

BAD MEDICINE

How a Political Agenda
is Undermining
Women's Health Care



TEXAS EDITION



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About the National Partnership for Women & Families

At the National Partnership for Women & Families, for more than 45 years we have fought for every major policy advance that has helped women and families. Today, we promote reproductive health and rights, access to quality, affordable health care, fairness in the workplace and policies that help women and men meet the dual demands of work and family. Our goal is to create a society that is free, fair and just, where nobody has to experience discrimination, all workplaces are family friendly and no family is without quality, affordable health care and real economic security.

Founded in 1971 as the Women's Legal Defense Fund, the National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C.

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The findings and conclusions presented here are those of the authors alone.

Introduction

Across the country, politicians are enacting more and more laws that mandate how health care providers must practice medicine, regardless of the provider's professional judgment, ethical obligations or the needs of his or her patients.¹

Texas has led the country in the proliferation of these types of intrusive restrictions. As this report explains, these laws undermine the high-quality, patient- and family-centered care that health care providers and advocates strive to achieve and take decision-making away from women. They are political interference in the provision of health care — they are **bad medicine**.

The following are examples of Texas 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.²

- ▶ **Mandatory Ultrasound:** This restriction requires an abortion provider to give — and a patient to receive — tests that are not supported by evidence, the provider's medical judgment or the patient's wishes.
- ▶ **Biased Counseling:** These requirements dictate the information that an abortion provider must give to a patient, including requirements to provide biased or medically inaccurate information.
- ▶ **Mandatory Delay:** This restriction forces an abortion provider to delay time-sensitive care regardless of the provider's medical judgment or the patient's needs.
- ▶ **Medication Abortion Restrictions:** These restrictions prohibit an abortion provider from prescribing medication using the best and most current evidence, medical protocols and methods.
- ▶ **Targeted Regulation of Abortion Providers (TRAP Laws):** These restrictions force an abortion provider or clinic to conform to burdensome requirements that are not based on scientific evidence, do not further patients' health or interests and are not required of other health care providers.

“[L]awmakers increasingly intrude into the realm of medical practice, often to satisfy political agendas without regard to established, evidence-based guidelines for care.”

— Leaders of the American College of Physicians, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and American College of Surgeons, *New England Journal of Medicine*, Oct. 2012

Each of these laws is contrary to medical evidence, intrudes on the patient-provider relationship and diminishes the quality of care a woman can obtain. Taken collectively — as is the case in Texas — the compounded effect of these laws creates significant burdens on a woman's access to abortion care. For example, because the ultrasound requirement is combined with a mandatory delay before a woman may receive abortion care, it is especially burdensome, requiring a woman to travel to a clinic at least twice, thereby raising the cost of gas and child care, forcing her to take more time off from work and, for many women, adding an overnight stay.

All patients deserve accurate information, high-quality care and the treatment options that best meet their needs. Health care providers should not be stymied by medically unnecessary restrictions enacted under the false pretense of protecting women's health.

What Is Quality Health Care?

Improving the quality of care is a central goal of a cross-sector national effort to transform our nation's health care system. According to the National Academy of Medicine, quality care is care that meets the patient's needs and is based on the best scientific knowledge.³ It is the *right care* at the *right time* in the *right setting* for the individual patient.⁴ It is care that aligns with the patient's values and preferences. It should be accessible and affordable.

The path to a high-quality, patient- and family-centered health care system is best reflected by the Institute for Healthcare Improvement's Triple Aim: improving patients' experience of care, improving health outcomes and reducing costs.⁵ Health care providers, policymakers and patient

“[Quality health care] is based on scientific and medical evidence, it takes the specific details of a patient's life into consideration and it is aimed at improving the health and life of the patient being treated.”

— National Committee for Quality Assurance, *The Essential Guide to Health Care Quality*, 2007

advocates across the country are all investing significant resources in promoting these values and transforming our health care system to better reflect them.⁶

While the nation works to achieve the Triple Aim with health care that meets patient needs and is evidence-based, Texas politicians have pushed the regulation of abortion care in the opposite direction. Medically unnecessary abortion restrictions interfere with patient-

centered practices and can change the way providers deliver care, denying their ability to provide a warm, welcoming and supportive environment for their patients and undermining the open and honest conversations that form the foundation of shared decision-making between patients and providers. These types of restrictions change the way women experience abortion care and deny them the respect and dignity they deserve.⁷ Patient-centered care should be oriented to the whole person, consistent with the patient's needs and delivered in culturally and linguistically appropriate ways, free of judgment or discrimination.

The laws discussed in this report force health care providers to deliver care that is not in line with patient interests and not based on the best medical knowledge. These laws make care more onerous to provide and difficult to access — driving up costs for both providers and patients without improving patient experience or health. Ultimately, these laws undermine patient- and family-centered quality care; subvert the goals of better care, better outcomes and reduced costs; and harm women's health.

Whole Woman's Health v. Hellerstedt

In June 2016, in the most significant abortion rights case in a generation, the United States Supreme Court ruled that two abortion restrictions in Texas House Bill (HB) 2 were unconstitutional. The medically unnecessary restrictions, designed to shut down access to abortion care, required that abortion clinics meet the facility specifications of ambulatory surgical centers (essentially mini-hospitals) and that physicians obtain admitting privileges at a hospital within 30 miles of the clinic. Had the Court allowed these restrictions to stand, nearly every abortion clinic in the state would have been forced to close.

The Court rejected Texas' pretense that the law protected women's health and found that neither provision "confer[ed] medical benefits sufficient to justify the burdens upon access that each impos[ed]."⁸ Relying on peer-reviewed studies and expert testimony, the Court "found nothing . . . that show[ed] that" the provisions improved women's health, adding that Texas could not produce evidence "of a single instance in which the [admitting privileges] requirement would have helped even one woman obtain better treatment."⁹

The Court also found "considerable evidence . . . that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary."¹⁰ Noting that "risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities," and that patients "will not obtain better care or experience more frequent positive outcomes,"¹¹ the Court determined that abortion procedures were "safer than numerous procedures that take place outside hospitals and to which Texas does not apply its surgical-center requirements" and that the provision "provid[ed] no benefit when complications arise."¹² The Court further noted that "childbirth is 14 times more likely than abortion to result in death . . . but Texas law allows a midwife to oversee childbirth in the patient's own home."¹³

Justice Ginsburg, concurring, drove to the heart of the case, explaining, "Targeted Regulation of Abortion Providers laws like [HB 2] 'do little or nothing for health, but rather strew impediments to abortion.'"¹⁴ The Supreme Court's definitive rejection of laws that purport to protect women's health, when in reality they limit access to care, was an important reaffirmation of the constitutional right to abortion and has far-reaching implications.

"[I]n the face of no threat to women's health, Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities. Patients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered."

— U.S. Supreme Court decision in *Whole Woman's Health v. Hellerstedt*, June 2016

Mandatory Ultrasounds

Bad medicine is requiring a health care provider to give — and a patient to receive — diagnostic tests that are not based on evidence or the provider’s professional judgment, or are against the patient’s wishes.

While ultrasound is a standard part of abortion care, best practices and medical ethics dictate that it should be administered only when it is necessary for medical purposes or the patient requests it.¹⁵ Laws requiring a provider to administer an ultrasound, along with other state-directed mandates such as forcing a provider to display the image and describe it, even when a woman objects, undermine quality health care. These mandates flout foundational principles of medical ethics,

“The hard part is turning the screen toward a woman who doesn’t want to look at it. Sometimes I find myself apologizing for what the state requires me to do, saying, ‘You may avert your eyes and cover your ears.’ This is unconscionable: my patient has asked me not to do something, and moreover it’s something that serves no medical value — and I, as a physician, am being forced to shame my patient.”

— Anonymous Physician, Texas

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.”¹⁶ It is a violation of medical standards to use a procedure to influence, shame or demean a patient.¹⁷

Texas requires health care providers to give or offer information on accessing ultrasound services prior to having an abortion.¹⁸ Texas law also requires providers to perform an ultrasound at least 24 hours prior to providing an abortion.¹⁹ The ultrasound must be performed by the same physician who

will provide the abortion, or that physician’s agent. The physician must describe and display the ultrasound image. The heartbeat of the fetus must also be made audible, if present.²⁰ This law forces the provider to give, and the patient to receive, information the patient may not want or need.

Quality care is based on evidence and medical need in the context of each patient’s individual circumstances. Yet Texas forces physicians to place the ultrasound image in the patient’s view and then give a detailed description of that image.²¹ The only way for the woman to avoid this intrusion may be to cover her eyes or ears until the procedure and speech are over.²² This process does not serve a medical need; rather, it serves to convey the state’s opposition to abortion.²³ The law usurps the medical judgment of health care providers and ignores the needs and best interests of women. The additional mandates in place in Texas — the 24-hour mandatory delay after the ultrasound and a requirement that the ultrasound and the abortion be performed by the same provider — defer care unnecessarily, make care inefficient and directly undermine a physician’s ability to make health care decisions with a patient based on what is medically appropriate in her particular circumstance.

Biased Counseling Restrictions

Bad medicine is dictating the content of a health care provider’s counsel to his or her patient and mandating that a provider share information that is not supported by medical evidence.

Informed consent is a fundamental requirement for medical practice and is foundational to patient-centered care and the patient-provider relationship.²⁴ But Texas law mandates the provision of information that is false, biased, irrelevant or otherwise outside the medical profession’s evidence-based standards of care.²⁵

The medical community has well-established standards for informed consent for an abortion that health care providers have a professional and ethical obligation to follow.²⁶ Informed consent must be based on an open and honest conversation between a patient and her health care provider. It allows a patient to engage in her care and make her own decisions and judgments. Quality patient-centered care requires providing medically accurate information that is tailored to the patient’s individual circumstances.²⁷

By contrast, Texas’ biased counseling law intrudes on that open and honest conversation by forcing health care providers to give women false and biased information. Abortion providers are required to ensure their patients receive medically inaccurate materials developed by the Texas Department of State Health Services.²⁸ The Department’s booklet, titled “A Woman’s Right to Know,” presents a series of fictions about abortion care, its physical health impacts and women’s feelings after abortion, all under the guise of providing public health information.²⁹ It suggests the possibility of a breast cancer risk related to abortion, even though extensive research shows no causal link between breast cancer and abortion.³⁰ The booklet also includes misleading and incorrect information that an abortion may risk a woman’s future fertility.³¹ It falsely asserts that a woman will experience only negative emotional responses to abortion despite definitive research demonstrating that a woman is no more likely to experience mental health concerns as a result of abortion than she is from unintended pregnancy or childbirth.³² Additionally, the booklet uses the term “your baby” rather than the clinical terms “embryo” or “fetus” and implies that a fetus has the ability to feel pain as early as 20 weeks, which is a false and unfounded assertion.³³

“Because of the tone of the pamphlet, I was made even more scared of what my community and family would think of my decision. It didn’t ultimately change my mind, it only made my experience more traumatizing.”

— Kryston Skinner, Community Organizer, Texas Equal Access Fund

The state-mandated booklet also seeks to mislead women about fetal development. It includes accelerated descriptions of embryonic and fetal development, implying that certain body systems are fully developed when they are not. A research team at Rutgers University worked to quantify the medical inaccuracy of the Texas booklet. In their review of the 2013 edition, they found nearly 50 percent of the statements regarding first trimester development — the period during which 89 percent of abortions occur³⁴ — were inaccurate, and more than 34 percent of all statements in the booklet were inaccurate.³⁵ They recently evaluated a draft of the 2016 edition and found that 45 percent of statements regarding first trimester development were medically inaccurate, along with 26 percent of statements pertaining to second trimester development.³⁶ Many of the inaccuracies remain in the final version of the 2016 booklet.³⁷

Patients rely on their health care providers to give them accurate information based on medical evidence and patient 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. This problem is further exacerbated when the false information is legitimized by a body charged with protecting the public health — like the Texas Department of State Health Services.

Mandatory Delays

Bad medicine is forcing a health care provider to withhold time-sensitive care regardless of his or her medical judgment or the patient’s needs and wishes.

Texas’ mandatory delay law requires patients to wait at least 24 hours before being able to obtain abortion care despite the fact that such delays serve no medical purpose and actually undermine the provision of care.³⁸ Because the delay does not begin until a woman has received biased counseling and has had an ultrasound described and displayed by the physician who will provide her abortion procedure, the mandatory delay necessitates at least two trips to the clinic. By contrast, quality

“[Mandatory delays] create additional burdens, especially for women in rural areas who often have to travel for many hours to reach a health care provider.”

— American College of Obstetricians and Gynecologists,
Committee Opinion Number 613, Nov. 2014

health care reduces duplicative, unnecessary medical visits for the patient.³⁹ The Texas mandatory delay law takes decision-making away from the health care provider and patient and disregards 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.⁴⁰ It is the patient, in consultation with her health care provider, who must make decisions about timing — not politicians. By contrast, the Texas law forces providers to withhold care, even if doing so contradicts their medical judgment and the patient’s best interests.

The impact of the Texas mandatory delay is exacerbated by the shortage of abortion providers and can result in waits of even greater duration than the state-mandated period. A 2014 study revealed that 96 percent of Texas counties had no abortion clinic.⁴¹

Given the shortage, many patients must travel long distances to reach an abortion provider. One study found that for patients whose nearest clinic had closed as a result of HB 2, the average distance traveled was 85 miles, compared with 22 miles for those whose nearest clinic remained open.⁴² Most women seeking abortion care already have children⁴³ and thus need to secure child care, as well as transportation and time off work. Because Texas requires two trips to the clinic, women may have to do each of those things twice. Those burdens are exacerbated by the fact that there is no law in Texas allowing private sector employees to earn paid sick days and nearly 45 percent of private sector workers in Texas cannot earn a single paid sick day, which means that women are forced to go without pay, and even risk losing their jobs, in order to make the trip — twice.⁴⁴ As a result of these compounding factors, unnecessary delay requirements place the heaviest burden on rural, young and low-income people, exacerbating health disparities.⁴⁵ Access to quality care should not vary depending on where a patient lives or how much money she makes.

Disproportionate Impact of Restrictions on Communities of Color

Many of the 2.5 million reproductive-aged Latinas in Texas face significant geographic, transportation, infrastructure and cost challenges in accessing health services.⁴⁶ There is a particular shortage of health care providers in predominantly Latino/a communities⁴⁷ and the lack of public and private transportation creates a major barrier. Latinas are much more likely to lack access to a personal doctor or to have not seen a doctor in the past year due to cost than Texan women from other racial and ethnic groups.⁴⁸ The four counties that make up the Lower Rio Grande Valley are among the poorest areas in the country,⁴⁹ and roughly 90 percent of the population is Latino/a.⁵⁰ It is also home to *colonias* — isolated border communities that are not considered formal municipalities by the state of Texas. Many people living in *colonias* lack basic services like paved roads, electricity, sanitation systems or safely constructed homes.⁵¹

The climate of fear surrounding immigration enforcement in the Rio Grande Valley affects undocumented people seeking abortion care, as well as those who are legal residents and U.S. citizens. For many, obtaining abortion care likely requires passing through a U.S. Border Patrol checkpoint, which women who are undocumented or rely on someone who is undocumented for transportation are unable to do.⁵² Interior checkpoints — up to 100 miles north of the border — leave thousands unable to travel north to seek care within Texas.⁵³ All but one clinic in Texas are beyond checkpoints for those living in the Rio Grande Valley.⁵⁴

Black women living in Texas also face significant barriers to obtaining quality health care. They are disproportionately more likely to experience unintended pregnancies and pregnancy-related health complications, and are at increased risk of maternal morbidity and mortality.⁵⁵ Although Black women accounted for only 11.4 percent of all births in Texas in 2011 and 2012, they suffered 28.8 percent of maternal deaths in the state.⁵⁶ Abortion restrictions add additional burdens by severely limiting their access to abortion and other critical services that are provided at reproductive health care clinics. Black women in Texas are more likely than white women to be economically disadvantaged and unable to overcome the increased cost and logistical barriers needed to access abortion care.⁵⁷

Women of color in Texas are mobilizing to improve the health of their communities. For example, in order to highlight the inequities faced by Latinas in the Rio Grande Valley, the National Latina Institute for Reproductive Health, Center for Reproductive Rights and US Human Rights Network held a human rights hearing in 2015.⁵⁸ Seventeen women from border communities — hardest hit by massive cuts to Texas family planning programs in 2011⁵⁹ — testified about the resulting hardships and the resilience of their communities.⁶⁰ Advocates also held a human rights training to equip participants to incorporate this framework into their local advocacy. Women of color came together to send the message that “reproductive rights are fundamental human rights that must be guaranteed for all Texans.”⁶¹ Organizations and activists on the ground continue to advance this important work and champion the rights of their communities.

“The clinics should be accessible to everyone. Regardless of our immigration status, we have rights.”

— Josefina, Nuestro Texas Human Rights Hearing, March 2015

Medication Abortion Restrictions

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

Texas prohibits providers from administering medication abortion according to the most current medical standards and prevents them from using advances in medical technology. These laws restrict a patient's ability to access appropriate, effective care that fits her needs in a timely manner and in the most appropriate setting.

Medication abortion is an abortion method in which medications are used to end a pregnancy.⁶² The patient takes two types of drugs, one or more days apart, according to her provider's written and verbal guidelines.⁶³ 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. Medication abortion, like all types of abortion care, is overwhelmingly safe; the rate of complication is very low — lower, in fact, than for other drugs currently available without a prescription.⁶⁴

Despite its proven safety, Texas imposes several restrictions on medication abortion, including:

- ▶ A prohibition on providing medication abortion via telemedicine.
- ▶ A prohibition on administering medication abortion according to evidence-based standards.

Prohibition Against Telemedicine

Telemedicine is a way to make health care more accessible, especially to individuals in underserved areas — yet Texas prohibits providers from using it to administer medication abortion.⁶⁵ According to the American College of Obstetricians and Gynecologists (ACOG), “Telemedicine is safe, effective, highly acceptable to patients, and facilitates access to care for women in rural areas.”⁶⁶

“In rural areas in the United States, women may have to travel for hours to see a physician, and this can be an insurmountable barrier to care. Being able to meet with a doctor using telemedicine could help address disparities in access to health care and improve women’s health and well-being.”

— Dr. Daniel Grossman in “New research finds providing medical abortion using telemedicine is effective, safe, and acceptable to women,” July 2011

Telemedicine is the delivery of a health care service or the transmission of health information using telecommunications technology in order to improve a patient's health.⁶⁷ Consultation through video conferencing, where a patient interacts with a remote provider, is an increasingly common method of providing care.⁶⁸ When medication abortion is administered via telemedicine, a woman first meets in-person with a trained medical professional at a health

care clinic. She then meets via a video conference system with an abortion provider who has reviewed her medical records, after which the medication is dispensed to the patient.⁶⁹

Telemedicine can improve the quality and efficiency of health care. For example, telemedicine is regularly used to expand access to mammography, chronic disease management, stroke diagnosis and treatment, high-risk pregnancy management and primary care.⁷⁰ It can be particularly important for rural women due to the significant shortage of reproductive health care providers.⁷¹ Texas has the nation's highest rural population with nearly 4 million rural residents,⁷² many of whom lack access to health care.⁷³ Studies and practice have shown that telemedicine can reduce health disparities for rural women and increase access to specialty care.⁷⁴

This is true for providing medication abortion via telemedicine — it is an effective way to improve access and timeliness with a high degree of patient satisfaction. Studies comparing in-person medication abortion provision with telemedicine medication abortion provision show equivalent effectiveness and rates of positive patient experience.⁷⁵ As ACOG has noted, the two types of visits are “medically identical.”⁷⁶ Telemedicine patients reported particularly valuing being able to receive abortion care at clinics closer to their homes and high numbers reported that they would recommend telemedicine to their friends.⁷⁷ Further increasing accessibility, an ongoing pilot program allows participants to access medication abortion via telemedicine with the medication provided by overnight mail after receiving the necessary tests at a local medical facility.⁷⁸

Despite the proven safety and success of telemedicine abortion, Texas’ prohibition interferes with the delivery of quality care by banning this innovative and effective method that could provide much-needed access to abortion throughout the state.

Prohibition on the Use of Evidence-Based Standards

Texas has prohibited the use of evidence-based prescribing for medication abortion. Physicians in the state are required to adhere to the protocol that is found on the label for the medication abortion drug, as approved by the U.S. Food and Drug Administration (FDA), rather than allowing physicians to administer it according to the most current research and evidence-based protocols.⁷⁹ When Texas enacted this restriction in 2013, the FDA label was significantly outdated. Required adherence to the FDA label substantially limited physicians’ ability to give their patients the best care by requiring that the first medication be given at a higher dosage than necessary⁸⁰ and cutting off the availability of medication abortion at just seven weeks of pregnancy, even though research and practice showed it could be effectively provided through 10 weeks. A study examining the effects of a similar law in Ohio found that patients were three times more likely to need additional intervention to complete their abortion than was the case prior to the law’s enactment, when providers were permitted to administer medication abortion using the most up-to-date standards and research.⁸¹

The way a drug is administered often evolves after the FDA has approved its use. Years of use in the field, as well as additional research and clinical studies, allow providers to learn much more about a drug and adjust the standard of practice based on the most current scientific evidence.⁸² The best practices for care constantly improve as new evidence is collected, while an FDA label will typically not be updated unless the manufacturer requests it, and even then only when the manufacturer has gone through a complicated and expensive updating process.⁸³ As ACOG has explained, “The 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.”⁸⁴ It is common practice — and often the best quality care — for providers to follow the medical community’s current evidence-based regimen in lieu of the protocol found on a medication’s label.

In 2016, the FDA updated the medication abortion label to reflect the evidence-based regimen developed since the drug’s initial approval in 2000.⁸⁵ The update reduced the required dosage of medication, decreased the number of visits a woman must make to her health care provider and extended the timeframe in which the drug has been shown to be effective from seven weeks to ten weeks of pregnancy.⁸⁶

Despite the update to the FDA label, physicians in Texas will still be limited in their ability to provide the most up-to-date care. As medical knowledge advances, the label will again become outdated, meaning that Texas’ FDA protocol requirement would again deny patients the best evidence-based care. This restriction not only undermines women’s access to a safe option for abortion care, but also threatens a central tenet of the practice of medicine: that evidence and research inform improvements in treatment and regimens for patients. The provision of health care should be based on medicine, not legislation.

Abortion Provider Shortage

In 2012, more than 40 abortion clinics served patients in Texas. After the state passed HB 2, more than half were forced to close, leaving only 19 clinics to provide care for the more than 5 million women of reproductive age in Texas.⁸⁷ The resulting rise in demand at the remaining clinics brought a dramatic increase of wait times for appointments. As of September 2015, the two clinics still open in Dallas reported wait times of up to 20 days, a

“At times, Routh Street [Women’s Clinic’s] 67-person waiting area was so full that many patients were required to sit on the floor or wait outside. Its efforts to handle the increase in patients necessitated a tremendous amount of overtime for its staff, as well as expanded hours and days of providing care, but even then Routh Street could not fully accommodate all of the patients left stranded by the closure of other providers. This increased workload took its toll on Routh Street’s physicians and staff, hastening the clinic’s closure.”

— National Abortion Federation, Amicus Curiae Brief Supporting Petitioners in *Whole Woman’s Health v. Cole*, Oct. 2015

clinic in Austin reported more than 20 days of wait time and a clinic in Fort Worth reported wait times of 23 days. By contrast, in Houston, where there were six open clinics, the wait time averaged 5 days.⁸⁸

The long wait times pushed many Texas patients seeking abortion care into the second trimester: Research shows a 27 percent increase in abortions after 12 weeks from 2013 to 2014.⁸⁹ The shift toward second trimester abortion raises the cost of the procedure, which becomes more expensive later in pregnancy.⁹⁰

The distance patients have to travel to access abortion has dramatically increased as the number of providers has decreased. The number of women of reproductive age in Texas living more than 50 miles from a clinic increased from 816,000 in May 2013 to 1,680,000 in April 2014. The number of women living more than 200 miles from a clinic increased from 10,000 in May 2013 to 290,000 in April 2014.⁹¹ Clinic

closures have left the remaining clinics clustered around four metropolitan areas, with approximately 80 percent of the population of Texas living outside of these areas.⁹²

Before the U.S. Supreme Court struck it down, HB 2 resulted in the closure of more than half the clinics in Texas.⁹³ While the case was making its way through the court system, many clinics lost their facility licenses or leases on clinic space, as well as their staff. Thus, despite the resounding victory, the number of clinics in Texas remains limited due to the logistical and financial difficulties of reopening a clinic or opening a new facility, and women across Texas will continue to face the additional burdens of increased wait times and travel distances.⁹⁴

Targeted Regulation of Abortion Providers (TRAP Laws)

Bad medicine is requiring a clinic or health care provider to comply with burdensome requirements that are contrary to accepted medical practice and evidence.

TRAP laws single out abortion clinics and providers for onerous, medically unnecessary requirements that are not imposed on comparable medical facilities and health care providers. While these restrictions are often passed under the guise of “patient safety,” in truth they are intended to make abortion less accessible. They raise the cost of care, limit the availability of qualified providers and force clinics to close, making it harder for women to access care and undermining women’s health. Each of these burdens undermines patient-centered quality care and runs counter to key health care system goals: improving care, including patients’ experience of care; improving health outcomes; and reducing costs.⁹⁵

Abortion is one of the safest medical procedures in the United States.⁹⁶ Data from the Centers for Disease Control and Prevention show that abortion has a safety record of more than 99 percent.⁹⁷ Women in the United States experience serious complications from abortion less than 1 percent of the time.⁹⁸ In fact, the risk associated with abortion is similar to other gynecological procedures commonly performed in office or clinic settings.⁹⁹ Despite this impressive safety record, state after state has enacted TRAP laws.

As discussed earlier, in 2013 Texas legislators passed HB 2, requiring abortion clinics to meet specifications comparable to those required of ambulatory surgical centers and requiring physicians to have admitting privileges at a hospital within 30 miles of the clinic. These requirements were struck down by the U.S. Supreme Court in 2016.

However, Texas continues to impose additional TRAP laws including:

- ▶ A requirement that some second trimester abortions be performed in an ambulatory surgical center (ASC) or hospital.
- ▶ A requirement that an abortion may only be provided by a physician, barring other trained clinicians from providing this care.
- ▶ Facility licensing and inspection requirements more onerous than those for other office and clinic settings.
- ▶ A requirement that embryonic or fetal tissue resulting from an abortion or miscarriage be buried or cremated.

Ambulatory Surgical Center Requirement

Texas requires that abortion procedures after 16 weeks be performed in an ASC or hospital¹⁰⁰ despite a lack of evidence that providing abortion care in those facilities improves patient health outcomes or decreases already low rates of complication.¹⁰¹ These medically unnecessary requirements increase the cost of care with no medical benefit or force providers to stop offering services altogether.

Physicians’ offices and clinics are adequately equipped to provide second trimester abortion procedures.¹⁰² Many procedures comparable to abortion care — including hysteroscopy, sigmoidoscopy, miscarriage management and vasectomy — are routinely performed in office and clinic settings.¹⁰³

The Texas 16-week ASC requirement had a significant and immediate impact on abortion access. Before the law took effect in 2004, there were more than 20 providers offering abortion care after 16 weeks. None were able to comply with the stringent requirements and all outpatient providers stopped providing those procedures.¹⁰⁴ By 2007, there were only four providers in Texas able to offer abortion care after 16 weeks and the cost of care had increased dramatically.¹⁰⁵ The number of abortions performed after 16 weeks dropped by more than 85 percent in 2004 and by 2006 was still less than half the number provided in 2003.¹⁰⁶

The American Public Health Association has observed that this type of requirement forces clinics to “make . . . expensive renovations that have little or nothing to do with the patient services they provide.”¹⁰⁷ 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”¹⁰⁸ and counseled that facility requirements that are not evidence-based nor tied to safety and efficiency should be eschewed.¹⁰⁹

The 16-week ASC requirement does nothing to enhance quality of care. It does, however, increase the cost of care as facilities’ operating expenses increase. This law forces care into an unnecessarily high-cost setting for no medical reason, undermining the health care goal to improve patient experience and outcomes while driving down costs.¹¹⁰

Physician-Only Requirement

Texas law requires that abortion care, including medication abortion, be provided only by a physician,¹¹¹ despite evidence that advanced practice clinicians can safely and effectively provide abortion care and do so in other states.¹¹² The Texas law ignores the extensive training of advanced practice clinicians, such as nurse practitioners, certified nurse-midwives and physician assistants, and their role in providing primary health care and managing chronic conditions and procedures that are more complex than abortion procedures or medication abortion.¹¹³

ACOG states in its guidelines on medication abortion that “[i]n addition to physicians, advanced practice clinicians, such as nurse-midwives, physician assistants, and nurse practitioners, possess the clinical and counseling skills necessary to provide first-trimester [medication] abortion,”¹¹⁴ and has recommended that the pool of aspiration abortion providers be expanded to include “appropriately trained and credentialed advanced practice clinicians.”¹¹⁵ A study conducted by the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco evaluated the safety, effectiveness and level of patient satisfaction associated with advanced practice clinicians in providing abortion care. Researchers confirmed that advanced practice clinicians can be trained to successfully provide first trimester aspiration abortion procedures as safely and effectively as physicians. Additionally, patients report high satisfaction with their experience whether their care was provided by an advanced practice clinician or a physician.¹¹⁶

The shortage of abortion providers creates an unnecessary barrier to abortion care that advanced practice clinicians can help address.¹¹⁷ ACOG and other professional associations recognize the importance of advanced practice clinicians as abortion providers and their role in increasing the number of qualified providers.¹¹⁸ However, by imposing this non-evidence-based physician-only requirement, Texas law has cut off an avenue for improving access to much-needed care.

Targeted Facility Licensing and Inspection Requirements

Texas law requires that clinics providing abortion care obtain a license to operate as an “abortion facility.”¹¹⁹ Texas’ licensing and inspection requirements for abortion clinics impose onerous and unnecessary requirements that do not apply to physicians providing comparable medical services in office and clinic settings. These requirements are burdensome, time consuming and increase the cost of providing care with no evidence that they improve patient experience or outcomes.

Texas’ extensive licensing requirements for abortion facilities govern nearly every aspect of a clinic’s operations.¹²⁰ These regulations include: specific staffing requirements and qualifications,¹²¹ physical and environmental requirements,¹²² and infection control policies and specialized equipment.¹²³ Abortion clinics are subject to intrusive and random unannounced inspections at least annually in addition to inspection upon renewal.¹²⁴ They are required to have a unique identifying number that must be disclosed in any advertisement.¹²⁵

These requirements treat abortion clinics differently than similar health care settings for no medical reason. They do nothing to improve patient safety and instead drive up facility operating expenses, increase the cost of care and take valuable time away from patient-centered care.

Burial or Cremation Requirement for Embryonic and Fetal Tissue

Recently, the Texas Department of State Health Services went a step further in its blatant targeted regulation of abortion. In late 2016, it finalized rules that require providers to bury or cremate embryonic and fetal tissue following an abortion, a procedure to manage early pregnancy loss (miscarriage) or ectopic pregnancy surgery.¹²⁶ This regulation treats embryonic and fetal tissue differently than all other tissue resulting from medical procedures. As the Texas Association of Obstetricians and Gynecologists has explained, it “does nothing to improve or protect the health and safety of Texans”¹²⁷ and fails to take a patient’s wishes into account. The medically unnecessary requirement creates an additional financial burden on providers, increasing cost without improving the quality of care. In fact, it diminishes patient experience by mandating a non-medical ritual designed to shame and stigmatize the patient.

The regulation requires that providers ensure that the embryonic or fetal tissue resulting from an abortion or miscarriage be cremated or buried, regardless of gestation or a patient’s individual circumstances.¹²⁸ This medically unnecessary requirement interferes with a provider’s ability to deliver individualized, patient-centered care by forcing him or her to adhere to burial or cremation rituals that may be out of step with a woman’s personal beliefs, values or desires. The requirement has the added possibility of interference with pathology and crime lab testing, meaning patients could be deprived of necessary diagnostic information or criminal evidence in sexual assault cases.¹²⁹ Because providers are responsible for compliance, they risk liability for how pathology or crime labs manage the tissue after testing. This could chill providers’ ability to offer the standard of care to their patients and could deny women important medical knowledge.

This new regulation also threatens to further limit the availability of abortion care in Texas. In order to continue offering abortion care, providers will be dependent on third-party vendors’ ability and willingness to comply with this potentially costly restriction. Providers who are unable to arrange for affordable burial or cremation services would be forced to close.¹³⁰

Recommendations

Texas lawmakers have stepped into the exam room with an ideological agenda that overrides providers' medical judgment and ignores patients' needs. Instead, they should acknowledge and support health care providers' ethical and professional obligation to put their patients first, and should strive to improve the quality of care — not undermine it.

- ▶ Texas lawmakers 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.
- ▶ Texas laws that are based on politicians' ideology and not sound medical evidence — such as ultrasound requirements, biased counseling laws, mandatory delays, restrictions on medication abortion and TRAP laws — should be repealed. Lawmakers should refrain from enacting legislation that provides no evidence of improved health outcomes.
- ▶ Lawmakers should take steps to protect the patient-provider relationship, and affirm the importance of individualized care and providers' ability to further the best interests of their patients. 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.

Conclusion

While in many areas there have been advances in making health care more accessible and more centered on the needs of the patient, in too many cases politicians have driven abortion care in the opposite direction. Women seeking abortion services deserve truthful information and quality care in their own communities. They should not be forced to experience unnecessary delays or medical procedures, be denied safe and timely abortion options or be forced to receive false and biased information that is unsupported by medical evidence and that is scientifically inaccurate. By the same token, health care providers should be able to focus their energies on their obligations to their patients.

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

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

— Leaders of the American College of Physicians, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and American College of Surgeons, *New England Journal of Medicine*, Oct. 2012

Endnotes

¹ See National Partnership for Women & Families. (2016, February). *Bad Medicine: How a Political Agenda is Undermining Women's Health Care* (2nd ed.). Retrieved 21 November 2016, from <http://www.nationalpartnership.org/research-library/repro/bad-medicine-download.pdf> (Discussing this trend with respect to abortion care.). The growing trend of imposing politics on medical care has broad implications. Restrictions like the ones discussed in this report impair health care providers' ability to counsel patients on gun safety and environmental risk factors, among other health and safety concerns. See National Partnership for Women & Families, National Physicians Alliance, Natural Resources Defense Council & Law Center to Prevent Gun Violence. (2015, October). *Politics in the Exam Room: A Growing Threat*. Retrieved 22 December 2016, from <http://www.nationalpartnership.org/research-library/repro/politics-in-the-exam-room-a-growing-threat.pdf> (Discussing this trend with respect to reproductive health care, toxic exposures and gun safety.).

² The examples discussed in this report are illustrative of the ways in which Texas restricts abortion care and undermines the practice of medicine. Sadly, Texas has imposed myriad restrictions on abortion access. To learn more about the breadth of restrictions, see Guttmacher Institute. (2017, January). *State Facts About Abortion: Texas*. Retrieved 17 January 2017, from <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-texas>; NARAL Pro-Choice Texas. (n.d.). *The Timeline of Texas Abortion Restrictions*. Retrieved 12 January 2017, from <http://www.prochoicetexas.org/txrestrictions/>

³ Institute of Medicine. (2001, March). *Crossing the Quality Chasm: A New Health System for the 21st Century* (p. 1). Retrieved 22 December 2016, from <https://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>. The Institute of Medicine was renamed in 2015 to the National Academy of Medicine.

⁴ See *ibid*; *What is Health Care Quality and Who Decides?: Hearings before the Subcommittee on Health Care, of the Senate Committee on Finance, 111th Cong. 1* (2009) (testimony of Carolyn M. Clancy).

⁵ Institute for Healthcare Improvement. (n.d.). *The IHI Triple Aim*. Retrieved 22 December 2016, from <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

⁶ National Committee for Quality Assurance. (2007). *The Essential Guide to Health Care Quality* (p. 7). Retrieved 22 December 2016,

from <http://www.ncqa.org/newsroom/resource-library/essential-guide-to-health-care-quality> ("Virtually every part of the health care industry — hospitals, health plans, physicians, nursing homes, home health providers and others — is working to improve health care quality. The federal government, states, employers and consumer advocates are also focused on improving care.").

⁷ See Peterson, L. (2016, June 13). Meet The Woman Fighting For Abortion Rights At The Supreme Court. *Refinery 29*. Retrieved 18 January 2017, from <http://www.refinery29.com/2016/06/113705/whole-womans-health-founder-interview>

⁸ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016).

⁹ *Whole Woman's Health*, 136 S. Ct. at 2311.

¹⁰ *Whole Woman's Health*, 136 S. Ct. at 2315.

¹¹ *Whole Woman's Health*, 136 S. Ct. at 2315 (quoting *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).

¹² *Whole Woman's Health*, 136 S. Ct. at 2315.

¹³ *Whole Woman's Health*, 136 S. Ct. at 2315.

¹⁴ *Whole Woman's Health*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) (quoting *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F. 3d 908, 921 (7th Cir. 2015)).

¹⁵ See, e.g., Minkoff, H., & Ecker, J. (2012, September). When legislators play doctor — The ethics of mandatory preabortion ultrasound examinations. *Obstetrics & Gynecology*, 120(3), 647–649 ("Ultrasonography may be an appropriate element of medical care in many cases, but its timing, context, and the way in which it is used and viewed should be a decision made between the patient and health care provider, not a decision scripted by law."); Committee on Ethics, American College of Obstetricians and Gynecologists. (2007, December; reaffirmed 2016). *Committee Opinion No. 390, Ethical Decision Making in Obstetrics and Gynecology* (p. 6). Retrieved 22 December 2016, from <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Ethics/co390.pdf?dmc=1&ts=20120305T0654106237> ("A patient's right to make her own decisions about medical issues extends to the right to refuse . . . medical treatment."); Committee on Ethics, American College of Obstetricians and Gynecologists. (2009, August; reaffirmed 2015). *Committee Opinion No. 439, Informed Consent* (p. 7). Retrieved 22 December 2016, from <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Ethics/co439.pdf?dmc=1&ts=20130415T1047469933> [hereinafter ACOG Opinion 439] (Advising that refusing information can "be itself

an exercise of choice, and its acceptance can be part of respect for the patient's autonomy"); National Abortion Federation. (2016). *2016 Clinical Policy Guidelines* (p. 10). Retrieved 18 January 2017, from <https://prochoice.org/wp-content/uploads/2016-CPGs-web.pdf>

¹⁶ *Stuart v. Loomis*, 992 F. Supp. 2d 585, 591 (M.D.N.C. 2014) (quoting *COMM. ON ETHICS, AM. COL. OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 439, INFORMED CONSENT 7* (Aug. 2009; reaffirmed 2012)).

¹⁷ See note 15, ACOG Opinion 439, p. 3 ("Consenting freely is incompatible with [a patient] being coerced or unwillingly pressured by forces beyond [her]self."); American Medical Association. (2001). *AMA Code of Medical Ethics, Principles of Medical Ethics*. Retrieved 22 December 2016, 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 22 December 2016, from http://www.acponline.org/running_practice/ethics/manual/manual6th.htm ("The physician's primary commitment must always be to the patient's welfare and best interests, whether in preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must respect the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status.") ("The physician must be professionally competent, act responsibly, . . . and treat the patient with compassion and respect . . .") ("Care and respect should guide the performance of the physical examination.").

¹⁸ Tex. Health & Safety Code § 171.015 (2015).

¹⁹ Tex. Health & Safety Code § 171.012(a)(4) (2015).

²⁰ Tex. Health & Safety Code § 171.012(a)(4)(D) (2015).

²¹ Tex. Health & Safety Code § 171.012(a)(4)(B)-(C) (2015).

²² A patient may choose not to receive a verbal explanation of the ultrasound if her pregnancy is the result of reported sexual assault, if she is a minor obtaining abortion care through the judicial bypass process or in the case of a diagnosed irreversible fetal anomaly. Tex. Health & Safety Code § 171.0122 (2015).

²³ See note 15, Minkoff & Ecker ("There are no circumstances in which a patient's viewing of

the fetus is medically necessary.” (“[Mandatory ultrasound laws] are clearly value-laden in intent and designed in no small measure to relay the opprobrium of those advancing such measures toward the woman’s decision to have an abortion.”); *Stuart*, 992 F. Supp. 2d at 598-99 (noting the state’s acknowledgment that one of the purposes of the ultrasound law in question is to dissuade women from terminating a pregnancy).

²⁴ See note 15, ACOG Opinion 439, p. 1 (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, 232-92.

²⁵ Tex. Health & Safety Code §§ 171.011-.016 (2015).

²⁶ See College Executive Board, American College of Obstetricians and Gynecologists. (Revised and approved 2014). *College Statement of Policy, Abortion Policy*. Retrieved 22 December 2016, from <https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20151215T1746509747>; see note 15, ACOG Opinion 439, p. 7 (Advising that refusing information can “be itself an exercise of choice, and its acceptance can be part of respect for the patient’s autonomy.”); see note 15, National Abortion Federation, p. 2.

²⁷ See American Medical Association. (2016, June). *Code of Medical Ethics, Chapter 2.1.1 Informed Consent*. Retrieved 18 January 2017, from <https://www.ama-assn.org/about-us/code-medical-ethics> (“Physicians should . . . [p]resent relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information.”); Epstein, R. M., & Street, R. L. (2011, March). The Values and Value of Patient-Centered Care. *Ann. Fam. Med.*, 9(2), 100-103 (Describing patient-centered care as “based on deep respect for patients as unique living beings, and the obligation to care for them on their terms. Thus, patients are known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care.”).

²⁸ Tex. Health & Safety Code §§ 171.011-.016 (2015).

²⁹ See Texas Department of State Health Services. (2016, December). *A Woman’s Right to Know*. Retrieved 3 January 2017, from <https://dshs.texas.gov/wrtk/>

³⁰ See American Cancer Society. (2014, June). *Abortion and Breast Cancer Risk*. Retrieved 3 January 2017, from <http://www.cancer.org/>

cancer/cancer-causes/medical-treatments/abortion-and-breast-cancer-risk.html (“[S]cientific research studies have not found a cause-and-effect relationship between abortion and breast cancer.”); National Cancer Institute. (2010, January). *Abortion, Miscarriage, and Breast Cancer Risk*. Retrieved 7 January 2017, from <https://www.cancer.gov/types/breast/abortion-miscarriage-risk>

³¹ See American College of Obstetricians and Gynecologists. (2015, May). *FAQ043 Induced Abortion*. Retrieved 13 December 2016, from <https://www.acog.org/-/media/For-Patients/faq043.pdf?dmc=1&ts=20161213T1233578816> (“[A]bortion does not affect your ability to get pregnant or the risk of future pregnancy complications.”).

³² See Rocca, C. H., Kimport, K., Roberts, S. C. M., Gould, H., Neuhaus, J., & Foster, D. G. (2015, July). Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study. *PLoS ONE*, 10(7). Retrieved 3 January 2017, from <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832>; Biggs, M. A., Upadhyay, U. D., McCulloch, C. E., & Foster, D. G. (2016, December 14). Women’s Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion. *JAMA Psychiatry*. Retrieved 19 December 2016, from <http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2592320>

³³ See Royal College of Obstetricians and Gynaecologists. (2010, March). *Fetal Awareness: Review of Research and Recommendations for Practice*. Retrieved 3 January 2017, from <https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf>; Lee, S. J., Ralston, H. J. R., & Drey, E. A. (2005). *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*. *JAMA*, 294(8), 947-954; Derbyshire, S. W. (2006, April). Can fetuses feel pain? *British Medical Journal*, 332(7546), 909-912.

³⁴ See Guttmacher Institute. (2017, January). *Induced Abortion in the United States*. Retrieved 17 January 2017, from <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>

³⁵ See Daniels, C. R. (2016). *Texas, Informed Consent Project*. Retrieved 21 November 2016, from <http://informedconsentproject.com/texas/>

³⁶ See Daniels, C. R. (2016, August 5). *Texas 2016 Draft of Women’s Right to Know Brochure*. Informed Consent Project. Retrieved 21 November 2016, from <http://informedconsentproject.com/texas/>

³⁷ See note 29.

³⁸ Tex. Health & Safety Code § 171.012 (2015).

³⁹ See Burns, M., Dyer, M. B., & Bailit, M. (2014, January). *Reducing Overuse and Misuse — State Strategies to Improve Quality and Cost of Health Care*. Robert Wood Johnson Foundation. Retrieved 22 December 2016, from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409990; Texas Policy Evaluation Project. (2013, April). *Impact of Abortion Restrictions in Texas* (Research Brief) (p. 1). Retrieved 22 December 2016, from https://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-ResearchBrief-ImpactofAbortionRestrictions.pdf (Finding that almost a third of women reported that a forced waiting period had a negative impact on their emotional well-being.).

⁴⁰ See note 3, p. 3.

⁴¹ See note 2, Guttmacher Institute.

⁴² See Gerds, C., Fuentes, L., Grossman, D., White, K., Keefe-Oates, B., Baum, S. E., Hopkins, K., Stolp, C. W., & Potter, J. E. (2016, May). Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas. *American Journal of Public Health*, 106(5), 857-864.

⁴³ See note 34.

⁴⁴ See National Partnership for Women & Families. (2015, July). *Texans Need Paid Sick Days*. Retrieved 21 November 2016, from <http://www.nationalpartnership.org/research-library/campaigns/psd/texas.pdf>

⁴⁵ See note 39, Texas Policy Evaluation Project, p. 1 (“These laws have had the greatest impact on low-income women and women in rural counties.”); Joyce, T., Henshaw, S., Dennis, A., Finer, L., & Blanchard, K. (2009, April). *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review* (p. 4). Guttmacher Institute Publication. Retrieved 22 December 2016, 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.).

⁴⁶ See Brief of Nat’l Latina Inst. for Reprod. Health, et al., as Amici Curiae Supporting Petitioners, *Whole Woman’s Health v. Cole* (Jan. 4, 2016) (No. 15-274).

⁴⁷ The U.S. Department of Health and Human Services designates El Paso County and all four counties in the Valley (Cameron, Hidalgo, Starr and Willacy Counties) as either fully or partially “medically underserved.” United States Department of Health and Human Services. (n.d.). *Health Resources & Services Administration Find Shortage Areas: MUA/P by State and County*. Retrieved 25 October 2016, from <http://muafind.hrsa.gov/index.aspx>

⁴⁸ See Center for Reproductive Rights & National Latina Institute for Reproductive Health. (2013, November). *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women’s Reproductive Health in the Rio Grande Valley* (p. 15). Retrieved 22 December 2016, from <http://www.nuestrotexas.org/pdf/NT-spread.pdf>

- ⁴⁹ See Grimes, A. (2014, January 22). In Texas' Rio Grande Valley, a Reproductive Health-Care Crisis Goes From Bad to Worse. *Rewire*. Retrieved 17 January 2017, from <https://rewire.news/article/2014/01/22/in-texas-rio-grande-valley-a-reproductive-health-care-crisis-goes-from-bad-to-worse/>
- ⁵⁰ See United States Census Bureau. (2015). *Quick Facts: Texas*. Retrieved 22 December 2016, from <http://www.census.gov/quickfacts/table/PST045215/48> (Cameron, Hidalgo, Starr and Willacy Counties).
- ⁵¹ See Culp-Ressler, T. (2013, November 13). Life In The Rio Grande Valley: Meet The Women Abandoned By Texas And Overlooked By The Media. *ThinkProgress*. Retrieved 18 January 2017, from <https://thinkprogress.org/life-in-the-rio-grande-valley-meet-the-women-abandoned-by-texas-and-overlooked-by-the-media-fc5a9501504c#krvskp2gn>
- ⁵² See *ibid*.
- ⁵³ See Fernandez, M. (2015, November 22). Checkpoints Isolate Many Immigrants in Texas' Rio Grande Valley. *New York Times*. Retrieved 5 December 2016, from http://www.nytimes.com/2015/11/23/us/checkpoints-isolate-many-immigrants-in-texas-rio-grande-valley.html?_r=0
- ⁵⁴ See Brief of Nat'l Latina Inst. for Reprod. Health, et al. as Amici Curiae Supporting Petitioners at 30-31 ("Fear of immigration stops is especially great near the Mexican border, including El Paso, Houston and the [Rio Grande] Valley, where both CBP and Immigration and Customs Enforcement have increased their presence in recent years. Not surprisingly, during the eleven-month period that the McAllen clinic could not perform abortions, their staff received calls from women who were unable to go to San Antonio because they were afraid of passing immigration checkpoints."); Paquette, D., & Somashekhar, S. (2016, March 1). South Texas's only abortion clinic is battleground for major Supreme Court case. *Washington Post*. Retrieved 23 January 2017, from https://www.washingtonpost.com/national/south-texas-only-abortion-clinic-is-battleground-for-major-supreme-court-case/2016/03/01/b93adc00-da5e-11e5-81ae-7491b9b9e7df_story.html?utm_term=.7f65259e3e4d
- ⁵⁵ See Brief of Twelve Orgs. Dedicated to the Fight for Reprod. Justice as Amici Curiae Supporting Petitioners, *Whole Woman's Health v. Cole* (Jan. 4, 2016) (No. 15-274).
- ⁵⁶ See Texas Department of State Health Services. (2016, July). *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report* (p. 5). Retrieved 17 January 2017, from https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm
- ⁵⁷ See Brief of Twelve Orgs. Dedicated to the Fight for Reprod. Justice as Amici Curiae Supporting Petitioners at 20-22.
- ⁵⁸ See Center for Reproductive Rights & National Latina Institute for Reproductive Health. (2015, September). *¡Somos Poderosas! A Human Rights Hearing in the Rio Grande Valley* (p. 7). Retrieved 13 December 2016, from http://www.nuestrotexas.org/wp-content/uploads/2015/09/NT_Hearing_RGV_Final_Web.pdf
- ⁵⁹ See *ibid*, pp. 8-9.
- ⁶⁰ See Center for Reproductive Rights & National Latina Institute for Reproductive Health. (2015, September). *Transcripts of the Human Rights Hearing Testimony*. Retrieved 23 January 2017, from http://www.nuestrotexas.org/wp-content/uploads/2015/09/NT_Hearing_RGV_Final_Transcripts_Web.pdf
- ⁶¹ See note 58, pp. 8-9.
- ⁶² See Boonstra, H. (2013). Medication Abortion Restrictions Burden Women and Providers — and Threaten U.S. Trend Toward Very Early Abortion. *Guttmacher Policy Review*, 16(1), 18–23. Retrieved 22 December 2016, from <http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.pdf>
- ⁶³ See *ibid*; see note 15, National Abortion Federation, p. 14.
- ⁶⁴ See Gatter, M., Cleland, K., & Nucatola, D. (2015). Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days. *Contraception*, 91(4), 269-273; Association of Reproductive Health Professionals. (2008, April). *Mifepristone Safety Overview*. Retrieved 22 December 2016, from <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/mifepristone-safety-overview> ("Mifepristone is safer than acetaminophen (Tylenol®) [and] Aspirin®").
- ⁶⁵ Tex. Health & Safety Code § 171.063(c) (2015). Texas law also requires any provider who utilizes telemedicine to establish "a physician-patient relationship which at a minimum includes . . . a face-to-face or in-person evaluation." 22 Tex. Admin. Code § 174.8(a) (2016) (enjoined in pending litigation).
- ⁶⁶ Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, November). *Committee Opinion No. 613, Increasing Access to Abortion*. Retrieved 3 January 2017, from <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>
- ⁶⁷ See American Telemedicine Association. (n.d.). *About Telemedicine*. Retrieved 22 December 2016, from <http://www.americantelemed.org/about/about-telemedicine>; Medicaid.gov. (n.d.). *Telemedicine*. Retrieved 22 December 2016, from <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/telemedicine.html>
- ⁶⁸ See Institute of Medicine. (2012, November 20). *The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary*. Retrieved 22 December 2016, from <http://www.nationalacademies.org/hmd/Reports/2012/The-Role-of-Telehealth-in-an-Evolving-Health-Care-Environment.aspx> (Noting that telemedicine via interactive video is used, for example, in ICU care, infectious disease treatment and stroke care.). The Institute of Medicine was renamed in 2015 to the National Academy of Medicine.
- ⁶⁹ See note 62.
- ⁷⁰ See Susman, E. (2006, March 25). Telemedicine Promises Greater Access for Breast Cancer Screening & Treatment. *Oncology Times*, 28(6), 33-35. Retrieved 22 December 2016, from http://journals.lww.com/oncology-times/Fulltext/2006/03250/Telemedicine_Promises_Greater_Access_for_Breast.19.aspx; Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion. (n.d.). *Telemedicine Interventions for Chronic Disease Management*. Retrieved 22 December 2016, from http://www.cdc.gov/dhds/pubs/docs/sib_oct2014.pdf; Mayo Clinic Health System. (n.d.). *Stroke Telemedicine*. Retrieved 22 December 2016, from <http://mayoclinichealthsystem.org/stroke-telemedicine>; American Telemedicine Association. (2014, January). *State Medicaid Best Practice: Telehealth for High-Risk Pregnancy*. Retrieved 22 December 2016, from <http://www.adph.org/ALPHTN/assets/StateMedicaidBestPracticeforHighRiskPregnancy.pdf>; Peterson, H. (2014, June 23). *Connecting Veterans with Telehealth*. Retrieved 22 December 2016, from <http://www.va.gov/health/newsfeatures/2014/june/connecting-veterans-with-telehealth.asp>
- ⁷¹ See Committee on Health Care for Underserved Women, American College of Obstetricians and Gynecologists. (2014, February; reaffirmed 2016). *Committee Opinion No. 586, Health Disparities in Rural Women* (p. 3). Retrieved 22 December 2016, from <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women>
- ⁷² See Douglas, K. M., Theodori, G. L., Hudec, C. L., & Beach, S. S. (2014). *The 2013 Texas Rural Survey: Respondents' Demographic Profile*. Retrieved 22 December 2016, from <http://www.shsu.edu/centers/rural-studies/Publications/-TRS%202013%20Demographic%20Profile%20Report.pdf>
- ⁷³ See Aaronson, B. (2012, May 8). Interactive: Mapping Access to Health Care in Texas. *Texas Tribune*. Retrieved 17 January 2017, from <https://www.texastribune.org/library/data/texas-shortage-health-care-providers/> ("The majority

of rural Texas lacks primary care physicians, pediatricians, obstetricians and gynecologists and other specialists, while more populated areas have a sufficient number of providers.”)

⁷⁴ See, e.g., note 71; Uscher-Pines, L., & Mehorthra, A. (2014). Analysis of Teladoc Use Seems to Indicate Expanded Access to Care For Patients Without Prior Connection To A Provider. *Health Affairs* 33(2). In collaboration with Texas A&M University, the Madison Outreach and Services through Telehealth (MOST) Network uses telemedicine to provide mental health and substance abuse prevention treatment programs to rural Brazos Valley, Texas, creating access to services that many in the community would otherwise go without. The MOST program is the only provider of Latino/a-focused health and social services in the county. Rural Health Information Hub. (n.d.). *Madison Outreach and Services through Telehealth (MOST) Network*. Retrieved 7 November 2016, from <https://www.ruralhealthinfo.org/community-health/project-examples/856>

⁷⁵ See Grossman, D., Grindlay, K., Buchacker, T., Lane, K., & Blanchard, K. (2011, August). Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics & Gynecology*, 118(2), 296–303.

⁷⁶ Brief for Am. Coll. of Obstetricians & Gynecologists as Amicus Curiae Supporting Petitioners-Appellants at 8, Planned Parenthood of the Heartland v. Iowa Bd. of Med., 865 N.W.2d 252 (Iowa 2015) (No. 14-1415).

⁷⁷ See note 75.

⁷⁸ See Gynuity Health Projects. (n.d.). *Providing medical abortion using telemedicine*. Retrieved 29 November 2016, from <http://gynuity.org/programs/more/providing-medical-abortion-using-telemedicine/>; *Telabortion: The Telemedicine Abortion Study*. (n.d.). Retrieved 23 January 2017, from <http://telabortion.org/>

⁷⁹ Tex. Health & Safety Code § 171.063(a)(2) (2015).

⁸⁰ The Texas law also allows physicians to administer the medication abortion drug “in the dosage amount prescribed by the clinical management guidelines defined by the American Congress [sic] of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013.” Tex. Health & Safety Code § 171.063(b) (2015). That protocol had not been updated since 2005. ACOG updated the practice bulletin in March 2014. See American College of Obstetricians and Gynecologists. (2014, March). *Medical Management of First-Trimester Abortion* (Practice Bulletin No. 143) (p. 11). Retrieved 14 December 2016, from <http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion>

⁸¹ See Upadhyay, U. D., Johns, N. E., Combellick, S. L., Kohn, J. E., Keder, L. M., & Roberts, S. C. M. (2016, August 30). Comparison of Outcomes before and after Ohio’s Law Mandating Use of the FDA-Approved Protocol for Medication Abortion: A Retrospective Cohort Study. *PLoS Med*, 13(8).

⁸² See Borkowski, L., Strasser, J., Allina, A., & Wood, S. (2015, December). *Medication Abortion*. Retrieved 10 January 2017, from https://publichealth.gwu.edu/sites/default/files/Medication_Abortion_white_paper.pdf (“Off-label prescribing is a common phenomenon across many types of care, and different protocols or uses often arise after a drug is approved for a specific condition.”); U.S. Food and Drug Administration. (2016, January). *“Off-Label” and Investigational Use of Marketed Drugs, Biologics, and Medical Devices*. Retrieved 3 January 2017, from <http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm>

⁸³ See *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 909 (9th Cir. 2014).

⁸⁴ Brief for Am. Coll. of Obstetricians & Gynecologists as Amicus Curiae Supporting Petitioners-Appellants at 25.

⁸⁵ See U.S. Food and Drug Administration. (2016). *Mifeprex (mifepristone) Information*. Retrieved 22 December 2016, from <http://www.fda.gov/Drugs/DrugSafety/ucm111323.htm>

⁸⁶ See Jones, R. K., & Boonstra, H. D. (2016, June). The Public Health Implications Of The FDA’s Update To The Medication Abortion Label. *Health Affairs Blog*. Retrieved 17 January 2017, from <http://healthaffairs.org/blog/2016/06/30/the-public-health-implications-of-the-fdas-update-to-the-medication-abortion-label/>

⁸⁷ See Ura, A., Murphy, R., Daniel, A., & Carbonell, L. (2016, June 28). Here Are The Texas Abortion Clinics That Have Closed Since 2013. *Texas Tribune*. Retrieved 10 January 2017, from <https://www.texastribune.org/2016/06/28/texas-abortion-clinics-have-closed-hb2-passed-2013/>; see note 2, Guttmacher Institute.

⁸⁸ See Texas Policy Evaluation Project. (2015, October 5). *Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*. Retrieved 18 January 2017, from <http://www.ibisreproductivehealth.org/sites/default/files/files/publications/Abortion%20Wait%20Time%20Brief%20Oct%205.pdf>

⁸⁹ See Carmon, I. (2016, July 6). More Second-Trimester Abortions Occurred Under Texas Law: Exclusive. *NBC News*. Retrieved 19 January 2017, from <http://www.nbcnews.com/news/us-news/more-second-trimester-abortions-occurred-under-texas-law-exclusive-n604246>

⁹⁰ See Henshaw, S. K., & Finer, L. B. (2004). The Accessibility of Abortion Services in the United States, 2001. *Guttmacher Institute* 35(1). Retrieved

3 January 2017, from <https://www.guttmacher.org/journals/psrh/2004/01/accessibility-abortion-services-united-states-2001> (“As a pregnancy advances into the second trimester, the abortion procedure becomes more complex, because it requires more time and more skill on the part of the clinician, and charges increase.”).

⁹¹ See Texas Policy Evaluation Project. (2014, July 1). *Access to abortion care in the wake of HB2*. Retrieved 1 November 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/AbortionAccessafterHB2.pdf

⁹² See Texas Policy Evaluation Project. (n.d.). *How Abortion Restrictions Would Impact Five Areas of Texas*. Retrieved 22 December 2016, from http://liberalarts.utexas.edu/txpep/_files/pdf/ImpactBrief-ProposedHB2-SB1AbortionBill.pdf

⁹³ See note 91.

⁹⁴ See Pattani, A. (2016, June 27). Don’t Expect Shuttered Abortion Clinics to Reopen Soon. *Texas Tribune*. Retrieved 3 January 2017, from <https://www.texastribune.org/2016/06/27/dont-expect-shuttered-abortion-clinics-reopen-soon/>

⁹⁵ See note 5 (Articulating the goals for a quality health care system).

⁹⁶ See, e.g., Brief for Am. Coll. of Obstetricians & Gynecologists et al. as Amici Curiae in Support of Petitioners at 6, *Whole Woman’s Health v. Cole* (Jan. 6, 2016) (No. 15-274).

⁹⁷ See Jatlaoui, T. C., Ewing, A., Mandel, M. G., Simmons, K. B., Suchdev, D. B., Jamieson, D. J., & Pazol, K. (2016, November 25). Abortion Surveillance — United States, 2013. *MMWR Surveillance Summaries* 65(12). Retrieved 3 January 2017, from <https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6512.pdf>

⁹⁸ See Planned Parenthood Federation of America & American Congress of Obstetricians and Gynecologists. (2015, January). *Protect Safe and Legal Abortion*. Retrieved 1 December 2016, from https://www.plannedparenthood.org/files/8514/2142/1056/AbortionSafety_FactSheet_Jan2015_V2_4.pdf

⁹⁹ See Scott Jones, B., & Weitz, T. A. (2009, April). Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences. *American Journal of Public Health*, 99(4), 627 (“Procedures that are comparable to abortions in the first or second trimester and that are often performed in outpatient clinics or physicians’ offices rather than ASCs include hysterectomy, surgical completion of miscarriage, vasectomy, sigmoidoscopy, and minor neck and throat surgeries.”); see note 98 (“Abortion is similar, in terms of level of risk, to other gynecological procedures that take place in doctor’s offices every day, including completion of miscarriage, loop electrosurgical excision procedure (“LEEP”) to remove abnormal cells from the cervix, hysterectomy, and endometrial ablation to treat abnormal uterine bleeding.”).

- ¹⁰⁰ Tex. Health & Safety Code § 171.004 (2015).
- ¹⁰¹ See, e.g., note 99, Scott Jones & Weitz, p. 627 (“Nonetheless, no data exist to show that providing abortions in ASCs positively affects complication rates or patient health outcomes or that physicians’ offices and outpatient clinics are inadequate or unsafe facilities for the performance of abortions.”).
- ¹⁰² See note 15, National Abortion Federation, pp. 29, 34 (“Abortion by dilation and evacuation (D&E) after 14 weeks from LMP is a safe outpatient surgical procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.”) (“Policy Statement: Medical induction abortion is a safe and effective method for termination of pregnancies beyond the first trimester when performed by trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.”); see note 99, Scott Jones & Weitz, p. 627 (“[N]o data exist to show that providing abortions in ASCs positively affects complication rates or patient health outcomes or that physicians’ offices and outpatient clinics are inadequate or unsafe facilities for the performance of abortions.”).
- ¹⁰³ See note 99, Scott Jones & Weitz, p. 627 (“Procedures that are comparable to abortions in the first or second trimester and that are often performed in outpatient clinics or physicians’ offices rather than ASCs include hysteroscopy, surgical completion of miscarriage, vasectomy, sigmoidoscopy, and minor neck and throat surgeries.”).
- ¹⁰⁴ See *ibid.*, p. 628.
- ¹⁰⁵ See *ibid.*
- ¹⁰⁶ See *ibid.*; Colman, S., & Joyce, T. J. (2010, March). Regulating Abortion: Impact on Patients and Providers in Texas (Working Paper 15825). *National Bureau of Economic Research*. Retrieved 3 January 2017, from <http://www.nber.org/papers/w15825.pdf>
- ¹⁰⁷ Brief for Am. Pub. Health Ass’n as Amicus Curiae Supporting Petitioners for Writ of Certiorari at 17, *Whole Woman’s Health v. Cole* (Oct. 5, 2015) (No. 15-274).
- ¹⁰⁸ World Health Organization. (2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed.) (p. 67). Retrieved 30 November 2016, from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1
- ¹⁰⁹ See *ibid.*, p. 96.
- ¹¹⁰ See note 5.
- ¹¹¹ Tex. Health & Safety Code § 171.003 (2015).
- ¹¹² 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*. Retrieved 19 December 2016, from <http://www.ansirh.org/sites/default/files/documents/hwppupdate-june2014.pdf> (Concluding that nurse practitioners, certified nurse midwives and physician assistants can “can provide early abortion care that is clinically as safe as physicians.”); see also note 15, National Abortion Federation, p. 1 (“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.”). Currently, advanced practice clinicians provide aspiration abortion care in California, Oregon, Montana, Vermont and New Hampshire. See Barry, D., & Rugg, J. (2015, March). *Improving Abortion Access by Expanding Those Who Provide Care* (p. 6). Center for American Progress. Retrieved 12 December 2016, from <https://www.americanprogress.org/issues/women/reports/2015/03/26/109745/improving-abortion-access-by-expanding-those-who-provide-care/>
- ¹¹³ See American Public Health Association. (2011, November 1). *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (Policy No. 20112). Retrieved 19 December 2016, 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>
- ¹¹⁴ See note 80, American College of Obstetricians and Gynecologists, p.10.
- ¹¹⁵ See note 66.
- ¹¹⁶ See note 112, *Advancing New Standards in Reproductive Health*.
- ¹¹⁷ See e.g., note 112, Barry & Rugg, p. 6.
- ¹¹⁸ See, e.g., note 66 (Supporting expansion of “the pool of first-trimester medication and aspiration abortion providers to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements.”); National Abortion Federation & Clinicians for Choice. (n.d.). *Role of CNMs, NPs, and PAs in Abortion Care*. Retrieved 17 January 2017, from https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/CNM_NP_PA_org_statements.pdf (Listing professional clinical associations that support an increased role of appropriately trained certified nurse-midwives, nurse practitioners or physician assistants, including American Academy of Physician Assistants, American College of Nurse-Midwives, American Medical Women’s Association, American Public Health Association, Association of Physician Assistants in Obstetrics and Gynecology and National Association of Nurse Practitioners in Women’s Health.).
- ¹¹⁹ Tex. Health & Safety Code § 245.003 (2015).
- ¹²⁰ Tex. Health & Safety Code §§ 245.001-.010 (2015); 25 Tex. Admin. Code §§ 139.1-.60 (2016).
- ¹²¹ 25 Tex. Admin. Code § 139.46 (2016).
- ¹²² 25 Tex. Admin. Code § 139.48 (2016).
- ¹²³ 25 Tex. Admin. Code § 139.49 (2016).
- ¹²⁴ Tex. Health & Safety Code § 245.006 (2015); 25 Tex. Admin. Code § 139.31 (2016). Although any health facility may be subject to an unannounced inspection, unannounced inspections are mandated for abortion clinics. Tex. Health & Safety Code § 12.018 (2015).
- ¹²⁵ Tex. Health & Safety Code § 245.0105 (2015).
- ¹²⁶ Texas Department of State Health Services. (2016, November 28). *Adopted Rules 25 Tex. Admin. Code §§ 1.132-.137*. Retrieved 19 December 2016, from <http://www.sos.state.tx.us/texreg/archive/December92016/Adopted%20Rules/25.HEALTH%20SERVICES.html>. The regulation is temporarily blocked through litigation.
- ¹²⁷ Texas District of the American Congress of Obstetricians and Gynecologists. (2016, October 21). *Comments on special waste from health care-related facilities*. On file with the National Partnership for Women & Families.
- ¹²⁸ See note 126.
- ¹²⁹ See Complaint at 12-13, *Whole Woman’s Health et al. v. Hellerstedt*, No. 1:16cv1300 (W.D. Tex. Filed Dec. 12, 2016); Mohnhey, G. (2016, December 12). *Abortion Providers Sue to Stop Texas Rule Requiring Burial for Fetal Tissue*. *ABC News*. Retrieved 17 January 2017, from <http://abcnews.go.com/Health/abortion-providers-sue-stop-texas-rule-requiring-burial/story?id=44150549>
- ¹³⁰ See Complaint at 13, *Whole Woman’s Health et al. v. Hellerstedt*, No. 1:16cv1300 (W.D. Tex. Filed Dec. 12, 2016).

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