about firearms and firearm safety." Judge Wilson also emphasized the corresponding impact on patient care, noting that "children will suffer fewer firearm related injuries if they – and their parents – know more about firearm safety, [b]ut now they will know less."<sup>113</sup> At present, Florida's gag rule significantly limits providers' ability to adhere

---

**The issue is whether there are firearms in the house, and if there are, the physician should be able to talk to patients about gun safety – the safe storage and maintenance of guns, for example, and keeping guns out of the reach of children. . . . [This is] an important safety issue and an appropriate topic for family physicians to discuss with their patients and the patients' families in regard to overall preventive health.**

— Glen Stream, M.D., M.B.I, former board chair, American Academy of Family Physicians<sup>111</sup>

---

to recommended standards of care and discuss the grave importance of safe gun storage with their patients. As Judge Wilson aptly explained, “the poor fit between what the Act actually does and the interests it purportedly serves belies Florida’s true purpose in passing this Act: silencing doctors’ disfavored message about firearm safety.” In July 2015, the three-judge panel issued a new opinion, reaching the same conclusion as before with only a slightly modified analysis. However, the case is not yet over, as the physicians challenging the law are likely to seek review either from the full Eleventh Circuit or from the U.S. Supreme Court.

## **Looking Ahead: Gag Rule Legislation Continues to Proliferate**

Since Florida’s gag rule passed, various forms of physician gag rule legislation have been introduced in 14 other states.<sup>114</sup> Although watered-down versions were enacted in Minnesota, Missouri and Montana, Florida’s gag law remains the most restrictive in the country. Similar bills are expected to be introduced in multiple states for the 2016 legislative session.

As is the case with environmental and reproductive health laws that intrude into exam rooms, censorship laws regarding gun safety suppress dialogue and harm patients. They constrain free communication between patients and health care providers, and effectively deny patients access to critical health care information. If providers cannot speak freely about any subject that affects the health and safety of their patients, patients suffer.

# Conclusion

From environmental health to reproductive health to gun safety, political encroachment on the patient-provider relationship is a dangerous trend. Imposing politics and ideology on clinical care threatens evidence-based, patient-centered medicine, the delivery of quality care and public health. Political intrusion inhibits health care providers' ability to fulfill their ethical and professional obligations to provide patients with comprehensive and effective care, and undermines patients' ability to be full and informed participants in charting their course of care.

Politicians have no place in the exam room. It is well past time for them to honor medical decision-making between patients and their trained health care providers.

Accordingly, we offer the following recommendations:

- ▶ Legislators and policymakers should reject legislative and regulatory proposals that interfere in the patient-provider relationship or force providers to violate accepted, evidence-based medical practices and ethical standards.
- ▶ The medical community, patients and advocates should speak out against government actions that inappropriately infringe on the relationship between patients and their health care providers, including mandates or restrictions that require providers to violate their professional standards or provide care that does not align with accepted, evidence-based medical practices.
- ▶ Laws regulating the patient-provider relationship that are not based on sound medical evidence should be repealed.
- ▶ Lawmakers should take steps to protect the patient-provider relationship: affirm the importance of individualized care; safeguard the ability of health care providers to further the best interests of their patients; ensure that health care providers can speak freely and honestly with patients; and secure patients' ability to receive the information they need from their health care providers. This includes advancing legislation that would prohibit interference with licensed health care providers' ability to exercise their professional judgment so that patients can receive care that is based on medical evidence, not politics.

# Endnotes

- 1 Weinberger, S.E., Lawrence, III, H.C., Henley, D.E., Alden, E.R., & Hoyt, D.B. (2012, October 18). Legislative Interference with the Patient–Physician Relationship. *New England Journal of Medicine*, 367, p. 1557. Retrieved 9 September 2015, from <http://www.nejm.org/doi/full/10.1056/NEJMs1209858>
- 2 American Academy of Pediatrics. (2011, June 6). *Press Release: Brady Center, Ropes and Gray Intend to File Suit today on Behalf of Doctors to Strike Down Florida Gun Law Limiting Free Speech*. Retrieved 1 September 2015, from <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Brady-Center-Ropes-and-Gray-Intend-to-File-Suit-today-on-Behalf-of-Doctors.aspx>
- 3 Russell, G. & McGinty, T. (2013, October 25). Energy Boom Puts Wells in America's Backyards: Hydraulic Fracturing Largely Driving Transformation of the Nation's Landscape. *The Wall Street Journal*. Retrieved 2 September 2015, from <http://www.wsj.com/articles/SB1001424052702303672404579149432365326304>
- 4 Guttmacher Institute. (2014, July). *Facts on Induced Abortion in the United States*. Retrieved 28 August 2015, from [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.pdf](http://www.guttmacher.org/pubs/fb_induced_abortion.pdf)
- 5 Guttmacher Institute. *State Data Center – Demographics*. Retrieved 28 August 2015 from <http://www.guttmacher.org/datacenter/profile.jsp>. The reproductive health restrictions discussed in detail in this paper are laws mandating pre-abortion ultrasound; requiring providers to give or offer abortion specific, state-developed information; mandating pre-abortion delays in care; and restricting how providers can administer medication abortion. The 29 states that have one or more of these laws are Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia and Wisconsin. The total is calculated by adding the total 2013 population estimates among all women aged 13–44 for each of the 29 states.
- 6 U.S. Centers for Disease Control and Prevention/ National Center for Injury Prevention & Control. (2015, June). *Fatal Injury Reports, National and Regional, 1999–2013*. Retrieved 28 August 2015, from [http://webappa.cdc.gov/sasweb/ncipc/mortrate10\\_us.html](http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html); U.S. Centers for Disease Control and Prevention/National Center for Injury Prevention & Control. (2013, March). *Nonfatal Injury Reports, 2001–2013*. Retrieved 28 August 2015, from <http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html>
- 7 Law Center to Prevent Gun Violence. (2012, January). *Statistics on Guns in the Home & Safe Storage*. Retrieved 31 August 2015, from <http://smartgunlaws.org/guns-in-the-homesafe-storage-statistics/>; Brady Center to Prevent Gun Violence. (2014) *The Truth About Kids & Guns* (p.21). Retrieved 31 August 2015, from <http://www.bradycampaign.org/sites/default/files/Children-and-Guns-Report.pdf>
- 8 American College of Physicians. (2012, July). *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* (p.2). Retrieved 1 September 2015, from [http://www.acponline.org/advocacy/current\\_policy\\_papers/assets/statement\\_of\\_principles.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/statement_of_principles.pdf) (“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.”).
- 9 See note 3.
- 10 See generally McFeeley, M. (2014). Falling Through the Cracks: Public Information and the Patchwork of Hydraulic Fracturing Disclosure Laws. *Vermont Law Review*, 38, (providing an overview of the concerns that have led to the development of hydraulic fracturing disclosure laws and a detailed look at the provisions of these laws).
- 11 New York State Department of Environmental Conservation. (2014, December 17). *Press Release: New York State Department of Health Completes Review of High-volume Hydraulic Fracturing*. Retrieved 1 September 2015, from <http://www.dec.ny.gov/press/100055.html> (noting in a subheading that “DEC Commissioner Martens Will Issue a Findings Statement Early Next Year to Prohibit High-Volume Hydraulic Fracturing”).
- 12 See Colborn, T., Kwiatkowski, C., Schultz, K., & Bachran, M. (2011). Natural Gas Operations from a Public Health Perspective. *Human and Ecological Risk Assessment: An International Journal*, 17(5), pp. 1039, 1040, 1045–46.
- 13 Ibid, p. 1050; TEDX: The Endocrine Disruption Exchange. *Chemicals in Natural Gas Operations – Health Effects Spreadsheet*. Retrieved 1 September 2015, from <http://endocrinedisruption.org/chemicals-in-natural-gas-operations/chemicals-and-health/>; International Agency for Research on Cancer. *Agents Classified by the IARC Monographs, Volumes 1–113*. Retrieved 1 September 2015, from <http://monographs.iarc.fr/ENG/Classification/index.php>
- 14 See, e.g., Finley, B. (2013, February 13). Water Fouled with Chemicals Spews Near Windsor. *The Denver Post*. Legree, L. (2009, October 23). Pa. fines Cabot \$56K for 3 chemical spills in Susquehanna County. *The Times-Tribune*.
- 15 See, e.g., Vaidyanathan, G. (2013, August 5). Hydraulic Fracturing: When 2 Wells Meet, Spills Can Often Follow. *Energystory*. Maykuth, A. (2011, January 26). Pa. Investigating Marcellus Well Blowout. *Philadelphia Inquirer*.
- 16 See, e.g., National Resources Defense Council. (2012, July). *Hydraulic Fracturing Can Potentially Contaminate Drinking Water Sources* (p.2). Retrieved 1 September 2015, from <http://www.nrdc.org/water/files/fracking-drinking-water-fs.pdf>; DiGiulio, D.C., Wilkin, R.T., Miller, C., & Oberley, G. (2011, December). *Draft Report: Investigation of Ground Water Contamination near Pavillion, Wyoming* (p.2). United States Environmental Protection Agency; Srebotnjak, T. & Rotkin-Ellman, M. (2014, December). *Fracking Fumes: Air Pollution from Hydraulic Fracturing Threatens Public Health and Communities*. National Resources Defense Council. Retrieved 1 September 2015, from <http://www.nrdc.org/health/files/fracking-air-pollution-IB.pdf>
- 17 Greene, S. (2008, July 24). Oil Secret Has Nasty Side Effect. *The Denver Post*. Retrieved 1 September 2015, from [http://www.denverpost.com/news/ci\\_9976257](http://www.denverpost.com/news/ci_9976257)
- 18 See note 10 (detailing requirements in twelve states’ hydraulic fracturing disclosure laws providing such information to health professionals or emergency responders). North Carolina has added such provisions since the publication of the foregoing article. See N.C. GEN. STAT. § 113-391.1(c)(2) (2014).
- 19 See, e.g., Snyder, L. (Ed.). *Ethics Manual, 6th Edition*. American College of Physicians. (“Information should be disclosed to patients and, when appropriate, family caregivers or surrogates, whenever it is considered material to the understanding of the patient’s situation, possible treatments, and probable outcomes.”); American Nurses Association. (2015). *Code of Ethics for Nurses with Interpretive Statements, Section 1.4* (“Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete and understandable information in a manner that facilitates an informed decision.”).
- 20 Ibid.
- 21 See, e.g., Solomon, G.M. & Kirkhorn, S.R. (2009, June). Physicians’ Duty to be Aware of and Report Environmental Toxins. *AMA Journal of Ethics (formerly Virtual Mentor)*, 11(6), p. 435. Bradshaw v. Daniel, 854 S.W.2d 865, 872 (Tenn. 1993) (holding a physician liable for failing to warn a patient’s family members of the risk of exposure to the source of the patient’s condition, in this case ticks carrying Rocky Mountain Spotted Fever). In Bradshaw, the court found that there was no reason to limit the duty to warn identifiable third parties to cases in which the patient’s contagious condition might be passed on to these third parties but found that where the patient’s family also had a risk of exposure to the same pathogen, the physician owed a duty to the patient’s family members to warn them of the potential they had also been exposed.
- 22 See generally Sando, E. (2013). Placing Physicians between Scylla & Charybdis: Chemical Disclosure Law Requiring Health Professionals to Sign Confidentiality Agreement Creates Risk of Liability for Physicians and Impedes Protection of Public Health. *Drexel Law Review*, 6. Note that the problems raised by the article are not unique to physicians but can also afflict other classes of health professionals.
- 23 See note 10, pp. 890–96.
- 24 58 PA. CONS. STAT. §3222.1(b)(10)–(b)(11) (2012).
- 25 See, e.g., 12 PA. CONS. STAT. §5 5302-04, 5308 (providing for monetary damages and injunctive relief in lawsuits for “misappropriation” of trade secrets and noting that other remedies are not affected, including contractual, civil and criminal remedies); 63 PA. CONS. STAT. § 422.41 (providing reasons for revocation and suspension of licenses for medical practice including “failing to conform to an ethical or quality standard of the profession”); Choma v. Iyer, 871 A.2d 238, 244 (Pa. Super. Ct. 2005) (laying out requirements for a patient’s claim of lack of informed consent, including failure to disclose all material facts before obtaining the patient’s consent to a particular medical procedure).
- 26 See MONT.ADMIN.R. 36.22.1016(3) (2011); N.C. GEN. STAT. § 113-391.1(c)(2) (2014); TENN. COMP. R. & REGS. 0400-53-01-.03(1)(f) (2013).
- 27 See COLO. CODE REGS. 404-1:205A(b)(5); KAN. ADMIN. REGS. § 82-3-1402(b).
- 28 See note 8, p. 6.
- 29 See Colorado Oil & Gas Conservation Commission. *Confidentiality Agreement: Form 35*. Retrieved 1 September 2015, from [http://cogcc.state.co.us/forms/PDF\\_Forms/form35.pdf](http://cogcc.state.co.us/forms/PDF_Forms/form35.pdf)
- 30 Ibid.
- 31 See N.C. GEN. STAT. § 113-391.1(d) (2014).
- 32 W. VA. CODE R. § 35-8-10.1.e (2014).
- 33 OHIO REV. CODE ANN. § 1509.10(H)(1) (2000).
- 34 225 ILL. COMP. STAT. ANN. 732/1-77(l) (West 2013).
- 35 CAL. PUB. RES. CODE § 3160(j)(2)(A) (West 2014).
- 36 See Rodriguez v. Krancer, 984 F. Supp. 2d 356, 362 (M.D. Pa. 2013).
- 37 See Rodriguez v. Sec’y of Pennsylvania Dep’t of Envtl. Prot. of Pa., 604 Fed. Appx. 113 (3d Cir. Mar. 16, 2015), *aff’d* Rodriguez v. Krancer, 984 F. Supp. 2d 356, 362 (M.D. Pa. 2013).
- 38 See Robinson Township v. Commonwealth, 96 A.3d 1104, 1115–19 (Pa. Commw. Ct. 2014).
- 39 Guttmacher Institute. (2015, July). *Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2015*. Retrieved 28 August 2015, from <http://www.guttmacher.org/media/inthenews/2015/07/01/index.html>
- 40 Guttmacher Institute. (2014, January). *Presentation: Trends in Abortion in the United States, 1973–2011*. Retrieved 30 August 2015, from <http://www.guttmacher.org/presentations/trends.pdf>

- 41 Brief for Am. Coll. of Obstet. & Gyn. and The Am. Med. Ass'n as Amici Curiae Supporting Plaintiffs-Appellees, p. 2, *Planned Parenthood of Greater Tex. v. Abbott*, 748 F.3d 583 (5th Cir. 2014) (No. 13-51008).
- 42 Brief for Am. Coll. of Obstet. & Gyn. and The Am. Med. Ass'n as Amici Curiae Supporting Plaintiffs-Appellees-Cross-Appellants, *Whole Women's Health v. Lakey*, 769 F.3d 285 (5th Cir. 2014) (No. 14-50928).
- 43 For example, some states are dictating how specific abortion procedures are performed, prohibiting preferred abortion methods and requiring health care providers to perform additional unnecessary procedures. In addition, a number of states have banned or are trying to ban abortion pre-viability based on disproven medical claims. In response to an effort to do so in Wisconsin, four leading state medical societies urged the legislature to reject "legislative proposals that are not based on sound science or that attempt to replace physicians' medical judgment. Interference in how physicians should care for their patients poses a threat to women's health." American Congress of Obstetricians and Gynecologists Wisconsin Section, Wisconsin Academy of Family Physicians, American Academy of Pediatrics Wisconsin Chapter, & Wisconsin Medical Society. (2015, June 1). Letter to the Wisconsin State Senate.
- 44 American College of Obstetricians and Gynecologists. (2009, August. Reaffirmed 2012). *ACOG Committee Opinion: Informed Consent*. Retrieved 3 September 2015, from <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent> (stating that informed consent is "integral to contemporary medical ethics and medical practice . . . [It] expresses respect for the patient as a person; . . . ensures the protection of the patient against unwanted medical treatment, [ . . . ] [and] also makes possible the patient's active involvement in her medical planning and care.") Informed consent is required by law in all 50 states. See, e.g., Manian, M. (2009, August). Article: The Irrational Woman: Informed Consent and Abortion Decision-Making. *Duke Journal of Gender Law & Policy*, 16, p. 235.
- 45 National Partnership for Women & Families. (2014, July). *Bad Medicine: How a Political Agenda is Undermining Women's Health Care* (p.7). Retrieved 28 August 2014, from <http://www.nationalpartnership.org/research-library/repro/bad-medicine-download.pdf>
- 46 American Medical Association. (2006). *AMA Code of Medical Ethics: Opinion 8.08 – Informed Consent*. Retrieved 2 September 2015, 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.").
- 47 Ibid.
- 48 Guttmacher Institute. (2015, August 1). *State Policies in Brief: Counseling and Waiting Periods for Abortion*. Retrieved 2 September 2015, from [http://www.guttmacher.org/statecenter/spibs/spib\\_MWPA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf).
- 49 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.) In Indiana, the provision is not enforced against Planned Parenthood of Indiana due to a court case.
- 50 Royal College of Obstetricians and Gynaecologists. (2010, March). *Fetal Awareness: Review of Research and Recommendations for Practice* (p. vii, 11). Retrieved 2 September 2015, from <https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf> (concluding that anatomical and physiological connections required to experience pain are not intact before 24 weeks gestation thus "the fetus cannot experience pain in any sense prior to this gestation."); Lee, S. J., Ralston, H.J.P., Drey, E.A., Partridge, J.C., and Rosen, M. A. (2005). Fetal Pain: A Systematic Multidisciplinary Review of the Evidence. *Journal of the American Medical Association* 294(8), p. 947.
- 51 See note 48. (Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Utah and West Virginia; Texas includes this information in its state-drafted written materials but it is not mandated by state law).
- 52 Rocca, C.H., Kimport, K., Roberts, S.C.M., Gould, H., Neuhaus, J., & Foster DG. (2015). Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study. *PLoS ONE* 10(7); Rocca, C.H., Kimport, K., Gould, H., & Foster, D.G. (2013). Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States. *Perspectives on Sexual and Reproductive Health* 45(3), p. 126. Retrieved 2 September 2015, from <http://bixbycenter.ucsf.edu/publications/files/Rocca%20et%20al%20TA%20Emotions%20PSRH%202013.pdf>; American Psychological Association Task Force on Mental Health and Abortion. (2008). *Report of the APA Task Force on Mental Health and Abortion* (p. 92). Retrieved 2 September 2015, 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".)
- 53 See note 48. (Arizona and Texas; Kansas and South Dakota include this information in their state-drafted written materials but it is not mandated by state law).
- 54 See note 4.
- 55 See note 48. (Kansas and Texas; Alaska, Mississippi and Oklahoma include this information in their state-drafted written materials but it is not mandated by state law).
- 56 ACOG Committee on Gynecologic Practice. (2009, reaffirmed 2013). *Committee Opinion No. 434, Induced Abortion and Breast Cancer Risk*. American College of Obstetricians and Gynecologists. Retrieved 2 September 2015, from <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co434.pdf?dmc=1&ts=20140618T1023081652>. American Cancer Society. (2014, June). *Is Abortion Linked to Breast Cancer?* Retrieved 2 September 2015, 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".)
- 57 See note 48. (Indiana, Kansas, Missouri, North Dakota and South Dakota; Oklahoma's law is scheduled to take effect on November 1, 2015).
- 58 See note 48. (Arizona and Arkansas). In Arizona, enforcement is temporarily blocked by court order. Ibid. In Arkansas, the policy is scheduled to take effect on January 1, 2016. H.B. 1394, 90th Gen. Assemb., Reg. Sess. (Ark. 2015).
- 59 Brief for Am. Coll. of Obstet. & Gyn., Am. Med. Ass'n & Ariz. Med. Ass'n as Amici Curiae Supporting Plaintiff's Motion for Preliminary Injunction, p. 3, *Planned Parenthood Arizona v. Brnovich*, No. 2:15-cv-01022 (D. Ariz. 2015).
- 60 *Stuart v. Loomis*, 992 F. Supp. 2d 585, 591 (M.D.N.C. 2014), quoting COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 439, INFORMED CONSENT 7 (Aug. 2009, reaffirmed 2012).
- 61 See note 45, p. 4.
- 62 Brief for American Public Health Association as Amicus Curiae Supporting Plaintiff-Appellees, *Stuart v. Camnitz*, 774 F.3d 238, 254 (4th Cir. 2014), *cert denied*, 135 S. Ct. 2838 (2015).
- 63 *Stuart v. Camnitz*, 774 F.3d 238, 254 (4th Cir. 2014), *cert denied*, 135 S. Ct. 2838 (2015).
- 64 Ibid., p. 253.
- 65 Ibid., p. 253-54.
- 66 See Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570 (5th Cir. 2012) (upholding Texas ultrasound and describe and display requirement).
- 67 *Walker-McGill v. Stuart*, 135 S. Ct. 2838 (2015).
- 68 Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p.1). Retrieved 2 September 2015, from <http://www.iom.edu/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>
- 69 See note 45, p. 11.
- 70 Chokshi, N. (2015, May 7). Oklahoma is extending its abortion waiting period; more states could follow. *Washington Post*. Retrieved 2 September 2015, from <http://www.washingtonpost.com/blogs/govbeat/wp/2015/05/07/oklahoma-is-extending-its-abortion-waiting-period-more-states-could-follow>
- 71 Guttmacher Institute. (2015, August 1). *State Policies in Brief: Targeted Regulation of Abortion Providers*. Retrieved 2 September 2015, from [http://www.guttmacher.org/statecenter/spibs/spib\\_TRAP.pdf](http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf); see note 45, p. 10.
- 72 Joyce, T.J., Henshaw, S.K., Dennis, A., Finer, L.B., & Blanchard, K. (2009, April). *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* (p.4). Retrieved 2 September 2015, 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.K., & Finer, L.B. (2003). The Accessibility of Abortion Services in the United States, 2001. *Perspectives on Sexual and Reproductive Health*, 35, p. 19. Retrieved 2 September 2015, 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."); Texas Policy Evaluation Project. (2013, April). *Impact of Abortion Restrictions in Texas* (p.1). Retrieved 2 September 2015, from [http://www.utexas.edu/cola/orgs/txpep/\\_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf](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.").
- 73 Boonstra, H.D. (2013). Medication Abortion Restrictions Burden Women and Providers – And Threaten U.S. Trend Toward Very Early Abortion. *Guttmacher Policy Review* 16(1), p. 18. Retrieved 2 September 2015, from <http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf>
- 74 Ibid.; National Abortion Federation. (2015). *2015 Clinical Policy Guidelines* (p. 14). Retrieved 2 September 2015, from [https://www.prochoice.org/pubs\\_research/publications/documents/2013NAFCPGsforweb.pdf](https://www.prochoice.org/pubs_research/publications/documents/2013NAFCPGsforweb.pdf)
- 75 Brief for Am. Coll. of Obstet. & Gyn. and Am. Med. Ass'n as Amici Curiae Supporting Plaintiffs-Appellees, p. 16, *Planned Parenthood Ariz. v. Humble*, 753 F.3d 905 (9th Cir. 2014) (No. 14-15624).
- 76 See note 41.
- 77 See note 74, National Abortion Federation.

- 78 American College of Obstetricians and Gynecologists. (2014, March). *Practice Bulletin No. 143, Medical Management of First-Trimester Abortion*. Retrieved 28 August 2015, from <http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion>
- 79 See note 41. See also note 78. El-Refaey, H., Rajasekar, D., Abdalla, M., Calder, L., & Templeton, A. (1995, April 13). Induction of Abortion with Mifepristone (RU 486) and Oral or Vaginal Misoprostol. *New England Journal of Medicine*, 332, pp. 985-86 (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.A., Fielding, S.L., Eisinger, S.H., Stadius, L.S., & Fuller, L. (2000). Low-dose Mifepristone Followed by Vaginal Misoprostol at 48 Hours for Abortion Up to 63 Days (abstract). *Contraception*, 61(1) (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.A., Fielding, S.L., & Westhoff, C. (2001). Randomized Trial of Oral Versus Vaginal Misoprostol at One Day After Mifepristone for Early Medical Abortion. *Contraception*, 64(2), 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.A., Fielding, S.L., Westhoff, C., Ellertson, C., Eisinger, S.H., Stadius, L.S., & Fuller, L. (2000). Vaginal Misoprostol Administered 1, 2, or 3 Days After Mifepristone for Early Medical Abortion: A Randomized Trial (p.1948). *Journal of the American Medical Association*, 284(15) (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(4), p. 527 (finding that lower doses of mifepristone (200 mg versus 600 mg) are comparably effective).
- 80 See note 75.
- 81 Ibid. In a brief to the Iowa Supreme Court, ACOG explains that "[T]he purpose [of an FDA-approved label] is not to restrict physicians in their practice of medicine, but rather to inform physicians about information gathered during the approval process, so as to enable physicians to practice medicine using all available scientific and medical evidence." Brief for Am. Coll. of Obstet. & Gyn. as Amicus Curiae Supporting Petitioners-Appellants, p. 25, *Planned Parenthood of the Heartland v. Iowa Bd of Med.*, 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).
- 82 See note 73, p. 20.
- 83 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), p. 302.
- 84 Brief for Am. Coll. of Obstet. & Gyn. as Amicus Curiae Supporting Petitioners-Appellants, p. 25, *Planned Parenthood of the Heartland v. Iowa Bd. of Med.*, 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).
- 85 *Planned Parenthood of the Heartland v. Iowa Bd. of Med.*, 865 N.W.2d 252, 265 (Iowa 2015).
- 86 Ibid.
- 87 Guttmacher Institute. (2015, April). *Trends in the States: First Quarter 2015*. Retrieved 28 August 2015, from <http://www.guttmacher.org/media/inthenews/2015/04/02/index.html>
- 88 See note 6.
- 89 Ibid., *Fatal Injury Reports*.
- 90 Wiebe, D. (2003, September). Firearms in U.S. Homes as a Risk Factor for Unintentional Gunshot Fatality. *Accident Analysis & Prevention*, 35(5), pp. 713-14.
- 91 Miller, M., Azrael, D., & Hemenway, D. (2001). Firearm Availability and Unintentional Firearm Deaths. *Accident Analysis & Prevention*, 33, p. 477.
- 92 Li, G., Baker, S.P., DiScala, C., Ling, J., & Kelen, G.D. (1996, November). Factors associated with the intent of firearm-related injuries in pediatric trauma patients. *Archives of Pediatric and Adolescent Medicine*, 150(11), p. 1162.
- 93 American Academy of Pediatrics. (2012, November). Policy Statement: Firearm Related Injuries Affecting the Pediatric Population. *Pediatrics*, 130(5), p. e1421.
- 94 Kellermann, A.L., Rivara, F.P., Simes, G., Reay, D.T., Francisco, J., Gillentine Banton, J., . . . Hackman, B.B. (1992, August). Suicide in the Home in Relation to Gun Ownership. *New England Journal of Medicine*, 327, p. 467.
- 95 Papadopoulos, F.C., Skalkidou, A., Sergeantanis, T.A., Killekidis, S., Ekselius, L., & Petridou, E. Th. (2009). Preventing Suicide and Homicide in the United States: The Potential Benefit in Human Lives. *Psychiatry Research*, 169; Miller, M., Azrael, D., & Hemenway, D. (2002, September). Household Firearm Ownership and Suicide Rates in the United States. *Epidemiology*, 13(5).
- 96 Miller, M., Azrael, D., & Hemenway, D. (2004, June). The Epidemiology of Case Fatality Rates for Suicide in the Northeast. *Annals Of Emergency Medicine*, 43(6), p. 726.
- 97 Harvard School of Public Health. *Means Matter: Attempters' Longterm Survival*. Retrieved 4 September 2015, from <http://www.hsph.harvard.edu/means-matter/means-matter/survival/>
- 98 Kiewra, K. (2008, Spring). Guns and Suicide: A Fatal Link. *Harvard Public Health Magazine*. Harvard School of Public Health. Retrieved 4 September 2015, from <http://www.hsph.harvard.edu/news/magazine/guns-and-suicide>
- 99 Campbell, J.C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M.A., . . . Laughon, K. (2003, July). Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study (p. 1092). *American Journal of Public Health*, 93(7).
- 100 Frattaroli, S. & Vernick, J.S. (2006, June). Separating Batterers and Guns: A Review and Analysis of Gun Removal Laws in 50 States. *Evaluation Review*, 30(3), p. 297.
- 101 American College of Obstetricians and Gynecologists. (2012, February). Committee Opinion No. 518: Intimate Partner Violence. *Obstetrics & Gynecology*, 119. Retrieved 1 September 2015, from <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Intimate-Partner-Violence>; Thackeray, J.D., Hibbard, R., & Dowd, M.D. (2010). Intimate Partner Violence: The Role of the Pediatrician. *Pediatrics*, 133(5), p. e147. Retrieved 1 September 2015, from <http://pediatrics.aappublications.org/content/125/5/1094.full>
- 102 Albright, T.L. & Burge, S.K. (2003, January-February). Improving Firearm Storage Habits: Impact of Brief Office Counseling by Family Physicians. *Journal of the American Board of Family Practice*, 40, p. 40.
- 103 Law Center to Prevent Gun Violence. (2014, July 31). *Eleventh Circuit Upholds Florida Law Preventing Doctors from Asking About Gun Ownership*. Retrieved 4 September 2015, from <http://smartgunlaws.org/eleventh-circuit-upholds-florida-law-preventing-doctors-from-asking-about-ownership-2>
- 104 Hagan, J.F., Shaw, J.S., & Duncan, P.M. (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. American Academy of Pediatrics. Retrieved 9 September 2015, from <http://www.firstskids.org/sites/default/files/download/Appendix%20B%20Bright%20Futures%20Guidelines.pdf>
- 105 U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012, September). *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Retrieved 1 September 2015, from [http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full\\_report-rev.pdf](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf)
- 106 Ibid.
- 107 McDowell, A.K., Lineberry, T.W., & Bostwick, J. M. (2011, August). Practical Suicide-Risk Management for the Busy Primary Care Physician (p. 792). *Mayo Clinic Proceedings*, 86(8), p. 792. Retrieved 1 September 2015, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146379/>
- 108 H.B. 155, 2011 Leg., 113th Sess. (Fla. 2011).
- 109 First Amended Complaint, *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012) (No. 11–22026–Civ).
- 110 *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1267 (S.D.Fla. June 29, 2012), *rev'd in part, vacated in part, and remanded sub nom Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th Cir. 2014) and *reh'g granted, vacated, and substituted opinion*, 2015 U.S. App. LEXIS 13070 (11th Cir. 2015).
- 111 American Association of Family Physicians. (2012, November 28). *AAFP Joins Other Groups Seeking to Overtune Florida Law*. Retrieved 9 September 2015, from <http://www.aafp.org/news/government-medicine/20121128amicusbrief.html>
- 112 See note 93; *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1233 (11th Cir. 2014) (Wilson, J., dissenting).
- 113 Ibid, *Wollschlaeger v. Governor of Florida*.
- 114 Kuehn, B. M. (2015). Battle Over Florida Legislation Casts a Chill Over Gun Inquiries. *Journal of the American Medical Association*, 313(19), p. 1893; Law Center to Prevent Gun Violence. (2015). *Summary of Enacted Laws Since Newton*. Retrieved 2 September 2015, from <http://smartgunlaws.org/summary-of-enacted-laws-since-newtown/>. Three states – Minnesota, Missouri, and Montana – have enacted gag laws. Nine other states introduced similar legislation: Alabama, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

To learn more about political interference in the patient-provider relationship,  
please visit [www.coalitiontoprotect.org](http://www.coalitiontoprotect.org).

