2017 ISSUE BRIEF

# Bad Medicine:

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

Across the country, politicians are passing anti-abortion laws that mandate how health care providers must practice medicine, regardless of established medical standards, their professional medical judgment or the needs of their patients. *Bad Medicine: How a Political Agenda is Undermining Women's Health Care*, a 2016 report by the National Partnership for Women & Families, documents this trend.[1] The report finds that a majority of states have one or more of these "bad medicine" laws.

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

In June 2016, the U.S. Supreme Court struck down two onerous Texas abortion restrictions in *Whole Woman's Health v. Hellerstedt*. In that decision, the Court made clear that states are not allowed to make up facts in order to justify restrictions on abortion, unfortunately a common practice in many places. The opinion strengthened the current legal standard for the constitutionality of abortion restrictions by stating that abortion restrictions must have enough benefit to justify the burdens on access they impose, and that states cannot rely on junk science to justify burdens.[3] This was a victory for science and abortion rights alike. Louisiana, however, has not taken any steps to remove from its books laws that disregard evidence and interfere in a woman's ability to obtain care.

This issue brief illuminates the ways in which Louisiana politicians legislate bad medicine. The brief highlights examples of laws that undermine quality abortion care by interfering in the patient-provider relationship and advancing an ideological agenda that flouts medical evidence and scientific integrity.[4] Taken collectively or individually, these Louisiana laws create significant burdens on a woman's access to abortion care.

1875 Connecticut Avenue, NW | Suite 650 | Washington, DC 20009
202.986.2600 | www.NationalPartnership.org

national partnership for women & families

## Louisiana's bad medicine laws include:

- **Mandatory provision of biased and inaccurate information.**
  Under Louisiana law, providers are required to offer women state-drafted materials that include biased and medically inaccurate information, such as a link between abortion and a risk to future fertility and a link between abortion and an increased chance of breast cancer[5] – both of which are patently false.[6] Additionally, the state-drafted materials discuss only negative emotional responses to abortion, including suicidal thoughts, depression or emotional distress – even though these claims have been debunked by the American Psychological Association and the "overwhelming majority" of women feel relief after, and do not regret having, an abortion.[7] Patients rely on their health care providers to give them accurate information based on medical evidence and their health needs, not on politicians' ideology. When laws require a health care provider to give information that is not based on scientific evidence or the interests of the patient – and indeed is patently false – the patient can no longer trust that she is receiving the best possible care. That, in turn, diminishes the trust that is essential to the patient-provider relationship and undermines women's ability to make informed medical decisions.[8]

  **Louisiana is a key offender when it comes to bad medicine laws that mandate how health care providers must practice medicine, regardless of established medical standards, their professional medical judgment or the needs of their patients.**

- **Describe and display ultrasound mandate.**
  In Louisiana, providers are required to administer an ultrasound, display the image and give a pre-scripted description of it – even when a woman objects.[9] Providers must also make the fetal heartbeat audible.[10] This process serves no medical need; instead it usurps health care providers' medical judgment and ignores the needs and decisions of women. The ultrasound mandate flouts 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."[11] It is a violation of medical standards to use a procedure to influence, shame or demean a patient.[12]

- **Mandatory delay in care and an extra unnecessary visit to the clinic.**
  Under Louisiana law, a patient must wait 24 hours after receiving a state-mandated ultrasound and biased information before being able to obtain abortion care[13] – despite the fact that such a delay serves no medical purpose and actually undermines the provision of care.[14] As a result of the mandatory delay, a woman seeking abortion care must make a medically unnecessary second trip to the clinic to receive the abortion. In 2016, Louisiana enacted a 72-hour mandatory delay – triple the current wait time.[15] This delay is not currently enforced pending litigation.[16]

- **Physician-only requirement.**
  In Louisiana, abortion care – including medication abortion – can only be provided by a physician currently enrolled in or who has completed a family medicine or obstetrics and gynecology residency.[17] This is despite evidence that advanced practice clinicians, such as nurse practitioners, certified nurse-midwives and physician assistants, can safely and effectively provide abortion care and do so in other states.[18] This Louisiana law ignores the extensive training advanced practice clinicians have, and their roles in providing primary health care and managing chronic conditions and procedures that are more complex than abortion procedures or medication abortion.[19] The law further ignores that organizations

like the American College of Obstetricians and Gynecologists (ACOG) recommend expanding abortion providers to include "appropriately trained and credentialed advanced practice clinicians."[20]

- **Ban on providing medication abortion via telemedicine.**
  Louisiana prohibits the provision of medication abortion via telemedicine, disregarding medical evidence demonstrating that it is safe and improves access.[21] Telemedicine 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 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.[22] Studies comparing in-person medication abortion with telemedicine medication abortion show equivalent effectiveness and rates of positive patient experience.[23] As ACOG has noted, the two types of visits are "medically identical."[24]

- **Burial or cremation requirement for embryonic and fetal tissue.**
  Under Louisiana law, providers must ensure that the embryonic or fetal tissue from an abortion is cremated or buried, regardless of gestation or a patient's individual circumstances.[25] This law treats embryonic and fetal tissue from abortion differently than all other tissue resulting from medical procedures. The medically unnecessary requirement creates an additional financial burden for providers, increasing cost without improving the quality of care.[26] In fact, it diminishes patient experience by mandating a non-medical ritual designed to shame and stigmatize the patient when it is not something she would otherwise choose.[27] This law is currently not in effect pending litigation.[28]

- **Targeted facility licensing requirements.**
  Under Louisiana law, abortion clinics must meet unnecessary and burdensome facility licensing specifications that are similar to those required of ambulatory surgical centers (ASCs).[29] ASCs are designed to provide complex and invasive surgeries historically provided in hospitals.[30] The American Public Health Association has observed that ASC-style requirements force clinics to "make . . . expensive renovations that have little or nothing to do with the patient services they provide."[31] Similarly, the World Health Organization has cautioned against "excessive requirements for infrastructure, equipment, or staff that are not essential to the provision of safe services"[32] and counseled that facility requirements that are not evidence-based should be eschewed.[33] In 2016, the U. S. Supreme Court agreed and struck down a Texas law that imposed ASC requirements as an unconstitutional "undue burden."[34]

- **Hospital admitting privileges and related requirements.**
  Until this restriction was blocked in April 2017 under the precedent set by the Supreme Court's *Whole Woman's Health* decision, Louisiana law required abortion providers to maintain admitting privileges with a hospital within 30 miles of where they perform abortions.[35] Admitting privileges can be difficult or impossible for abortion providers to secure for reasons that have nothing to do with a provider's skill level.[36] Some hospitals only grant admitting privileges to physicians who accept faculty appointments.[37] Other hospitals require physicians to admit a certain number of patients per year, but because abortion is such a safe procedure – less than one percent of procedures include complications[38] – abortion providers are unlikely to admit a sufficient number of patients.[39] Some hospitals only grant privileges to physicians who live within a certain radius of the hospital.[40] Moreover, admitting privileges requirements for abortion providers ignore the way modern medicine is practiced. Not only

are emergency rooms required to admit and treat any patient with an emergent condition, but they rely on in-hospital doctors to provide care on-site – not outside physicians.[41] Louisiana's law is permanently blocked by a court order,[42] though the state is appealing that order in spite of the law's clear unconstitutionality under *Whole Woman's Health*.[43]

## Conclusion

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

**It is time for those of us who oppose government interference in our most personal decisions to stand up for medically accurate, patient-centered care that takes politics out of the exam room.**

[1] National Partnership for Women & Families. (2016, February). *Bad Medicine: How a Political Agenda is Undermining Women's Health Care* (2nd ed.). Retrieved 19 May 2017, from http://www.nationalpartnership.org/research-library/repro/bad-medicine-download.pdf

[2] Blount, L.G., Gonzales-Rojas, J., & Yeung, M. (2015, April 30). Women of Color Leaders Call for a Change: End Barriers to Abortion Care. *TruthOut*. Retrieved 5 June 2017, from http://www.truth-out.org/opinion/item/30520-women-of-color-leaders-call-for-a-change-end-barriers-to-abortion-care (For example, due to pervasive inequalities in access to quality health care, women of color are at a higher risk for unintended pregnancy – more than twice as much as white women); National Partnership for Women & Families. (2016, September). *A Double Bind: When States Deny Abortion Coverage and Fail to Support Expecting and New Parents* (p. 4). Retrieved 5 June 2017, from http://www.nationalpartnership.org/research-library/repro/abortion/a-double-bind.pdf. Additionally, the one-two punch of racism and sexism against women of color helps create conditions of socioeconomic inequality, meaning financial barriers can be more difficult to surmount. Women of color who also experience other intersecting identities, such as insecure immigration status, disability, and/or language barriers, among others, will necessarily experience discrimination and barriers based on these intersections. See, e.g., Harris, J.D. (2017, January 21). To understand the Women's March on Washington, you need to understand intersectional feminism. *Vox*. Retrieved 5 June 2017, from http://www.vox.com/identities/2017/1/17/14267766/womens-march-on-washington-inauguration-trump-feminism-intersectionaltiy-race-class (discussing the concept of multiple barriers – intersectionality – and how it operates in the lives of women of color in particular). It stands to reason that any obstacles to abortion will fall hardest on women of color, especially on women of color who are also low-income or experiencing other intersecting barriers to care.

[3] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2309 (2016).

[4] The examples discussed in this report are illustrative of the ways in which Louisiana restricts abortion care and undermines the practice of medicine. Sadly, Louisiana has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2017, May). *State Facts About Abortion: Louisiana*. Retrieved 5 June 2017, from https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana

[5] La. Rev. Stat. Ann. § 40:1061.17(B)(5). Louisiana law requires providers to give information claiming that there is a link between abortion and breast cancer and a risk to future fertility. Guttmacher Institute. (2017, May 1). *State Policies in Brief: Counseling and Waiting Periods for Abortion*. Retrieved 12 May 2017, from http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf. In multiple studies, researchers found that a woman's risk of developing breast cancer does not correlate at all – negatively or positively – with having an abortion. American Cancer Society. (June 2014). *Abortion and Breast Cancer Risk*. Retrieved 1 June 2017, from https://www.cancer.org/cancer/cancer-causes/medical-treatments/abortion-and-breast-cancer-risk.html. In fact, the American College of Obstetricians and Gynecologists stated that, "…recent studies demonstrate no causal relationship between induced abortion and subsequent increase in breast cancer risk." Commitee on Gynecologic Practice, American College of Obstetricians and Gynecologists. (June 2009, reaffirmed 2015). *Committee Opinion No. 434*. Retrieved 8 June 2017, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Induced-Abortion-and-Breast-Cancer-Risk. The same holds true for future fertility – multiple studies find no correlation between the most common method of first trimester

abortion and impact on future fertility. Gold, R.B., & Nash, E. (2017, May). *Flouting the Facts: State Abortion Restrictions Flying in the Face of Science*. Guttmacher Institute Publication. Retrieved 1 June 2017, from https://www.guttmacher.org/gpr/2017/05/flouting-facts-state-abortion-restrictions-flying-face-science

[6] State-drafted materials in Louisiana also include an unfounded assertion that fetuses can feel pain, despite the lack of scientific evidence, and content emphasizing negative emotional responses to abortion. Guttmacher Institute. (2017, May 1). *State Policies in Brief: Counseling and Waiting Periods for Abortion*. Retrieved 12 May 2017, from http:// www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf; See, e.g., Royal College of Obstetricians and Gynaecologists. (2010, March). *Fetal Awareness: Review of Research and Recommendations for Practice* (p. viii – Summary). Retrieved 1 June 2017, from https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf (finding that it is impossible for a fetus to feel pain prior to 24 weeks of gestation, and highly improbable thereafter).

[7] Rocca, C.H., Kimport, K., Roberts, S.C.M., Gould H., Neuhaus J., & Foster, D.G. (2015). Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study (p. 2). *PLoS ONE, 10*(7). Retrieved 1 June 2017, from http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0128832&type=printable; see also Rocca, C.H., Kimport, K., Gould, H., & Foster, D.G. (2013). Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States. *Perspectives on Sexual and Reproductive Health (p. 122 – Results), 45*(3); 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 1 June 2017, 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 related risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.")

[8] National Partnership for Women & Families. (2016, February). *Bad Medicine: How a Political Agenda is Undermining Women's Health Care* (2nd ed.) (p. 6). Retrieved 19 May 2017, from http://www.nationalpartnership.org/research-library/repro/bad-medicine-download.pdf

[9] With a narrow exceptions. La. Rev. Stat. Ann. § 40:1061.10(D).

[10] With narrow exceptions. La. Rev. Stat. Ann. § 40:1061.10(D).

[11] Stuart v. Loomis, 992 F. Supp. 2d 585, 591 (M.D.N.C. 2014) (quoting Comm. on Ethics, Am. Col. of Obstetricians and Gynecologists, Comm. Opinion No. 439, Informed Consent 7 (Aug. 2009; reaffirmed 2012)).

[12] Committee on Ethics, American College of Obstetricians and Gynecologists. (2007, December; reaffirmed 2016). *Committee Opinion No. 390, Ethical Decision Making in Obstetrics and Gynecology* (p. 3). Retrieved 5 June 2017, from http://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co390.pdf?dmc=1&ts=20170605T1823417699 ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."); American Medical Association. (2001). A*MA Code of Medical Ethics, Principles of Medical Ethics*. Retrieved 5 June 2017, from https://www.ama-assn.org/sites/default/files/media-browser/principles-of-medical-ethics.pdf ("A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."); American College of Physicians. (2012). *ACP Ethics Manual* (6th ed.). Retrieved 5 June 2017, 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 interest, 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.")

[13] La. Rev. Stat. Ann. § 40:1061.17(B)(3). The 72-hour waiting period is not currently enforced pending litigation, but a 24-hour waiting period is still in place. See 2015 La. Rev. Stat. Ann. § 40:1061.17(B)(3).

[14] Mandatory delays disregard a fundamental principle of quality care articulated by the National Academy of Medicine: Care should be timely, reduce waits and delays and be provided according to medical need and the patient's best interests. Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p. 3). Retrieved 5 June 2017, from https://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20 report%20brief.pdf. (The Institute of Medicine was renamed in 2015 to the National Academy of Medicine.) It is the patient, in consultation with her health care provider, who must make decisions about timing — not politicians.

[15] La. Rev. Stat. Ann. § 40:1061.17(B)(3)(b). The 72-hour waiting period is not currently enforced pending litigation, but a 24-hour waiting period is still in place. See 2015 La. Rev. Stat. Ann. § 40:1061.17(B)(3).

[16] Center for Reproductive Rights. (2016, July 1). *Center for Reproductive Rights Files New Lawsuit Challenging Every Abortion Restriction Passed in Louisiana This Year* [Press release]. Retrieved 5 June 2017, from https://www.reproductiverights.org/press-room/center-for-reproductive-rights-files-new-lawsuit-challenging-every-abortion-restriction-passed-in-louisiana-this-year

[17] See 2015 La. Rev. Stat. Ann. § 40:1061.10(A)(1). A new law, not currently enforced, would further limit the types of physicians that can perform abortions. La. Rev. Stat. Ann. § 40:1061.

[18] Studies show that advanced practice clinicians can provide safe and effective abortion care. See Advancing New Standards in Reproductive Health. (2014, June). *Health Workforce Pilot Project #171 Final Data Update* (p. 2). Retrieved 18 May 2016, from http://www.ansirh.org/sites/default/files/documents/hwppupdate-june2014.pdf (Concluding that nurse practitioners, certified nurse midwives and physician assistants "can provide early abortion care that is clinically as safe as physicians."); See also National Abortion Federation. (2016). *2016 Clinical Policy Guidelines* (p. 1). Retrieved 18 May 2017, from https://prochoice.org/wp-content/uploads/2016-CPGs-web.pdf ("Abortion is a safe procedure when provided by qualified practitioners. . . . This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, and other health professionals."). As of March 2015, advanced practice clinicians provide aspiration abortion care in California, Montana, New Hampshire, Oregon and Vermont. See Barry, D., & Rugg, J. (2015, March). *Improving Abortion Access by Expanding Those Who Provide Care* (p. 6). Center for American Progress Publication. Retrieved 17 May 2017, from https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/

[19] See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 18 May 2017, from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants

[20] Committee on Healthcare for Underserved Women, American College of Obstetricians and Gynecologists. (2014, November). *Committee Opinion No. 613, Increasing Access to Abortion* (p. 1). Retrieved 1 June 2017, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion

[21] La. Rev. Stat. Ann. § 40:1061.11(A).

[22] 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. 20. Retrieved 17 May 2017, from http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf

[23] See, e.g., 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.

[24] Brief for American College of Obstetricians & Gynecologists as Amicus Supporting Petitioners-Appellants at 10, Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (No. 14-1415) available at https://www.iowaappeals.com//wp-content/uploads/2015/03/Brief-of-Amicus-Curiae-American-College-of-Obstetricians-and-Gynecologists.pdf

[25] La. H.B. 815, Regular Sess. (2016) (Act 593), to be codified at La. Rev. Stat. § 40:1061.25. This provision is currently blocked in pending litigation.

[26] National Partnership for Women & Families. (2017, March). *Bad Medicine: How a Political Agenda is Undermining Women's Health Care* (Texas ed.) (p.13). Retrieved 1 June 2017, from http://www.nationalpartnership.org/research-library/repro/abortion/bad-medicine-texas.pdf

[27] Ibid.

[28] See note 16.

[29] See generally La. Admin. Code 48:1 Ch. 44, available at http://dhh.louisiana.gov/assets/medicaid/hss/docs/Abortion/Regulations/Abortion_LaReg_Vol41_No04_042015.pdf

[30] Brief for Am. Coll. of Obstetrics & Gynecologists, Am. Med. Ass'n, Am. Acad. of Family Physicians, & Am. Osteopathic Ass'n as Amici Curiae Supporting Petitioners for a Writ of Certiorari, p. 10, Whole Woman's Health v. Cole, *sub nom* Whole Woman's Health v. Hellerstedt, No. 15-274 (filed Oct. 5, 2015).

[31] Brief for Am. Pub. Health Ass'n as Amicus Curiae Supporting Petitioners for Writ of Certiorari at 17, Whole Woman's Health v. Cole *sub nom* Whole Woman's Health v. Hellerstedt, No. 15-757 (filed Oct. 5, 2015).

[32] World Health Organization. (2nd. ed. 2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (p. 67). Retrieved 17 May 2017, from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

[33] Ibid, p. 96.

[34] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2300 (2016).

[35] La. Rev. Stat. Ann. § 40:1061.10(A)(2)(a). This law is currently enjoined. See June Medical Servs. LLC v. Kleibert, No. 14-CV-00525-JWD-RLB at 11 (Middle Dist. LA Apr. 26, 2017), available at http://www.lamd.uscourts.gov/sites/default/files/opinions/Findings%20of%20Fact%20and%20Conclusions%20of%20Law%20in%2014cv525.pdf

[36] Brief for Am. Coll. of Obstetricians & Gynecologists, Am. Med. Ass'n, Am. Acad. of Family Physicians, Am. Osteopathic Ass'n and Am. Acad. of Pediatrics as Amici Curiae Supporting Petitioners at 16, Whole Woman's Health v. Cole, *sub nom* Whole Woman's Health v. Hellerstedt, No. 15-274 (filed Jan. 4, 2016).

[37] Ibid.

[38] See Planned Parenthood Federation of American & American Congress of Obstetricians and Gynecologists. (2015, January). *Protect Safe and Legal Abortion*. Retrieved 5 June 2016, from https://www.plannedparenthood.org/files/8514/2142/1056/AbortionSafety_FactSheet_Jan2015_V2_4.pdf

[39] Ibid.

[40] See note 31.

[41] See note 30.

[42] June Medical Servs. LLC v. Kleibert, No. 14-CV-00525-JWD-RLB at 11 (Middle Dist. LA Apr. 26, 2017), available at http://www.lamd.uscourts.gov/sites/default/files/opinions/Findings%20of%20Fact%20and%20Conclusions%20of%20Law%20in%2014cv525.pdf

[43] See Center for Reproductive Rights. (2016, July 1). *Louisiana Facing $4.7 Million Legal Bill as State Continues to Defend Unconstitutional Clinic Shutdown* [Press release]. Retrieved 5, June 2016, from https://www.reproductiverights.org/Louisiana-Facing-Million-Legal-Bill-State-Continues-Defend-Unconstitutional-Clinic-Shutdown-Law

---

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

Thank you to our partners at Lift Louisiana for their invaluable input into this issue brief and their tireless advocacy.