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The TRAP: Limiting Women's Access to Abortion through Strategic, State-level Legislation

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THE TRAP: LIMITING WOMEN'S ACCESS TO ABORTION THROUGH STRATEGIC, STATE-LEVEL LEGISLATION

A thesis presented

by

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to

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The TRAP: Limiting Women's Access to Abortion through Strategic, State-level Legislation

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Introduction

“In public health we identify a problem, figure out the causes, look for solutions, and implement them. Here we see a vigorous response in the absence of a problem. It’s science run amok. Its public health run backwards.” - David Grimes, former chief of the Center for Disease Control branch for abortion safety.

When Wendy Davis left her house in Texas the morning of June 25th, 2013, she probably was not aware of the impact she would soon have as a female Democratic state senator. That day, she led an eleven hour filibuster that would not only bring her name and reputation to an entirely new level in the political realm, but that would bring newfound attention to the unyielding issue of abortion legislation. Displaying impressive stamina as she voiced her opposition to Texas House Bill 2, a series of restrictive laws that would lead to the closing of most of Texas’ 42 abortion clinics, Senator Wendy Davis’ performance earned instant attention from the media. Her success however was short lived, as Texas Governor Rick Perry proceeded to call a second special legislative session, allowing the Republican dominated legislature to quickly pass another bill. House Bill 2, signed on July 12th less than three weeks after the filibuster, bans abortions after 20 weeks of pregnancy, requires abortion clinics to meet the same standards as hospital surgical centers, restricts the administration of medicated abortion, and mandates that a doctor have admitting privileges at a hospital within 30 miles of the clinic where he performs abortions. Of the provisions, it is the admitting privileges requirement that has garnered the most attention among Texas women and abortion activists.

Texas is one of several states that have passed restrictive abortion laws. In 2011, legislators in all 50 states introduced more than 1,100 provisions related to reproductive health

3 Ibid.
and rights. This resulted in states adopting 135 new reproductive health provisions, a dramatic increase from the 89 enacted in 2010, and the 77 enacted in 2009.\textsuperscript{4} Unique to this type of legislation is the underlying message that each enactment carries. When asked of the role that the various provisions in House Bill 2 played in her decision to conduct the filibuster, Wendy Davis responded, “what the bill really was about…was closing women’s access to a very important health care service in the state of Texas...women literally are going to lose their access to care.”\textsuperscript{5}

The law went beyond simply restricting access to abortion, negatively impacting access to women’s basic, indisputably beneficial health care services. By imposing restrictions upon abortion providers, the bill caused several clinics to close because of an inability to meet the new standards.

What Wendy Davis was referring to was the Targeted Regulation of Abortion Providers, otherwise known as TRAP laws. Unlike other forms of restrictive abortion legislation that require mandatory waiting periods, parental consent, informed consent, or limited insurance coverage, TRAP laws target the actual abortion facility and its physicians. This is an effective strategy because it no longer targets the woman’s right to choose, but instead the provider itself; thereby taking the emotionally charged difficulties associated with deciding to obtain a procedure out of the question.

Laws regulating clinics in which abortions were performed first emerged in the years immediately following the Supreme Court decision in \textit{Roe v. Wade}\textsuperscript{6} in 1973. Moving against the


\footnotesize{\textsuperscript{6} \textit{Roe v. Wade}, 410 U.S. 113 (1973). The Supreme Court ruled 7–2 that a right to privacy under the 14\textsuperscript{th} Amendment extended to a woman’s decision to have an abortion. The right must consider that state’s interests in regulating abortion: protecting prenatal life and protecting women's health. The Court applied a trimester framework to decide the degree of state regulation as the time of the pregnancy progressed.}
Roe decision, which solidified a woman’s legal right to an abortion, several states sought to impose strict restrictions on abortion clinics. Since many of the restrictions went beyond what was necessary to ensure a patient’s safety, they were struck down in the lower federal courts in the 1980s. The efforts and types of approaches to restricting access then shifted to a more conservative direction, and beginning in the mid 1990s, Republicans in the U.S. House of Representatives and Senate introduced legislation to ban “partial birth” abortions, a procedure that aborted a semi-developed fetus in a later term of pregnancy. It was not until later in the 1990s that laws regulating abortion clinics resurfaced.

Most TRAP law requirements apply states’ standards for ambulatory surgical centers to abortion clinics, even though surgical centers tend to provide more invasive and risky procedures and use higher levels of sedation. These standards usually impose burdensome structural requirements upon the facility, beyond what is necessary to ensure patient safety in the event of an emergency. The provisions also often require that facilities maintain relationships with hospitals, “provisions that add nothing to existing patient protections while granting hospitals effective veto power over whether an abortion provider can exist.” Finally, several of the laws mandate that physicians performing abortions have admitting privileges with local hospitals, a condition that is nearly impossible to achieve. For example, Louisiana requires that abortions can only be performed in rooms that are a minimum of 120 square feet; North Carolina requires that abortion providers hire a registered nurse who is on duty at all times; and Missouri requires that abortion providers be located within 30 miles of a hospital and have procedure rooms that are at

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8 Ibid.
9 Ibid.
least 12 feet long and 12 feet wide, with ceilings at least 9 feet high and doors as least 44 inches wide.\textsuperscript{10} 

In 2005 alone, twenty-one state legislators considered TRAP bills.\textsuperscript{11} There were four restrictive TRAP laws aimed at abortion providers enacted that year,\textsuperscript{12} as compared to the 27 laws that were enacted by 2013.\textsuperscript{13} In the February 2014 policy briefing for TRAP laws, Guttmacher reported that 25 states require facilities where abortion services are provided to meet standards intended for ambulatory surgical centers, including provisions requiring specific sizes for procedure rooms, specific corridor widths, a set distance from a hospital, and a transfer agreement with a nearby hospital. Additionally, 13 states require abortion providers to have some affiliation with a local hospital, including admitting privileges or specific board certifications.\textsuperscript{14} Burdensome and unnecessary, the laws place strict regulations on hospitals and providers of abortions that do not apply to other medical professionals.

This thesis focuses on the recent influx of TRAP legislation since 2000, and whether it has had a different impact on women’s access to abortion than previous forms of restrictive abortion legislation. It asks why TRAP laws suddenly became so popular, and looks to the impact of the laws in certain states in order to determine the actual effects of the laws’ enactment. The thesis will explore the way in which TRAP legislation has been successful in state legislatures, as well as the specific behavior of the legislators and organizations involved in the policy-making process. TRAP legislation enacted in Texas and North Carolina in 2013 reveals an apparent coordinated effort on the part of pro-life organizations and conservative pro-

\footnotesize
\begin{itemize}
\item \textsuperscript{12} Ibid.
\item \textsuperscript{13} “State Policies in Brief: Targeted Regulation of Abortion.”
\item \textsuperscript{14} Ibid.
\end{itemize}
life legislators. This thesis will examine this strategy and how its implementation has ultimately closed abortion clinics and restricted access to abortion. Most importantly, the thesis will address the false claims aimed at supporting the legislation and the actual detrimental effects to women’s reproductive choice that the legislation has caused.

It is important to understand that TRAP legislation is a relatively new phenomenon that has yet to be thoroughly researched. Researcher Marshall Medoff argues that this is primarily due to the fact that TRAP laws have really only been enacted since the Supreme Court’s decision for *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992. He explains that previous studies of restrictive abortion policy have been constructed with unreliable measures, most notably the number of anti-abortion provisions passed by a state between 1973 and 1989, including gender selection, fetal pain, private health insurance restrictions, spousal notification, calls for a constitutional convention on the abortion issue, parental involvement laws, conscience clauses for medical personnel, and pro-life license plates. As mentioned earlier, however, previous restrictive laws are predominantly aimed at the women’s right to choose and are fundamentally different than TRAP laws. As Medoff explains, the studies do not reflect a state’s political, legal or social environment at the time that the law was enacted. Additionally, the types of laws previously examined in studies are merely symbolic, and do no limit women’s access to an abortion in the same way as physical requirements imposed on the abortion providers.

In order to fully understand the emergence of TRAP laws and their unique applicability to a woman’s access to abortion, a closer examination of the history leading up to the passage of new TRAP laws is needed. Chapter 1 provides the historical context necessary to understand

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18 Ibid., 955.
how the TRAP law strategy is a coordinated effort between conservative Republicans and socially conservative religious groups. Since the Catholic Church played an important role in shaping the conservative Republican Party ideology on social issues, the chapter examines the religious influence on the abortion debate and the formation of the Christian Right. The republican alliance with the Christian Right as a means to an electoral strategy is seen most clearly in the presidential elections of Nixon, Carter and Reagan and explains the conservative pro-life ideology that is recognized within the ideology of Republican Party members today.

Chapter 2 delves further into the issue of TRAP laws, explaining the emergence of the specific legislative strategy since the end of the 1990s. With crucial data compiled from the Guttmacher Institute, as well as NARAL Pro-Choice America, the chapter traces the increasing dominance of TRAP laws in state legislatures. A study of the model legislation promoted by Americans United for Life reveals a clear connection between pro-life organizations and state governments.

To contextualize the impact of the model legislation and the conservative, pro-life push for restrictive TRAP laws, Chapter 3 examines Texas legislation that was enacted in the summer of 2013. Texas House Bill 2, despite vehement opposition on behalf of Democratic legislators in the state, represents the effect of a coordinated pro-life strategy at the state level. The recent closure of several abortion providers in Texas is shown to be a direct result of the law’s requirement that abortion clinicians obtain admitting privileges from a nearby hospital.

In addition to admitting privileges, TRAP laws often require abortion provider facilities to meet the same standards as ambulatory surgical centers. Chapter 4 serves as the critical link between the actual TRAP law and the conservative effort to enact it. Looking to recent legislation enacted in North Carolina in 2013, the discussion reveals the false pretenses under
which Republican legislators defend TRAP laws, namely, as a means to improving women’s health and safety. The law, Senate Bill 353, severely limits women’s access to the state’s abortion providers by imposing standards that force the facilities to shut down.

The final chapter concludes with a discussion of the empirical evidence that exists with respect to the enactment of TRAP laws. Drawing upon the findings of Marshall Medoff and Christopher Dennis, it makes clear that the TRAP law strategy is unique, and different from previous restrictive abortion policy, in the sense that it targets the providers rather than the individual woman’s right to choose. The Republican led strategy, despite its assertions that the new laws serve to make abortion safer for women, actually has the opposite effect, and the empirical evidence supports this. There is a clear association between TRAP legislation and the decline in the number of abortions nationwide, and it is happening in states where Republicans control both the legislature and the governor’s office.
Chapter 1: The Christian Right

“Every legislator, every doctor, and every citizen needs to recognize that the real issue is whether to affirm and protect the sanctity of all human life, or to embrace a social ethic where some human lives are valued and others are not. As a nation, we must choose between the sanctity of life ethic and the "quality of life" ethic” – President Ronald Reagan

At the time he signed Mississippi’s latest abortion bill into law in 2012, Governor Phil Bryant (R) declared, “today you see the first step in a movement to do what we campaigned on…to try to end abortion in Mississippi.” Lieutenant Governor Tate Reeves followed suit, declaring that the bill “should effectively close the only abortion clinic in Mississippi.” This bill was one of several restrictive abortion laws that were emerging across the nation. According to legal correspondent Dahlia Lithwick, the successful enactment of the laws is attributable to a legislative strategy that has been promoted under the “guise of a tender concern for women, their vulnerable bodies and unstable emotions.” This false concern for women’s health has been utilized by pro-life advocates as a legislative strategy for restricting abortion since the early 1990s, and has resulted in the successful closing of abortion clinics across the nation. In fact, the focus on women’s health is only a small component of a much broader set of objectives aimed at restricting women’s access to abortion. In order to fully understand the legislative approach, it is necessary to examine the underlying ideology and political origins of the pro-life position on abortion, which is primarily informed by the concerns of the Christian Right.

This chapter will trace the rise of the Christian right from the early nineteenth century to the end of the 1980s. It will first look at the impact of grassroots feminist movements in the 1960s and the increased attention given to women’s reproductive rights. The chapter will then

21 Ibid.
consider the position of religious groups with respect to abortion and contraceptives at that time. Then, it will move on to the 1970s and 1980s, in which religious groups that were traditionally supportive of reproductive rights began to change their position, becoming more conservative. The chapter will assess how this change in the 1970s and 1980s impacted the constituency of the Republican Party, as seen through the presidential elections of Nixon, Carter and Reagan. Lastly, it will address the overarching influence that the Catholic Church had in reshaping the Republican Party ideology, especially with respect to its position on abortion.

The Early Stages

For the first half of the nineteenth century, pregnancy was regarded as a private matter, and first and second trimester abortions faced very little legal regulation.\(^{23}\) In fact, it wasn’t until the second half of the nineteenth century that abortion began to emerge as a social problem. Newspapers began to run accounts of women who had died from “criminal abortions,” and physicians began arguing that abortion was both morally wrong and medically dangerous.\(^{24}\) During the twentieth century, attitudes toward abortion continued to change as the practice of medicine became professionalized and regulations, including those on abortion, were legally mandated.\(^{25}\) Author Kristin Luker explains that at first, the medical profession’s control of abortion gave rise to a wide variety of abortion practices, “permitting a considerable degree of arbitrariness in the decision.”\(^{26}\) For the first half of the twentieth century, there was little formal regulation of abortion procedures. Since the safety of the procedure varied wildly and lacked a strict, institutionally based medical assessment, doctors and state medical boards sought to


\(^{24}\) Ibid., 20.

\(^{25}\) Ibid., 44.

\(^{26}\) Ibid., 45.
impose new regulations on doctors and hospitals. By the time that the Supreme Court decided
*Roe v. Wade* in 1973, abortion was “no longer a technical, medical matter controlled by
professionals, [but] emphatically a public and *moral* issue of nationwide concern.”27 The
heightened public awareness of abortion and contraceptives presented a complicated political
and religious dynamic in the years that followed.

**Conservative Religious Influence**

What is important to understand, however, is that abortion was not originally the highly
politicized issue that it is known to be today. In fact, originally Republicans supported a pro-
choice platform, and the GOP was the first major party to endorse the Equal Rights
Amendment.28 In the 1940 Republican platform, the party wrote, “We favor submission by
Congress to the States of an amendment to the Constitution providing for equal rights for men
and women.”29 For the 1940s and 1950s, the Republican Party maintained a relatively liberal
ideology with respect to women’s equal rights. As time progressed and women became more
vocal in their support for equal rights, the conversation began to include issues concerning
contraceptives and abortion. As a result, Republican support for women’s equal rights came to
include support for reproductive rights. Since contraceptives and abortion were highly
contentious issues at the time, support for either reflected a complicated choice for the
Republican Party in its efforts to keep its voting constituency.

In fact, the grassroots and feminist movements of the 1960s gave rise to the formation of
a new Republican electoral strategy. As mentioned previously, many feminists began to view

27 Luker, 127.
28 Daniel K. Williams, “The GOP’s Abortion Strategy: Why Pro-Choice Republicans Became Pro-Life in the
29 “Republican Party Platform of 1940,” June 24, 1940,” *The American Presidency Project*,
http://www.presidency.ucsb.edu/ws/?pid=29640.
challenging policies concerning childbearing as essential to women’s equality and advocated for the right to a legal abortion.\textsuperscript{30} The abortion issue became part of a much larger debate regarding women’s rights in general. As GOP researcher and journalist Robert N. Karrer explains, “the growth of the feminist movement and women’s rights contributed to the growing chasm that existed between traditional, family-oriented women and career-minded, liberal women.”\textsuperscript{31} Issues concerning family planning, contraceptives and abortion became central to the feminist movement’s rhetoric, and a large part of the policy debate involved religious objections to birth control and abortion.

In 1961, the National Council of Churches of Christ approved the use of birth control devices,\textsuperscript{32} which was received very well by most Christian religious groups. For example, Reverend James Pike, an Episcopal bishop, called family planning a “positive duty” for married couples that could not support a child.\textsuperscript{33} The Catholic Church, however, disagreed with the other denominations and expressed itself in several different ways, including letters to lay officials and members of the legislature, testimony before legislative committees, and speeches at events involving the city bishops.\textsuperscript{34} For example, in Connecticut where Planned Parenthood challenged a state law banning contraceptive use, Catholic legislators equated the use of birth control to abortion. They argued that the law could be a step towards legalizing abortion and explained, “we are not trying to impose our religious views on others, but we feel the use of the sex function solely for pleasure [and not for procreation]… is an unnatural practice.”\textsuperscript{35} While the Catholic

\footnotesize
\begin{itemize}
  \item[33] Ibid.
  \item[34] Ibid.
  \item[35] Ibid., 77.
\end{itemize}
opposition to birth control succeeded in making the discussion of abortion more public, it did not fundamentally change the platform of the Republican party, or other denominations’ positions on birth control and abortion.

In fact, many Republicans supported the liberalization of state abortion laws. Another scholar of the Republican voting strategy, Daniel K. Williams, explains that Republicans believed that abortion law reform fit well with the party’s traditional support for birth control, middle-class morality, and Protestant values. At this time in the 1960s, Protestant churches were also in favor of the liberalization of state abortion laws, and accepted birth control and the idea of a “planned” family. In 1967, the Episcopal General Convention declared support for,

The "termination of pregnancy" particularly in those cases where "the physical or mental health of the mother is threatened seriously, or where there is substantial reason to believe that the child would be born badly deformed in mind or body, or where the pregnancy has resulted from rape or incest”...Termination of pregnancy for these reasons is permissible.

This religious support continued into the next decade, as the Episcopal Church went on to acknowledge state laws related to abortion: “the Episcopal Church express[es] its unequivocal opposition to any legislation on the part of the national or state governments which would abridge or deny the right of individuals to reach informed decisions in this matter and to act upon them.” Additionally, the Presbyterian Church noted in its 1970 General Assembly, “when for misinformation, miscalculation, technical failure, or other reasons, contraception fails and an unwanted pregnancy is established, we do not think it either compassionate or just to insist that

37 Ibid.
38 General Convention, Journal of the General Convention of...The Episcopal Church, Minneapolis, 1976 (New York: General Convention, 1977), C-3.
39 Ibid, C-3.
available help be withheld.” The Southern Baptist Church also recognized abortion legislation at the start of the 1970s,

This Convention expresses the belief that society has a responsibility to affirm through the laws of the state a high view of the sanctity of human life, including fetal life, in order to protect those who cannot protect themselves… we call upon Southern Baptists to work for legislation that will allow the possibility of abortion under such conditions as rape, incest, clear evidence of severe fetal deformity, and carefully ascertained evidence of the likelihood of damage to the emotional, mental, and physical health of the mother.41

That being said, Protestants were not the leaders of the pro-life debate in its early political stages. Since opposition to contraceptives and abortion was primarily a Catholic concern, and two-thirds of Catholics at the time were Democrats, opposition to women’s reproductive rights was not a main concern for the predominantly Protestant Republicans.42

It was not until the Catholic Church increased its vocal opposition to abortion that the Republican Party changed its position. One of the main religious groups opposed to abortion was the National Conference of Catholic Bishops (NCCB), which in 1970 released its Declaration on Abortion. The NCCB said:

We remind Catholic physicians and nurses that regardless of changing laws, direct abortion is always morally wrong… Society should do all that is possible to provide necessary medical and other assistance. We urge government and all voluntary agencies…to intensify and broaden counseling and care for expectant mothers who otherwise may be tempted to resort to solutions contrary to God’s law.43


At this point, the Catholic Church was successfully bringing the discussion of birth control, abortion and women’s rights to the forefront of political debate. In doing so, they succeeded in denouncing the liberal platform of the Republican Party, especially surrounding the Equal Rights Amendment.

The Catholic Church reiterated socially conservative, family oriented values as a way to clarify its opposition to abortion and unhampered sexual liberty. As a result, the Republican Party began to respond to the Catholics’ remarks. As Williams points out,

> Even if the White House viewed abortion primarily as a “Catholic issue,” there were also signs that it had broader appeal among a larger contingent of social conservatives who perhaps had been amenable to abortion law liberalization at one time, but who were turning against the idea because of their opposition to feminism and the sexual revolution.\(^\text{44}\)

Public awareness of abortion, feminism and the sexual revolution in the 1970s spurred a broader anti-abortion movement. The early stages of the anti-abortion movement were comprised predominantly of women homemakers.\(^\text{45}\) These were socially conservative women who had no previous experience in political activities, but who saw the possibility of legalized abortion as threatening. They were women who had experienced pregnancy first hand, and their personal values were centered on these experiences.\(^\text{46}\) Many were “far right Republicans and Protestant fundamentalists…For [these] women, the rallying cause was defeating the Equal Rights Amendment. They viewed the ERA as undermining women's God-given traditional role and, with it, an idealized nuclear family.”\(^\text{47}\) They believed that the ERA and the easy access to birth control and abortion would be detrimental to families. One of the group’s main leaders, Phyllis

\(^{45}\) Luker, 145.
\(^{46}\) Ibid., 145.
Schlafly, explained in a 1979 speech that to function effectively in the family, a woman must believe her role as wife and mother is “worthy, honorable, useful and fulfilling.” Women like Phyllis Schlafly reframed the issue of birth control and abortion from a more socially conservative perspective. This, coupled with the continued opposition on behalf of the NCCB to women’s sexual freedom and reproductive rights, led to a prevalent shift in the Republican Party’s religious constituency.

Protestants who had previously supported the liberalization of abortion began to view the issue with apprehension. To use William’s words, “they were convinced that the nation was on a path to secularism.” They began to align themselves more closely with the views of the Catholic Church. For example, the Episcopal Church, which had previously submitted statements in support of abortion in the 1960s, passed a resolution in 1988 stating: "All human life is sacred.... We regard all abortion as having a tragic dimension, calling for the concern and compassion of all the Christian community…We emphatically oppose abortion as a means of birth control, family planning, sex selection, or any reason of mere convenience." This reflected a swift change in the Protestant stance on abortion and reproductive rights. For the Republican Party, which had relied upon the Protestant vote in presidential elections, the loss of Protestant support was significant. In 1972, the year before Roe v. Wade legalized abortion, the Republican party received 68.8% of the Protestant vote for president. As Catholics and Protestants began to put aside their previous differences in order to unite in political coalitions

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50 General Convention, Journal of the General Convention of...The Episcopal Church, Detroit, 1988 (New York: General Convention, 1989), 683.
against aspects of the sexual revolution, it became more apparent to Republicans that abortion could function as an electoral tool to capture new Christian votes. Conscious of the large Catholic and Protestant voting blocs that stood to be won over, Republican politicians adopted a conservative, pro-family oriented ideology that would bring abortion to the political stage and transform the Republican electoral strategy.

The Nixon Campaign

Emphasizing socially conservative values in order to win the Catholic voting bloc first took hold as a strategy in the Republican Party with Richard Nixon in 1969. By the late 1960s, Southern Democrats and Catholics, given their strong opposition to abortion and contraceptives, had been identified as target groups whom Republicans might persuade to shift party affiliation.52 The Nixon campaign relied heavily on a book written by Kevin Phillips, The Emerging Republican Majority, which argued that social issues were producing a political realignment that would benefit Republicans. The Emerging Republican Majority does not directly identify the abortion issue as a means of attracting the Catholic vote, but as women’s rights researchers Linda Greenhouse and Reva Siegel point out, Phillips famously advised the Republican Party to recruit blocs of voters traditionally affiliated with the Democratic Party, including Southerners “who were estranged from the party’s civil rights agenda.”53 Soon after the book was published, Republican campaign strategists began to experiment with its advice. For example, Harry Dent, the man in charge of Nixon’s campaign operations in the south, told the President that “Midwestern Catholics would be just as vital as southerners in the President’s reelection calculations,”54 and urged Nixon to “find a way to bring conservative Catholics into

52 Greenhouse and Siegel, 215.
the Republican camp by adopting a moderately conservative policy.” Nixon had only won 33 percent of the Catholic vote in the presidential election of 1968, so he resolved to try Dent’s recommendations and appeal to Catholics through a socially conservative agenda during his presidency. In an odd juxtaposition, Nixon began his presidency with an expansion of the federal government’s family-planning initiatives, only to later abandon the premise of the initiatives in favor of a belief in the “sanctity of life.” It is clear that Nixon’s shift in ideology during the reelection campaign was not because of a change in his fundamental values or religious beliefs, but rather was a result of the advice of the President’s conservative election strategists, which he accepted. As the reelection campaign approached, strategists understood Nixon’s need to win the conservative Catholic vote and pushed for a socially conservative, anti-abortion campaign message.

In April of 1971, for example, Nixon emphasized conservative morals in his statement on a new policy that required military hospitals to conform to state laws; “From personal and religious beliefs I consider abortion an unacceptable form of population control. Further, unrestricted abortion policies, or abortion on demand, I cannot square with my personal belief in the sanctity of human life—including the life of the yet unborn.” He was advised to emphasize his religious beliefs by campaign operative Charles Colson, who on the issue of military abortions, told a fellow operative, “I hope to hell that any of our spokesmen who are out talking about this make it very clear the President is against abortion.” The strategy was successful, and well received by Catholics. For example, James T. McHugh of the Family Life Division of

55 Ibid.
56 Ibid.
57 Ibid., 518.
the U.S. Catholic Conference issued an official commendation of the presidents directive:

“President Nixon has been forthright and courageous in stating his opposition to abortion on demand.”60 The support of the Catholic Church gave the “Christian Strategy” that campaign operatives were pressing on Nixon a new sense of legitimacy. He even agreed to sign a letter drafted by his speech writer, Pat Buchanan, that was sent to New York’s Terence Cardinal Cooke, in which he applauded Catholics’ “noble endeavor” to “act as defenders of the right to life of the unborn.”61 This is important, because he decided to inform influential members of the Catholic Church of his abortion position. As the election campaign continued, he managed to successfully establish himself as the more conservative candidate and was able to defeat George McGovern in the reelection campaign with 60.5% of the Catholic vote, becoming the first Republican presidential candidate to win the Catholic majority.62

It is important to understand that the fundamental change to the Republican platform on abortion was a result of the work of religiously committed activists. It is worth noting that when Roe v. Wade was decided in 1973, the decision did not command significant attention from politicians, but rather from pro-life religious grassroots organizations. Alliances between varying religious institutions became a key component of the pro-life movement’s success. Therefore, it is not surprising that the pro-life movement was originally a creation of the Family Life division of the National Conference of Catholic Bishops (NCCB). The NCCB collaborated with pro-life organizations, most predominantly the National Right to Life Commission (NRLC) to launch a legal and educationally based opposition campaign.63 For example, in 1975, the NCCB presented a detailed strategy for the church’s antiabortion crusade, called the “Pastoral Plan for Pro-Life

60 Ibid., 519.
61 Ibid.
63 Luker, 186.
The strategy called for a network of “prolife committees” based in the parishes that would do the following: effect the passage of a “prolife amendment,” elect pro-life sympathizers to local party organizations, monitor officials on their abortion stands, and work for qualified candidates who would vote for a constitutional amendment and other prolife issues. From the outset, as abortion scholar Rosalind Petchesky explains, “the [pro-life] movement was set up to be a political action machine to influence national and local elections.” The strength found in the collaboration between prolife organizations and religious institutions would play a crucial role in the upcoming 1976 election.

**The Reagan Era**

As mentioned earlier, the unified stance of Catholics and Evangelicals had built a strong pro-life framework. For Republicans, it was becoming increasingly clear that in order to win the large block of Christian voters, candidates would have to articulate a conservative, pro-life position. In other words, the Republican platform did not shift towards a conservative, anti-abortion framework merely because of a shift in ideology within the party, but more so because of the need to gain votes. In the elections of 1976 and 1980, the Republican Party saw most clearly and profoundly the consequences of failing to adopt a pro-life stance. Southern Baptist Jimmy Carter, for example, was chosen by pro-life activists as the candidate likely to favor their cause. During his 1976 presidential campaign, Carter promised social conservatives that, if elected, he would convene a conference to examine how the federal government could support American families. In the words of religion scholar Seth Dowland, “That promise, coupled with

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66 Ibid.
his description of being a “born again,” devout Christian thrilled American evangelicals, providing him a crucial bloc of support in the election”.67

Once elected, Carter stuck to his promise and convened a Conference that would examine the “traditional” American family. Announcing his Conference in January of 1978, he declared, “the main purpose of this White House Conference will be to examine the strengths of American families, the difficulties they face, and the ways in which family life is affected by public policies.”68 Although Carter did not directly address the issue of abortion in the Conference, he emphasized traditional family values as a means to gaining Catholic and Evangelical support. The problem, however, was that the members involved with the Conference insisted on examining the pressures facing homosexual and single-parent families, refusing to define a family as a heterosexual, two-parent household.69 This was troublesome, since Catholics and Evangelicals now were committed to the defense of the “traditional family” and were opposed to abortion, feminism and gay rights.70 For Christian activists, their faith based belief in the “traditional family” shaped their political strategy for opposing abortion, and the goals of President’s Conference were contrary to that. What President Carter had hoped to be a successful reevaluation of the definition of “family” resulted in immense conservative and religious backlash. With the failed reputation of the Conference, Carter lost the electoral support of conservative Catholic and Evangelicals. This alienated a large bloc of pro-life Christian voters, leaving them to be swept up by the next presidential candidate willing to support their cause.

70 Ibid.
Ronald Reagan capitalized on the opportunity to gain Catholic and Evangelical votes by meeting with pro-life activists before the 1980 New Hampshire presidential primary, advocating a Constitutional amendment that would ban all abortions except those necessary to save the life of the mother. His support for the amendment reflected the pro-life ideology of the Catholic Church, but puzzled many observers; “After all, could a non-churchgoing, divorced former Hollywood actor who had signed an abortion liberalization bill in California and had refused to back an anti-gay- rights referendum in his state really have been sincere in his endorsement of the Christian Right?” Regardless of his shaky reputation as a Catholic and Evangelical supporter, Reagan’s belief in a religiously based moral order resonated with the views of the Christian Right, especially Evangelicals and Catholics. For example, in the 1980 presidential debate in Baltimore against John Anderson, Reagan said,

I think all of us should have a respect for innocent life. With regard to the freedom of the individual for choice, with regard to abortion, there's one individual who's not being considered at all. That's the one who is being aborted. And I've noticed that everybody that is for abortion has already been born.

Establishing his clear opposition to abortion, Regan included a pro-life narrative in his speeches during the campaign in an attempt to appeal to conservative Christian voters. As part of the National Affairs Briefing in Dallas, Reagan spoke before 15,000 conservative Christians. With all of the statements on abortion and contraceptives that have been publicized since the years of Nixon and Carter, his words reflected most clearly the Republican strategy to win over the Catholic and Evangelical vote,

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Religious America is awakening, perhaps just in time for our country's sake. If we believe God has blessed America with liberty, then we have not just a right to vote but a duty to vote... If you do not speak your mind and cast your ballot, then who will speak and work for the ideals we cherish? Who will vote to protect the American family and respect its interests in the formulation of public policy? I know you can't endorse me because this is a nonpartisan crowd, but I ... want you to know that I endorse you and what you are doing.  

By reaffirming his commitment to the conservative values, Reagan solidified a relationship between the Republican Party, Catholics, and Evangelicals.

Following the National Affairs Briefing, the Southern Baptist Convention released a statement in the Baptist Press that summarized his speech and noted his promise to appoint Christians to the Administration if elected. Although the Southern Baptist Convention did not formally endorse Reagan, it was clear that his promise to appoint Christians to the Administration played a significant role in winning the Evangelical vote. Southern Baptist Ed McAteer, a participant in the roundtable discussions during the National Affairs briefing, said, “My feeling is that [Reagan] is in sympathy with what we are in sympathy with.” Increased public discussion of and press attention to Reagan’s conservative ideology reflected a growing support for the presidential candidate among conservative Christians. Delighted by the fact that Reagan supported their positions on contraceptives and abortion and was willing to incorporate those opinions into the Republican Platform, conservative Evangelical activists quickly focused their efforts on supporting the Reagan campaign. In the election, he won 53.7% of the

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76 Ibid.
Protestant vote, as well as 54.5% of the Catholic vote. Reagan’s decision to commit to the faith-based ideology of conservative Christians with respect to reproductive rights reshaped the Republican Party’s ideology in the American political debate.

A New Conservative Platform

By the end of the 1980s, Conservative Catholics and Evangelicals had gained control of the GOP, making it virtually impossible for a Republican to win the presidential nomination without supporting the pro-life movement. The conservative pro-life organizations, under the influence of religious groups like the NCCB, “bolstered the party’s pro-life stance, ensuring that the issue would remain a central consideration in Supreme Court nominations and national elections.” The fusing of religious institutions and pro-life activist groups transformed the Republican Party ideology. The 1980 Republican platform officially signified a position that aligned with the conservative Christian doctrine. Under a separate, specific plank labeled “Abortion”, it read,

We reaffirm our belief in the traditional roles and values of the family in our society. The damage being done today to the family takes its greatest toll on the woman…the importance of support for the mother and homemaker in maintaining the values of this country cannot be over-emphasized.

Since the national Republican Party had realigned itself with a stringent conservative position on reproductive rights, an entirely new set of obstacles in approaching the abortion issue were created. The newly adopted platform for the Republican Party was in large part developed

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because of religious influence. Moreover, the Party’s official position against abortion had become the symbol for a culturally conservative movement that was more powerful than Republican Party leaders themselves, “even the ones who had created the party platform statement were unable to reverse it.”81 Today, as a result of these changes in the Republican Party orientation, a majority of Catholics who attend church weekly vote Republican in presidential elections, as well as more than 70 percent of white evangelicals.82 By 2009, only 26 percent of Republicans were pro-choice.83

Predictably, the decline in the number of pro-choice Republicans corresponds to an increase in pro-life legislation. The nationwide influx of new legislation in the past 30 years reflects a new strategy aimed at restricting women’s access to abortion and contraceptives. Most recently, especially since 2005, Republicans have supported new laws that focus on access to abortion rather than the actual “right to choose.” Moreover, they reflect a shift away from the original concerns that Republicans expressed regarding abortion as “anti-family” and “non-traditional.” Instead, the new laws target the abortion provider and the facility in which the procedure is performed. These are known as TRAP laws, or the Targeted Regulation of Abortion Providers. These laws are controversial because they focus on whether or not the facility or physician providing the abortion is safe, rather than the conditions under which a woman may choose to terminate a pregnancy. The abortion debate has been reshaped to focus instead on safety and public health concerns, but it is problematic because of the people who are making the health claims, namely conservative, pro-life Republicans.

Given the fact that the main proponents of these laws are in fact the socially conservative, pro-life Republican legislators, the Christian Right has helped shape the new laws to achieve its

82 Ibid., 534.
83 Ibid., 513.
objectives. As the next chapters will show, the enactment of TRAP laws is in large part due to the advocacy of conservative pro-life organizations that have designed model legislation for restricting abortion. By targeting pro-life legislators, the conservative organizations have successfully circulated the model laws into the state legislative sessions. Due to the fundamental realignment of the Republican Party in the 1980s, organizations are able to appeal to the party platform and pass laws that, once enacted, will reflect the party’s principal goal: to limit access to abortion, and, ultimately, overturn Roe. The implications of these laws make it necessary to examine the TRAP movement more closely.
Chapter 2: What is a TRAP law?

“One of the most exciting things is looking back at where we were in 2008, when there was such desperation in the pro-life movement, and comparing it to now, when we are seeing a tidal wave of pro-life victories” – Charmaine Yoest, President and CEO of Americans United for Life.  

In political debate since 2000, Christian Right efforts have been characterized by its opponents as constituting a “war on women.” Democratic politicians have utilized the expression to describe certain Republican Party policies as a wide-scale effort to restrict women’s rights, especially those related to reproduction. In a recent article published by RH Reality Check, journalist Zerlina Maxwell uses the words of Rand Paul to characterize Republican sentiment regarding abortion and reproductive rights. She writes that when asked about the “war on women,” Rand Paul said,

Well, you know, I think we have a lot of debates in Washington that get dumbed down and are used for political purposes. This whole sort of ‘war on women’ thing, I’m scratching my head because if there was a ‘war on women,’ I think they won. You know, the women in my family are incredibly successful.

Although Rand Paul’s logic seems to make sense, since women have continued to gain equivalent success in the workforce in the past 30 years, the same success does not hold true for reproductive rights. As Maxwell explains, “there may not be a “war on women” in the traditional sense, but there is, however, an all-out and persistent assault on women’s bodies, choices, equality, freedom, and rights.”

87 Ibid.
Much of this is attributable to the state level restrictive legislation aimed at abortion since 2005. The new legislation that has been pushed forward has “stripped away much of the feminist progress of the past generation.”88 This legislative aim is most notable with TRAP laws, which target abortion providers with burdensome, unnecessary laws. There are three main categories of TRAP laws. The first requires abortions facilities to meet special licensing requirements and subjects clinics to “surprise” inspections. The second kind requires all abortion clinics to meet the same structural and regulatory standards as ambulatory surgical centers, regardless of the types of abortions performed at the facility. And the third type requires doctors who perform abortions in the state to enter into special agreements with local hospitals, in the form of transfer arrangements or admitting privileges.89 TRAP laws have been advanced in state legislatures by conservative, pro-life members in states with conservative, pro-life governments. The requirements aimed at the provider are problematic because even though they do not directly impact the women’s right to choose, they nevertheless limit access to abortion. This is a coordinated effort, and although it may not be an all out war against women, it interferes with the freedom of the woman to make her own choices, as Roe guarantees. It is for this reason that pro-choice advocates contend that these policies constitute a war against reproductive rights.

This chapter will trace the emergence of TRAP laws since the end of the 1990s, and the effect that the laws have had on restricting abortion. It will examine the new incremental legislative approach that conservative policymakers have adopted, as well as the influence of conservative pro-life organizations in promoting the laws. A close assessment of the TRAP law

88 Ibid.
strategy will help to reveal how this type of restrictive legislation differs from previous approaches to limiting access to abortion.

A New Approach

In 1992, the Supreme Court decided Planned Parenthood v. Casey,\textsuperscript{90} upholding several different provisions that restricted access to abortion, including parental consent, a 24 hour waiting period, and informed consent. The Court reaffirmed the right to abortion, but created a new “undue burden” standard to determine whether a law was constitutional. An undue burden exists if the purpose or effect of a provision places substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability. This meant that states could require provisions restricting access to abortion, so long as the regulations did not place an “undue burden” on a woman’s ability to obtain the procedure. Pro-life advocates began to revise their strategy. Instead of focusing on provisions that curtailed or constrained an individual pregnant woman’s decision, like waiting periods and parental consent, they would focus on laws that regulated the abortion procedure and could be justified as health regulations.\textsuperscript{91} As Dorinda Bordlee, staff counsel for the conservative Americans United for Life organization, explained:

The Casey decision started abortion opponents rethinking their tactics. Since direct assaults on Roe wouldn't fly, there had to be a shift in strategy by regulation on the outskirts of abortion... By claiming that abortions take place in dirty facilities and cause such illnesses as depression and breast cancer, right-to-lifers realized they could subtly move the focus of the debate.\textsuperscript{92}

With legal approaches aimed at overturning *Roe* in the courts seemingly at a standstill, pro-life strategists undertook an incremental approach that chips away at abortion indirectly. In the United States Congress, the move to apply incremental legislative efforts in the past 20 years has been quite clear. This is in large part because of the fact that the legislation proposes less of a sweeping change, and is easier to pass: “Incremental legislation has the advantage of being minor. Small or minor moves may not seem like an advantage, but small policy moves are less prone to counteractive lobbying by opposition advocates.”

As seen in the table below, Congress has increasingly proposed legislation that utilizes the incremental strategy; 31% of incremental proposals were made in the 1970s and 1980s, as compared to 87% in the mid 1990s and early 2000s.

<table>
<thead>
<tr>
<th>Congress/Year</th>
<th>Incremental</th>
<th>Nonincremental</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>93-98 (1973-1984)</td>
<td>137 (31%)</td>
<td>308 (70%)</td>
<td>445</td>
</tr>
<tr>
<td>99-102 (1985-1992)</td>
<td>163 (77%)</td>
<td>50 (24%)</td>
<td>213</td>
</tr>
<tr>
<td>103-108 (1993-2004)</td>
<td>303 (87%)</td>
<td>45 (13%)</td>
<td>348</td>
</tr>
</tbody>
</table>

The incremental proposals have had dangerous implications; in the 95th Congress for example, House Joint Resolution 5 would have extended due process and equal protection to the individual from the moment of conception, and House Joint Resolution 133 would have prohibited abortions after the fetus’ heart began to beat. Looking at the progression of incremental proposals in the U.S. Congress, it is not surprising that the same trend has emerged in state legislatures. With a gridlock on abortion policy in Congress, it is more difficult to enact legislation at the federal level. Therefore, pro-life state legislators who favor restrictive abortion

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94 Ibid., 117.
95 Ainsworth and Hall, 110.
legislation have the best opportunity to enact new laws. As legislative correspondent Abby Scher explains, “With the Beltway divided between the anti-choice house and the pro-choice Senate, and the U.S. Supreme Court still pro-choice, the states are where most of the action is right now for anti-abortion groups.” The move to enact restrictive provisions at the state level has been gaining traction since the 1990s, and opponents recently have stepped up their efforts to block clinics from providing abortions. The growing effectiveness of applying restrictions to abortion clinics and physicians’ offices has led to an influx in the past decade of laws that apply states’ standards for ambulatory surgical centers to abortion clinics, include requirements for the physical plant, such as room size and corridor width, and require that facilities maintain relationships with hospitals.” As a result, TRAP requirements are now in place in 27 states, where 60% of women of reproductive age live. In the graphics below, it is clear that a pattern seems to exist between anti-choice state governments and restrictive laws aimed at requiring ambulatory surgical centers or hospital admitting privileges.

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97 Gold and Nash, “TRAP Laws Gain Political Traction While Abortion Clinics-And the Women They Serve-Pay the Price,” 7.
98 “State Policies in Brief: Targeted Regulation of Abortion.”
99 Gold and Nash, “TRAP Laws Gain Political Traction While Abortion Clinics-And the Women They Serve-Pay the Price,” 8.
States with Anti-Choice Governments (represented in red)\textsuperscript{100}

States with Structural Standards Equivalent to those for Surgical Centers (represented in red)\textsuperscript{101}

States that Require the Clinic to have Hospital Privileges or an Alternative Agreement (represented in red)\textsuperscript{102}


“State Policies in Brief: Targeted Regulation of Abortion.”

\textsuperscript{101} Ibid.

\textsuperscript{102} Ibid.
Model Legislation

The pro-life leadership recognized that the piecemeal, incremental approach to permanently overturning Roe was becoming widely accepted as a more effective means to restricting abortion. For American’s United for Life (AUL), an active pro-life organization since 1971, the overarching maxim was that, “when a complete and immediate prohibition is not possible, enact prudential limits to contain the social evil as a means to ultimately eliminating it.”

Adopting a policy of incrementalism, the pro-life activists found a strategy that effectively sidestepped the roadblocks faced with the previous, more direct approach. It was a successful strategy because it did not focus directly on a woman’s right to choose to terminate a pregnancy, and therefore avoided the rights claims imposed in the federal courts. Essentially, AUL reframed the abortion debate in terms of the health threats that the procedure posed for women. AUL President Charmaine Yoest confirmed this:

Repeatedly, the Supreme Court has turned away from the threat that abortion poses for the baby, because the Supreme Court has said repeatedly they’re concerned about the woman. So we basically want to say to the court, “we share your concern for women. You need to look at the fact that abortion itself harms women.”

Her words verify the main goal of pro-life activists, namely to overturn Roe. Moreover, by focusing on rhetoric that abortion itself harms women and by reframing the abortion issue as a public health and safety matter, AUL has helped legislatures write laws that have forced several abortion providers to shut down, as will be discussed in subsequent chapters.

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102 Ibid.
The pro-life activists are clear about their embrace of this indirect, incremental strategy. In its booklet of model restrictive abortion legislation, *Defending Life*, AUL includes the words of 19th century philosopher Kierkegaard to support its legislative strategy,

> An illusion can never be destroyed directly, and only by indirect means can it be radically removed...That is, one must approach from behind the person who is under an illusion...A direct attack only strengthens a person in his illusion, and, at the same time, embitters him...the indirect method, which, loving and serving the truth, arranges everything dialectically for the prospective captive.  

This speaks directly to the fact that AUL has deliberately sought to enact manipulative, misleading legislation. This is especially significant for understanding why a flood of TRAP laws has recently been enacted. The restrictions aimed at abortion providers and abortion clinics can successfully bypass the legal limitations in the federal courts, allowing for a nearly seamless incremental approach to their enactment. On March of 2014, the Fifth Circuit Court of Appeals ruled on a Texas law that required abortion providers to obtain hospital-admitting privileges, holding it to be constitutional. In April of 2014, the Fifth Circuit Court of Appeals will also hear oral arguments for an admitting privileges requirement in Mississippi, likely to result in a similar ruling. In several cases, the restrictive laws have not even faced legal challenges. In March of 2014, for example, a settlement was reached for a lawsuit that challenged a North Dakota admitting privileges requirement, keeping the requirement in place. As laws continue to be enacted nationwide, it will be crucial to track the ways in which the legislation is being challenged in the courts.

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105 Burke, ed. *Defending Life 2013*, 42.
Leading the incremental strategy is AUL, which, in an effort to eliminate abortion through the regulation of abortion clinics, has designed model legislation for Republican legislatures to adopt. AUL developed both the “Abortion Patients’ Enhanced Safety Act,” which imposes ambulatory surgical standards on abortion clinics, and the “Women’s Health Protection Act,” which mandates that abortion clinics meet national abortion care standards. The development of such model legislation is explained as a necessary component to assist the states in combating “back alley abortions” where abortion procedures are performed in unsanitary clinics under the slipshod direction of the physicians. AUL also recommends to states the AUL model clinic regulations and “Abortion Providers’ Privileging Act,” that would limit the performance of abortions to properly licensed physicians and mandate that abortion providers have hospital admitting privileges that are “critical to ensuring that women receive proper and competent abortion care.” Examples of the AUL model legislation can be seen in the appendix section of this thesis.

Within the model legislation, AUL meticulously outlines and emphasizes the health risks that women face because of the lack of clinic and provider restrictions. The “Abortion Providers’ Privileging Act,” for example, relies upon previous court doctrine to push forward its conservative agenda. The drafted legislation describes the state as having “legitimate interests from the outset of pregnancy in protecting the health of women,” (Planned Parenthood v. Casey), “legitimate concern with the health of women who undergo abortions” (Akron v. Akron Ctr.), “legitimate concern for the publics health and safety” (Williamson v. Lee Optical), and “legitimate interest in seeing to it that abortion, like any other medical procedure, is performed

109 Burke, ed. Defending Life 2013, 104. 
110 Ibid.
under circumstances that ensure maximum safety for the patient” (*Roe v. Wade*). With a disguised concern for women’s health, AUL pushes the model legislation as a means to effectively curb “unsafe abortions.” What cannot be forgotten, however, is the underlying effort of the pro-life movement to create an illusion.

The model legislation neglects to mention the fact that abortion procedures are already regulated, and that all health care facilities, including abortion providers, are required to comply with federal and state regulations, including the Clinical Laboratory Improvement Amendments (CLIA) and the Occupational Safety and Health Administration requirements (OSHA). In fact, abortion is one of the safest and most commonly provided procedures in the United States, and less than 0.3% of abortion patients experience a complication requiring hospitalization. Given that 90% of all abortions take place in outpatient facilities such as doctors’ offices and clinics, the reality of such model legislation is not actually a safer environment for women. The true goal is the elimination of abortion clinics and as a result, the reduction in access to abortion and other reproductive health services. Several pro-life advocates have candidly admitted this. For example, Mississippi Governor Phil Bryant, said of the state’s only abortion clinic being subject to closure because of strict admitting privileges requirements, “my goal of course is to shut it down.”

Yet, despite such blatant disregard for women’s health and safety, the restrictive laws continue to be enacted.

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111 Ibid., 238.
112 Brown, “The TRAP: Targeted Regulation of Abortion Providers.”
113 Ibid.
Emerging Restrictive Laws

In the past decade, from 2000-2011, the United States experienced a dramatic increase in the number of states with restrictive abortion laws. A 2012 Guttmacher Institute report revealed that the number of anti-choice provisions that have been enacted has increased significantly since 1985. This information is represented by the graphic below. The Guttmacher report found that a number of states shifted from having only a moderate number of abortion restrictions to several substantial ones.115 This evidence demonstrates the success of the new conservative strategy aimed at restricting access to abortion nationwide.

Number of Abortion Restrictions Enacted, 1985-2011116

Although the data represented includes all types of restrictive provisions; and not just TRAP laws, it is important to note the significance with which the incremental strategy has been successfully adopted. Especially considering that TRAP laws began to gain traction in 2000, it is

116 Ibid., 16.
likely that the laws aimed at abortion providers contributed to the increasing trend in anti-choice measures since then.

In 2005 alone, twenty-one state legislators considered TRAP bills. In the February 2014 policy briefing for TRAP laws, Guttmacher reported that 25 states require facilities where abortion services are provided to meet standards intended for ambulatory surgical centers, including provisions requiring specific sizes to procedure rooms, specific corridor widths, a set distance from a hospital, and a transfer agreement with a nearby hospital. Additionally, 13 states require abortion providers to have some affiliation with a local hospital, including admitting privileges or specific board certifications. To reiterate, these laws are burdensome and unnecessary, and place strict regulations on hospitals and providers of abortions that do not apply to other medical professionals.

In order to assess how the volume of abortion restrictions had changed since 2000, the Guttmacher report compared restrictions in 2000, 2005 and 2011. Labeling states as either “supportive,” “middle ground” or “hostile” to abortion, the report listed ten different categories for restrictive provisions. A state was considered supportive if it enacted a provision in no more than one of the categories; middle ground if it enacted two or three of the categories, and hostile if it enacted provisions in four or more of the categories. The increase in the number of provisions enacted since 2000 shows that anti-choice legislators utilized an increasing variety of provisions to restrict abortion access. The report found that in 2000, the U.S. was almost evenly

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117 Brown, “The TRAP: Targeted Regulation of Abortion Providers.”
118 “State Policies in Brief: Targeted Regulation of Abortion.”
119 The categories Guttmacher used were: mandated parental involvement prior to a minor’s abortion; required pre-abortion counseling that is medically inaccurate or misleading; extended waiting period paired with two in-person counseling sessions; mandated performance of a non medically indicated ultrasound prior to the abortion; prohibition of Medicaid except in cases of life endangerment, rape or incest; restriction of abortion coverage in private health insurance plans; medically inappropriate restrictions on the provision of medication abortion; onerous requirements on abortion facilities that are unrelated to patient safety; unconstitutional ban on abortions prior to fetal viability, and preemptive ban on abortion outright in the even Roe is overturned.
120 Gold and Nash, “Troubling Trend: More States Hostile to Abortion Rights as Middle Ground Shrinks,” 15.
divided, with nearly a third of American women of reproductive age living in states solidly hostile to abortion rights, slightly more than a third in states supportive of abortion rights, and close to a third in middle ground states; a stark difference from 2011, however, when more than half of the women of reproductive age were living in hostile states."\(^{121}\) Accompanying the increase in restrictive laws was the fact that abortion laws were increasingly targeted at providers, rather than at individual women seeking an abortion. Laws that included onerous requirements on abortion facilities, unrelated to patient safety, were some of the most prevalent in states that were considered to be “hostile.”

The report found that while the number of supportive states remained relatively consistent, the number of middle ground states decreased significantly, and the number of hostile states intensified. In 2000, 19 states were middle ground and only 13 were hostile. By 2011, 26 states were hostile to abortion rights, and the number of middle ground was nine.\(^{122}\)

### Summary of Guttmacher Institute Data Representing States as Supportive, Middle Ground or Hostile towards Abortion\(^{123}\)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive</td>
<td>19</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Middle Ground</td>
<td>18</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Hostile</td>
<td>13</td>
<td>19</td>
<td>26</td>
</tr>
</tbody>
</table>

In addition to the sharp change in numbers, it is noteworthy that the majority of the states that have shifted to a more hostile rating were those in the middle of country, including Idaho, Indiana, Kansas, Nebraska and South Dakota, all of which have anti-choice governors and state

\(^{121}\) Ibid.
\(^{122}\) Ibid., 17.
\(^{123}\) Ibid., 15.
legislatures. The fact that the dramatic shift in anti-abortion legislation in the past decade occurred predominantly in conservative, anti-choice run states, speaks to the significance of the emerging and successful conservative-led TRAP movement.

The breakdown of pro-life and pro-choice legislatures reveals an important connection between TRAP laws and conservative legislators. In state governments where the majority of the legislature and the governor share the same position on abortion, there are seven states with pro-choice governments, as compared to 21 states with anti-choice governments. Considering that TRAP laws have been enacted as part of a conservative led legislative movement, the prevalence of anti-choice state governments is concerning. For example, of the 25 states in which facilities are required to meet certain ambulatory surgical center standards, all but 5 have anti-choice governments. As for the requirement that providers obtain hospital admitting privileges, all but one of the eight states that have enacted this measure have an anti-choice government.

The impact of the TRAP laws that have been enacted is clear, since most of the laws have forced abortion providers to shut down. The number of U.S. abortion providers declined 4% between 2008 and 2011, while 12 clinics were forced to stop providing abortion services. In fact, 89% of all U.S. counties lacked an abortion clinic in 2011. An additional concern to the ongoing decline in both providers and clinics is the decline in states that are supportive of abortion rights, which has fallen from 17 to 13 since 2000. These data confirm the effectiveness of the TRAP law approach over the past decade in restricting access to abortion.

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126 Key Findings: Political Landscape, NARAL Pro-Choice America.
127 Ibid.
129 Ibid.
130 Ibid.
The reason that the approach has been so successful is because of the fact that organizations like AUL have spearheaded a legislative strategy through model legislation. According to the non profit news organization, Mother Jones, AUL can claim credit for 24 new restrictive laws that were passed in 2011.\textsuperscript{131} Americans United for Life and its legal team is the source of \textit{Defending Life}, often called “the playbook” of pro-life legislation, providing a template for legislators who want to work to protect women’s health and the lives of the unborn.\textsuperscript{132} In reference to the 2013 legislative session, AUL President, Youst, said, “Equipped with the best legal tools, state leaders are courageously putting the pro-life convictions of their constituents over the abortion lobby’s disingenuous and politically motivated pressure campaigns.”\textsuperscript{133} In fact, the 2013 AUL Legislative Session report provided several examples of cases in which states adopted the model legislation, labeling them as “AUL victories,”

Alabama enacted a provision, inspired by AUL model language, requiring that abortion clinics meet the same medically appropriate standards of patient care as ambulatory surgical centers; AUL and its allies helped Texas enact a measure requiring individual abortion providers to have hospital admitting privileges; AUL provided legal and policy resources to 39 states, while AUL Action, through our state representatives and other allies, worked in 31 states to promote life-affirming legislation and to defeat anti-life initiatives.\textsuperscript{134}

Although these are just a few examples of AUL’s specific involvement with restrictive abortion legislation, the trend is clear. In order to fully realize the impact of the litigation, and the profundity of the statistics that continue to emerge in its favor, the true intentions behind the TRAP law must be exposed.

\textsuperscript{131} Sheppard, “Wham, Bam, Sonogram! Meet the Ladies Setting the New Pro-Life Agenda.”
\textsuperscript{133} Ibid.
Chapter 3: Admitting Privileges in Texas

“To be clear, my goal, and the goal of many of those joining me here today, is to make abortion, at any stage, a thing of the past.” – Governor Rick Perry (TX)135

When the conservative pro-life organization, Americans United for Life (AUL) announced its 2014 rankings for the states that best protected women from what they called “abortion industry horrors,”136 Texas was named an All-Star. According to AUL president and CEO Charmaine Yoest, the All-Stars ranking is awarded to states based on the enactment of “protective, common-sense legislation” and “each of AUL’s 2014 All stars enacted life saving legislation to protect women from a dangerous procedure that is too often performed in substandard facilities.”137 The sweeping accusation aimed at the abortion industry was expected, coming from a longstanding conservative organization like AUL. The ranking however, although virtually meaningless outside of the sphere of pro-choice and pro-life activists, still suggests troubling implications. The All-Star ranking was released as a parallel component to AUL’s newest legislative push, the Women’s Protection Project. The project, launched in preparation for the 2014 legislative session, offered a set of model legislation that seeks to limit and overturn pro-choice legislation by highlighting abortion’s negative impact and the growing concern regarding health risks to women.138 Amplifying the pro-life message to a higher, more accusatory level, the project suggests a legitimate and serious concern for the health of women on behalf of social conservatives, putting pro-choice advocates on the defense while presenting the proposed model legislation as the only viable solution. AUL has succeeded in disseminating

137 Ibid.
this message in large part because of outreach to Republican legislators. For example, in an email to David Lifferth, a Republican in the Utah House of Representatives, Youst begins,

Dear David, As you begin work on the 2014 state legislative session, Americans United for Life has launched the Women’s Protection Project to highlight abortion’s negative impact on women and to recommend specific legislative solutions to the growing concerns regarding the health risks to women caused by abortion. We encourage you to review the Women’s Protection Project booklet, evaluate AUL’s assessment of your state’s current legislative status, and consider any bills in this package relevant to your state as you consider enacting pro-life legislation this year.\(^{139}\)

By providing key legislators in strong pro-life states with a booklet full of model legislation, AUL is able to spread the pro-life message and reframe the debate in terms of women’s health and safety.

So, what does the All-Star label \textit{really} mean? It is doubtful that the state legislators who are rewarded the arbitrary honor publically celebrate the achievement, or hang a plaque on their office wall to boast of the recognition. Yet despite such a trivial label, AUL has succeeded in generating state support and adoption of the model legislation. Texas Governor Rick Perry wrote, “AUL plays a key role in developing and promoting legislation in all 50 states, legislation crafted to minimize the damage done by the abortion industry and its proponents.”\(^{140}\) Given the government support, it is clear that AUL and Governor Perry share the same position on abortion, and it is for this reason that conservative, pro-life states have succeeded in enacting restrictive pro-life legislation. By looking at the 2013 Texas House Bill, House Bill 2, and its close ties to AUL, it becomes clear how the conservative pro-life strategy does not actually


\(^{140}\) AUL 2014 Life List.
further the goal of making women’s reproductive health services safer, despite claims to the contrary.

This chapter will address the recent decline in abortion providers in Texas. It will look closely at the legislative process for Texas House Bill 2, and determine how AUL model legislation played a role in the law’s enactment. Lastly, it will examine the legal arguments made in court when the law was challenged and determine whether the law has, as pro-life legislators claimed, improved Texas women’s reproductive health and safety.

**Abortion in Texas**

Finding new and more powerful ways to limit access to abortion, Texas has made women’s reproductive health services in the state less accessible by adopting legislation that requires abortion physicians to have hospital admitting privileges. This is a stringent requirement that led to the closing of nine clinics in the first six months since the law’s enactment.¹⁴¹

Since the years of *Roe*, the abortion issue in Texas remains a contentious and highly politicized topic. Currently, the state requires that a woman receive state directed counseling, parental consent if she is a minor, and a mandatory ultrasound in which the provider shows and describes the image to her before the procedure. She also is required to wait 24 hours before obtaining an abortion, and cannot obtain public funding unless the abortion is the cause of life endangerment, rape or incest.¹⁴² Most recently, however, Texas has enacted laws that are focused on requirements that a women must meet prior to the procedure, but that instead restrict the abortion provider. This recent shift towards targeting the provider is reflected in the stark decline

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in abortions over the past decade. In 2010, there were 5,689,320 women of reproductive age (aged 13-44) in Texas, among which 505,220 (aged 20-44) were below 100% of the federal poverty level.\textsuperscript{143} In 2000, there were 89,160 women who had obtained abortions in Texas, compared to 73,200 in 2011.\textsuperscript{144} Although the information is based on abortions for women who are both residents of Texas and those living out of state, it is clear that access to abortion in the state has become progressively more limited. Despite being the second most populous state, Texas only represents 6.9% of all abortions in the United States.\textsuperscript{145} The graph below shows the clear decline in abortion incidence since the 1980s, with an especially sharp decline since 2008.

\begin{center}
\textbf{Number of abortions, by state of occurrence}
\end{center}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{abortion_graph.png}
\caption{Graph showing the number of abortions by state of occurrence.}
\end{figure}

\textsuperscript{143} “State Reproductive Health Profile: Texas,” Guttmacher Institute, last modified April 1, 2014, \url{http://www.guttmacher.org/datacenter/profiles/TX.jsp}.
\textsuperscript{144} Guttmacher State Data Center: Trend Data, Guttmacher Institute, last modified April 1, 2014, \url{http://www.guttmacher.org/datacenter/trend.jsp#}.
\textsuperscript{145} Ibid.
\textsuperscript{146} Ibid.
The abortion rate has declined 17% since 2008, from 18.8 abortions per 1,000 women of reproductive age to 13.5. One possible explanation for such a strong decline is access in Texas to abortion providers. In 2011, there were 62 abortion providers in Texas, representing a 7% decrease since 2008, a stark change in the mere span of three years.\textsuperscript{147} This trend is represented in the graph below.

\textbf{Number of abortion providers}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{abortion_providers_graph.png}
\caption{Number of abortion providers in Texas from 2000 to 2014.}
\end{figure}

\begin{flushright}
\textit{Source: Guttmacher Institute}
\end{flushright}

In considering the decline in the number of abortion providers, it is also important to note the degree of accessibility that women have to providers in Texas. In 2011, 93% of Texas counties

\textsuperscript{147} Ibid.
\textsuperscript{148} Ibid.
had no abortion clinic, yet 35% of Texas women lived in those counties.\textsuperscript{149} As legislation in the pro-life Texas legislature concerning abortion providers continues to be pushed forward, as seen most recently with the enactment of House Bill 2, it is clear that the decline in abortion providers is in one way or another connected to the requirement that abortion clinicians obtain admitting privileges. Since House Bill 2 was voted upon in a second special legislative session, called by a Republican governor in a state with a majority pro-life legislature, it is also evident that that the decline in abortion providers is inherently connected to the action of conservative, pro-life legislators.

\textbf{House Bill 2}

For June 2013, one woman’s name dominated political newscasts, headlines, and social media pages not only in Texas, but nationwide. Her name was Wendy Davis and she rose to fame in less than 24 hours; “she was a state senator Tuesday morning. By Wednesday, she was a political celebrity known across the nation. But also hoarse, hungry and thirsty.”\textsuperscript{150} As mentioned at the start of the thesis, Wendy Davis’ famous 11-hour filibuster in 2013 grabbed the attention of pro-life and pro-choice advocates across the nation, bringing Texas’ most recent legislative effort to restrict abortion, H.B. 2, into the limelight. What State Senator Davis was standing up against was a proposed bill that would impose new standards upon abortion providers that would effectively lead to the closure of all but five abortion clinics in Texas.\textsuperscript{151} House Bill 2 bans abortions after 20 weeks of pregnancy and medical abortions after seven weeks; it requires that abortion clinics meet the same standards as hospital-style surgical centers and that women visit

\textsuperscript{149} “State Reproductive Health Profile: Texas.”


\textsuperscript{151} Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”
the clinic four separate times before completing the procedure (one visit for a sonogram, a second and third for doses of a drug, and a fourth for a follow-up); and finally it mandates that all physicians conducting the procedure have hospital admitting privileges within 30 miles of the clinic where he or she is performing the abortion. The first three provisions went into effect November 1, 2013, causing nine abortion providers to close in the first four months. This will most likely be exacerbated even further when the surgical-center requirement goes into effect on September 1, 2014, resulting in the closing of an additional 19 abortion providers. The bill has generated strong support from both sides of the abortion debate, including several organizations that have filed briefs for the Planned Parenthood v. Abbott case dealing with House Bill 2. The American Civil Liberties Union (ACLU), the American Medical Association (AMA), and the American College of Obstetricians and Gynecologists (ACOG) filed amicus briefs in support of Planned Parenthood. Texas Alliance to Life and Americans United for Life also contributed to the amicus briefs on behalf of Abbott.

Republicans dominate both houses of the Texas legislature; and Governor Rick Perry is pro-life. House Bill 2 failed to pass before the end of the legislative session on May 27, 2013, prompting Governor Perry to call a special legislative session. When a preliminary version of the bill passed through the Senate, Lieutenant Governor David Dewhurst wrote, “we fought to pass

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152 Novack, “How Republicans Won the Fight Over Abortion in Texas.”
153 Ibid.
154 Ibid.
[House Bill 2] the Senate last night [and] this is why!”159 He followed up with a graphic that depicted how the legislation would force many Texas clinics to close.160 Ironically, Dewhurst retreated from his statements when he was criticized for claims that were contrary to helping women’s health and safety. When he received attention from opponents for what they called a Republican “backdoor statewide ban on abortion,” he tried to soften the fact that the graphic he had posted revealed the true goal of the legislation, which was to close abortion clinics. Instead he wrote that he and the bill were “unapologetically pro-life and for women’s health.”161 His defense against accusations for utilizing a manipulative legislative strategy was merely that he and the legislation were for women’s health; yet no additional evidence supporting this claim was offered. Dewhurst’s view was shared by Governor Perry, who after passage said, “the Senate continues its important work in support of women’s health and protecting the lives of our most vulnerable Texans,”162 despite no more than six months earlier having declared his goal to “make abortion a thing of the past.”163 After the bill passed through the House, it faced Wendy Davis’ filibuster in the Senate, which succeeded in stalling the legislative session, preventing a vote on the bill. Yet, House Bill 2 was brought up in a second special legislative session called by Governor Perry, and Wendy Davis’ filibuster efforts were defeated. Although there were clear signs of a coordinated conservative strategy aimed at restricting abortion, the Republican Party still was able to dominate the Texas legislative vote, allowing House Bill 2 to become law.

After the special session in July, the ACLU, the Center for Reproductive Rights, Planned Parenthood of Greater Texas and the owners of several other Texas clinics brought a legal

159 Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”
160 Ibid.
161 Ibid.
163 Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”
challenge against the new law, *Planned Parenthood of Greater Texas Surgical Health Services et al. v. Gregory Abbott, Attorney General of Texas*. The suit specifically challenged two provisions of the law, the requirement that abortion providers obtain admitting privileges, and the ban on medication abortion after seven weeks of pregnancy. The lawsuit pitted pro-life and pro-choice advocates against each other. Ironically, both sides relied on a concern for women’s health as the centerpiece of their arguments, abortion rights lawyers said that the provisions would have “dramatic and draconian” effects on women’s access to the procedure, but lawyers for the state countered by saying that these predictions “were exaggerated and that the measures served the state’s interest in “protecting fetal life.”

Three months after House Bill 2 became law, Judge Lee Yeakel of the U.S. District Court in Austin accepted the argument of the pro-choice groups and abortion clinics, blocking the provision that would have required doctors performing the procedure to have admitting privileges at a nearby hospital. In his opinion he concluded, “The act's admitting-privileges provision is without a rational basis and places a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus.” Declaring the state’s argument insufficient, he wrote, “admitting privileges make no difference in the quality of care received by an abortion patient in an emergency room.” He went on to predict that the law would result in the closing of several clinics,

By requiring abortion providers to have hospital admitting privileges, the evidence is that there will be abortion clinics that will close. The record reflects that 24 counties in the Rio Grande Valley would be left with no abortion provider because those providers do not have admitting privileges and are unlikely to get

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167 Ibid, 10.
Judge Yeakel’s ruling confirmed what later proved to be true of the consequences of enacting House Bill 2. But only three days after he blocked the new provision of the law, the United States Court of Appeals for the Fifth Circuit, in New Orleans, reversed the decision, allowing the rule to go into effect while it considered the appeal. On March 27, 2014, the Court of Appeals upheld the law on that basis that it did not pose an undue burden on women’s rights. It claimed that the District Court opinion applied the wrong legal standards and “erred in finding that the admitting privileges requirement amounts to an undue burden for a “large fraction” of the women that it affects.” Both the medication abortion provision and the admitting privileges provision were upheld. As New York Times writer Erik Eckholm explained, “the decision was not unexpected because the Appeals Court, in New Orleans, is considered conservative and has previously signaled that it was likely to find the law constitutional.” Given the blatant conservative influence throughout the process of House Bill 2 being passed, it is important to further assess how conservative, pro-life advocates shaped their arguments so as to keep the law in place.

The Influence of Americans United for Life

Despite intense opposition by the pro-choice organizations and abortion clinics in Texas, the law restricting abortion providers was passed. In the wake of the Court of Appeals decision, Brigitte Amiri of the ACLU Women’s Reproductive Freedom project wrote,

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168 Ibid, 11.
169 Eckholm, “In Reversal, Court Allows Texas Law on Abortion.”
171 Ibid., 8.
You might start by asking who proposed this law. Was it a medical organization? Nope. A doctors' group? Nope. All of the major medical organizations, including the American Medical Association, the American College of Obstetricians and Gynecologists, and the Texas Hospitals Association, all opposed this law. Rather, this bill came from Americans United for Life (AUL), a group dedicated to making abortion if not illegal, then impossible to get. AUL has touted restrictions like these as great ways to shut down abortion providers. And tellingly, this law only applies to doctors who provide abortion.\textsuperscript{173}

This is important because it signifies that the restrictive abortion laws are not in fact derived from scientific research showing a connection between stricter abortion regulations and improved health and safety for women, but instead from a conservative organization that seeks to limit abortion access by providing legislative models to republican legislators. The influence of AUL in the passage of House Bill 2, as well as the subsequent ruling in favor of pro-life conservatives, was not surprising considering President and CEO Youst’s support following the July special session. After the bill passed, Youst praised Governor Rick Perry, as well as House and Senate members, for “protecting the lives and health of women too often victimized in abortion clinics,”\textsuperscript{174} reiterating the efforts that conservative pro-life organizations have made to reframe the abortion debate in terms of public health. Criticizing an abortion lobby that is “out of touch with the American people,” as well as the “unmonitored and unsupervised abortion industry,”\textsuperscript{175} she portrayed the pro-life activists as compassionate, concerned individuals. Her words echo the sentiment heard from pro-life legislators across the nation: “Texans asked for greater protections for women and girls, and their legislators responded. For too long, the abortion lobby has bullied the country through the courts, but a desire for common-sense

\textsuperscript{175} Ibid.
regulation of abortion is being heard across the country.”

What is troubling about this is the fact that the same model legislation is being used nationwide, applying the same restrictive laws to states with varying degrees of abortion incidence. In 2011, AUL was able to claim credit for 24 new restrictive abortion laws that were enacted. As Jordan Goldberg, a lawyer at the Center for Reproductive Rights, claims, “it’s troubling when you see the same bill language introduced in 27 states that you know came out of an anti-abortion think tank in Washington instead of coming from the corners of the sponsor or that particular state.” The consistency with which AUL’s model legislation has been adopted makes it difficult to deny the fact that the model laws are part of a larger legislative strategy aimed at limiting abortion access. The ulterior motives are not difficult to spot; “for us, it is very much a military strategy,” explained Youst, “Never attack where the enemy is strongest…We pick our battles. What we do is very much under the radar screen.” With language like this, it is difficult to find evidence of a sincere, compassionate concern for women’s health and safety. For AUL, empty promises of compassion are only one piece in the much larger puzzle that makes up their legislative strategy.

Aside from the strong connection between the language in AUL’s “Women’s Health Protection Act” and the language of House Bill 2, AUL has also involved itself in the legal battle, submitting an amicus curie brief for Planned Parenthood v. Abbott in support of the state. The intricacy of AUL’s involvement in Texas abortion legislation is indisputable. In the 2013 AUL state legislative session report, for example, AUL praised Texas for enacting the requirement that abortion clinics meet the same patient care standards as facilities performing

176 Ibid.
177 Sheppard, “Wham, Bam, Sonogram! Meet the Ladies Setting the New Pro-Life Agenda.”
178 Ibid.
179 Scher, “Anti-Abortion Forces on the March.”
outpatient surgeries, as well as the requirement that regulates the provision of medication abortion. AUL attributes the regulations to AUL model legislation, the *Abortion Patient Enhanced Safety Act* and *Abortion-Inducing Drugs Safety Act*, respectively.\(^{180}\) In the report, AUL begins by acknowledging its success: “Americans United for Life and AUL Action spearheaded 2013 state legislative efforts to enact life-affirming laws that both built on 2011 and 2012’s significant gains and laid the groundwork for future victories in 2014 and beyond.”\(^{181}\)

The report then proceeds to describe “AUL victories” for individual states. For Texas, AUL writes, “Texas enacted a requirement that abortion clinics meet the same patient care standards as other facilities performing outpatient surgeries. The measure was inspired by AUL’s *Abortion Patient Enhanced Safety Act*.\(^{182}\) Proceeding even further to describe it’s involvement with Texas abortion legislation, and confirming any suspicion of HB 2 being connected to AUL model legislation, the report shows that “AUL and its allies helped Texas enact a measure requiring individual abortion providers to have hospital admitting privileges.”\(^{183}\) These were just two of the six different legislative models that AUL recommended for Texas in 2012,\(^{184}\) but the desire to take credit for the organization’s role in the legislative strategy signifies that TRAP laws truly are a manifestation of a socially conservative movement aimed at eliminating a women’s right to choose through the targeting of abortion providers.

**The Pro-Life/Pro-Choice Argument**

In the aftermath of the legislative special session in July, pro-choice advocates, women and Texas abortion providers were concerned about the impact that the law would have on

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\(^{180}\) Americans United for Life and AUL Action, “2013 State Legislative Session Report.”

\(^{181}\) Ibid.

\(^{182}\) Ibid.

\(^{183}\) Ibid.

\(^{184}\) Burke, ed. *Defending Life 2012*, 804.
women’s access to abortion. As Amy Hagstrom Miller, chief executive of the abortion clinic organization in Texas, Whole Woman’s Health, explained, “Patients are walking through the door, they are crying—they are freaking out […] We can’t stay open without any sources of income.” The provision requiring doctors performing abortions to have admitting privileges at nearby hospitals would most likely force the closing of clinics that relied heavily on local hospitals or visiting doctors, leaving only five abortion clinics, in Austin, San Antonio, Dallas and Houston that actually met the standards. The threatened closure of Texas clinics was a crucial point in the pro-choice arguments surrounding House Bill 2. The Court of Appeals in Planned Parenthood v. Abbott, however, did not find this to be of major or convincing concern. Referencing the federal court opinion, the majority argued,

The opinion’s finding that “there will be abortion clinics that will close” is too vague. The opinion made no “baseline” finding as to precisely how many abortion doctors currently lack admitting privileges required by House Bill 2. Planned Parenthood cannot resurrect its assertion that one-third of the state’s clinics will close or over 22,000 women will be deprived of access to abortion services each year because the District Court also refused to accept these findings. Although some clinics may be required to shut their doors, there is no showing whatsoever that any woman will lack reasonable access to a clinic within Texas.

This part of the opinion is significant because it disregards the aspect of the provision that is most damaging to women, access to clinics that provide not only abortion services, but to other essential reproductive health services that are a necessary component of women’s health and reproductive safety. The structure of the legislation, shaped with the help of pro-life activists, makes it difficult for women to prove to a panel of conservative judges the extent to which the clinics are closing. The damage that the law has produced in less than a year speaks to the need

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186 Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”
for intervention. As executive director of the American Civil Liberties Union of Texas, Terri Burke, points out, “What makes Texas different is our size: House Bill 2 leaves 35 percent of the population without access to abortion care and those are rural and, often, poor women.”\footnote{Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”}

Referring in its amicus brief to the closing of two of the six ASCs providing abortions, in Austin and Fort Worth, the ACLU argues,

The record shows that as a result of the admitting privileges requirement, more than 20,000 women annually would no longer be able to access abortion due to the shortfall in capacity among remaining providers. Given that over 60,000 women will seek abortion each year in Texas, this amounts to approximately one in three women unable to effectuate their constitutionally protected choice to terminate a pregnancy. This number is solely related to capacity; it does not include those women who cannot overcome other obstacles created by the requirement, such as women forced to travel significant distances to access services because a closer provider lacks privileges.\footnote{Planned Parenthood of Greater Tex. Surgical Health Services et al. v. Abbott et al., 6.}

The reality of the situation is that most women cannot feasibly access the few clinics that will remain open in the cities.

In its amicus brief for \textit{Planned Parenthood v. Abbott}, the American Medical Association (AMA) provided a clear example of this harsh reality. It explained that as a result of the requirement, the only two clinics in the lower Rio Grande Valley were forced to shut down, making the closest abortion provider 150 miles away, and the closest ambulatory surgical center 250 miles away.\footnote{Brief for American College of Obstetricians and Gynecologists and the American Medical Association as Amicus Curiae Supporting Plaintiffs-Appellees, Planned Parenthood of Greater Tex. Surgical Health Services et al. v. Abbott et al., 10.} This adds approximately eight extra hours of travel time for any of the 275,000 women of reproductive age living in the Rio Grande Valley near the Texas-Mexican border. As the AMA explained, “Even for women who do have the resources to travel, the travel required may force some women to delay their procedures until later in pregnancy, which
…increases their exposure to complications and risks.”¹⁹¹ In direct contradiction to what pro-life legislators asserted about the provision helping to improve the health and safety of women, it actually makes the process for Texas women inherently more dangerous. If we look at the graph below, the extent of lost access to clinics is dramatic. It is important to note that since the enactment of the admitting privileges requirement in November of 2013, nine clinics have closed. Looking at the dark yellow marks representing these nine clinics, it is clear that several of these clinics were located in the peripheral regions of Texas. Additionally, many clinics are subject to closure under the provision of House Bill 2 that requires abortion clinics to meet the same standards as ambulatory surgical centers (ASC). This provision is set to begin on September 1ˢᵗ, 2014 and has yet to be challenged in court, however, the graphic shows that by September, only six clinics will remain. Looking to the blue marks representing the remaining clinics, it is clear that the geographical location will make it difficult for women living in the more rural areas to access abortion services, given that the remaining clinics are centered in the city locations.

¹⁹¹ Ibid., 9.
Women’s Health and Safety

At this point in Texas, TRAP laws have become a dominant legislative strategy. Pro-life politicians who are connected to active conservative organizations like Americans United for Life utilize the laws to restrict access to abortion in a very effective way. Abortion opponents reframe the abortion issue in terms of public health and a concern for women’s reproductive safety, but it is a sham argument. The validity, or legitimacy of a pro-life or pro-choice claim with respect to legislation now must relate to a concern for women’s health. Take for example Dr. John Throp, an Obstetrician Gynecologist who spoke on behalf of the state in Planned Parenthood v. Abbott. He provided four main benefits for supporting the admitting privileges requirement:

(a) It provides a more thorough evaluation mechanism of physician competency which better protects patient safety; (b) it acknowledges and enables the importance of continuity of care; (c) it enhances inter-physician communication

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192 Novack, “How Republicans Won the Fight Over Abortion in Texas.”
and optimizes patient information transfer and complication management; and (d) it supports the ethical duty of care for the operating physician to prevent patient abandonment.\textsuperscript{193}

With language that strongly emphasizes a safer environment for abortions with a high level of accountability, Dr. Thorp succeeds in making a compelling argument. The 5\textsuperscript{th} Circuit Court of Appeals accepted both the continuity of care and credentialing “benefits” in its decision. Yet, as pro-choice proponents point out, the measures taken in the name of preserving women’s health are unnecessary, and play up the dangers of abortion. In its amicus brief, the AMA argues that the privileges requirement imposed by House Bill 2 does nothing to enhance the safety of healthcare for women, and there is no medically sound reason for Texas to impose more stringent requirements. According to Texas statistics from 2011, there have been no reported maternal deaths out of 227,912 abortions in Texas since 2008.\textsuperscript{194} The AMA also explains, “continuity of care is achieved through communication and collaboration between specialized health care providers, which does not depend on those providers having hospital privileges.”\textsuperscript{195}

Rather than helping to ensure that the specific quality of care necessary in the clinics is achieved, the hospital privileges requirement places an obstacle in the way of physicians, making it difficult for them to comply, and therefore forcing clinics to close. The law specifically targets clinicians who provide abortions, and not those covering other outpatient procedures, regardless of the greater risk those procedures may carry.\textsuperscript{196} The blatant discrepancies speak directly to the strategic objectives of pro-life legislators. This is important because it shows how House Bill 2,

\textsuperscript{193} Planned Parenthood of Greater Tex. Surgical Health Services et al. v. Abbott et al. 3.
\textsuperscript{194} Brief for American College of Obstetricians and Gynecologists and the American Medical Association as Amicus Curiae Supporting Plaintiffs-Appellees, Planned Parenthood of Greater Tex. Surgical Health Services et al. v. Abbott et al., 3.
\textsuperscript{195} Ibid., 5.
\textsuperscript{196} Amiri, “A Devastating Loss for Texas Women.”
and state pro-life legislation in general, is serving as a tool for conservative pro-life advocates who seek to reframe the abortion debate in terms of women’s health and safety.

Rather than improving women’s reproductive health, the burden imposed by the admitting privileges requirement will prevent women from obtaining safe abortions altogether, which could lead some women to self-induce abortion. As the AMA points out, Texas already has a higher average number of attempts to self-induce an abortion than the national average, which is 2.8%. Evidence suggests that such attempts will become more common under House Bill 2. A 2013 report investigating abortion in Texas revealed that the most concerning aspect of House Bill 2 was the effect that it would have on the health of Texas women and the potential rise of abortion self-induction, especially low income and young women who lack appropriate resources to travel. The researchers explained,

In 2012, we conducted a survey with 318 women seeking abortion in six cities across the state to assess the impact of the 2011 restrictions. We found that 7% of women reported taking something on their own in order to try to end their current pregnancy before coming to the abortion clinic. This proportion was even higher — about 12% — among women at clinics near the Mexican border.”

Despite evidence pointing to the fact that further restrictions will exacerbate health concerns for Texas women seeking an abortion, abortion opponents press further, making sure that their word is heard. A clear example of this is seen with Texas Right to Life lobbyist Emily Horne, who alleged that the conditions of Texas clinics that auditors found in 2012 “could have easily lead to women getting sick or injured.” Her language, though seemingly of serious concern, is mere speculation, and contradicts the fact that the Department of State Health Services deemed all

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198 Ibid., 11.
facilities’ corrective actions plans sufficient to protect patients.\textsuperscript{201} The anti-abortion strategy is a manipulation of the facts, designed to achieve the ultimate goal, which is to enforce stringent requirements upon providers so as to make an abortion difficult to obtain.

In March of 2014, two clinics operated by Whole Woman’s Health were forced to shut down, contributing to the decline and making the total number of clinics in Texas 24, from the 44 that were running in 2011.\textsuperscript{202} Whole Women’s Health founder Amy Hagstrom Miller explains that the main reason several of the clinics have been forced to close is due to the difficulties that physicians encountered in obtaining admitting privileges.\textsuperscript{203} The number of clinics is estimated to drop even more with the enactment of the ambulatory hospital standards for clinics in September. What will this mean for women in distant counties who need to obtain an abortion, or basic assistance that helps to improve their reproductive health and safety? Will they drive the 100-200 miles? And even if they do, is travelling over 100 miles really the solution that pro-life advocates see for \textit{improving women’s reproductive health and safety}? After all, Governor Perry and other Republicans have repeatedly said that House Bill 2 will improve patient safety and hold abortion clinics to safer standards,\textsuperscript{204} and pro-life advocates like Joe Pojman, executive director of Texas Alliance for Life, have supported the legislature, declaring on behalf of his pro-life organization, “we are pleased that women will never again receive substandard care from either of these abortion facilities.”\textsuperscript{205} The facts are clear but the legislative strategy is more potent. In order to change the direction that Texas legislators and Americans United for Life are taking women’s health, the false concern for safety and the realities of the new burdensome TRAP laws must be exposed.

\textsuperscript{201} Ibid.
\textsuperscript{202} Fernandez, “Abortion Law Pushes Texas Clinics to Close Doors.”
\textsuperscript{203} Ibid.
\textsuperscript{204} Fernandez, “Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight.”
\textsuperscript{205} Fernandez, “Abortion Law Pushes Texas Clinics to Close Doors.”
When Wendy Davis stepped down from the podium after her 11-hour filibuster, the threat that restrictive legislation presented to women was likely more unambiguous and comprehensible than it ever had been to Texas senators familiar with the law. Yet despite the brief setback to the legislative process, the law was enacted soon after, because of the conservative Republican leadership. After House Bill 2 passed the following month, Wendy Davis said, “the fight for the future of Texas is just beginning.”206 Her words are telling not only for Texas, but also for the abortion issue nationwide. The socially conservative strategy has taken on a new dynamic that is gaining strength and momentum, and all the while doing so under the guise of concern for women’s health and safety. The future for women’s reproductive health is no longer concerned simply with access to abortion, but also with the risk of all reproductive services being eliminated.

206 Schwartz, “Texas Clinics Stop Abortions After Court Ruling.”
Chapter 4: Ambulatory Surgical Center Standards in North Carolina

"It's not too difficult to imagine that somewhere in some major pro-abortion organization, there's a bull's-eye with Charmaine's face in the middle" - Gary Bauer, AUL President Charmaine Yoest’s former boss at the Family Research Council

“Sometimes a plate of cookies is just a plate of cookies.” These were the words of Kim Genardo, communications director for Governor Pat McCrory of North Carolina, the day after the Governor had signed a controversial piece of restrictive abortion legislation in July, 2013. What Ms. Genardo was referring to was a hasty public relations move, in which Governor McCrory had offered chocolate chip cookies to protesters outside of his mansion the day after the bill signing. The men and women who had gathered outside his home were protesting against Senate Bill 353, a piece of legislation that would effectively lead to the closing of several North Carolina abortion clinics. The Bill itself had its own problematic implications, but what the protesters really were riled up about was the fact that McCrory, who had only recently been elected Governor that past November, had turned on his campaign promise. When a version of the legislation first passed through the North Carolina Congress in July, 2013, McCrory vehemently opposed it, calling it an attempt at restricting access to abortion. Yet two weeks later when a new version of the legislation (with the exact same implications) was proposed, he voted for it. The cookie gimmick, whatever is true intention, was hardly successful. The Governor’s actions, however, rang loud and true. In response to the public relations move, the protesters slipped the plate under the mansion gate, attaching a note that read, “We want women’s health care, not cookies.” The message, a mere seven words, summed up an issue that has been

210 Frank and Cornatzer, “McCrory gives protesters cookies.”
gaining significant traction nationwide, namely that restrictive TRAP laws are leading to closed abortion clinics. In its simplest form, the Governor’s actions were just another example of the Republican strategy to reframe the abortion debate, making clinics the biggest enemy to women’s health and safety.

This chapter will, like Chapter 3, reveal the true impact that TRAP laws have on women’s access to abortion clinics. It will show that not only are the conservative legislators who favor these laws providing false justification as part of a deceptive strategy for successful enactment, but also that the resulting impact of the laws is detrimental to women’s health and safety. This chapter will start by providing an overview of the abortion incidence in North Carolina. The discussion will then explain the process in which the North Carolina legislature came to accept the final piece of legislation, SB 353, as well as the deceitful behavior on behalf of Republican legislators that contributed to its passage. Finally, it will focus on the impact that the law will have on abortion clinics in North Carolina and explain why the purported health issues used to defend the legislation are in fact untrue. Rather, the new law is a manifestation of conservative pro-life efforts intended to both change the terms of the debate about abortion and achieve their true goal, which is to make abortion unavailable.

**Abortion in North Carolina**

Like the trend in Texas, abortion in North Carolina has been on the decline. Currently the state requires that a woman receive state-directed counseling designed to discourage abortion, wait 24 hours before going through with the procedure, and obtain parental consent if she is a minor. Additionally, it requires that public funding and insurance for abortion only be provided in cases of life endangerment, rape or incest, and that the use of medication abortion is
prohibited. This recent shift reflects a considerable decline in the number of abortions performed, especially in the past ten years. In 2011, 28,600 women obtained abortions in North Carolina, compared to 37,610 in 2000. The rate of abortions has declined 15% since 2008, when it was 17.1 abortions per 1,000, compared to 14.6 in 2011. The graph below represents this trend. Although it is important to consider that women may be travelling from surrounding states to obtain a procedure, the strong decline is noteworthy and merits further investigation.

As postulated for Texas, the decline in the number of abortions may be attributable to a parallel decline in the number of providers. As seen by the graph below, despite the slight increase in 2011, the number of North Carolina providers has been steadily declining. In 2000, there were 55

212 Guttmacher State Data Center: Trend Data
213 Ibid.
214 Ibid.
providers in the state, as compared to 36 in 2011.\textsuperscript{215} Sixteen of these providers are abortion clinics, only one of which meets the standards of an outpatient surgical center.\textsuperscript{216} This is important, because the legislation signed by Governor McCrory in July of 2013 would require clinics to adhere to some, if not many, outpatient surgical center standards, as will be discussed later in the chapter.

![Number of abortion providers](image)

Given the fact that a state as large as Texas has 62 providers, and North Carolina is closely matched with 36, it would seem as though North Carolina is serving its population of reproductive women relatively well. Yet, the reality is that in 2011, 90\% of North Carolina

\textsuperscript{215} Ibid.
\textsuperscript{217} Guttmacher State Data Center: Trend Data.
counties had no abortion clinic, with 53% of North Carolina women living in those areas. The majority of North Carolina abortion clinics are located within the center of the state in Mecklenburg County, Orange County, Durham County, Wake County and Forsyth County. Notably, Mecklenburg is near Charlotte, a major city; Orange, Durham and Wake are centered around Raleigh, the state capital; and Forsyth is in between the two cities. Looking to the most recent abortion legislation in the state, SB 353, it is clear that the difficulty that women may already have in accessing a clinic will become worse.

**House Bill 695 and Senate Bill 353**

The process that led to the passage of SB 353 began with the election campaign of Governor McCrory in October of 2012. In the month before the gubernatorial elections, during an October 24, 2012 debate, a local North Carolina news reporter asked McCrory what further restrictions on abortion he would agree to sign if elected for Governor. His response was “none.” McCrory was elected Governor that November. Six months later, in July 2013, his words were brought back into public view.

In the 2013 legislative session, House Bill 695, the “Family, Faith and Freedom Protection Act” was passed in the House on May 16, 2013. The Bill was mainly designed to prohibit the recognition of foreign laws in family courts, such as Islamic Sharia Law. Then, when the Bill moved to the Senate to be considered for a vote, a provision was added that would require abortion clinics to meet the same standards as ambulatory surgical centers, as well as to

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have “transfer agreements” with nearby hospitals. The provision, given the strict requirements it would impose on abortion providers, essentially would have the same effect as the admitting privileges provision did in Texas. The Senate waited until the end of the legislative session was only a few weeks away, and passed HB 695 on July 7, 2013 with the new requirement,

The Department of Health and Human Services (Department) shall amend its rules pertaining to clinics certified by the Department to be suitable facilities for the performance of abortions...The rules shall ensure that standards for the clinics certified by the Department to be suitable facilities for the performance of abortions are similar to those for the licensure of ambulatory surgical centers. These rules shall address the on-site recovery phase of patient care at the clinic as well as the requirement for a transfer agreement between a clinic and a hospital.

At this point, Governor McCrory, whether upset at the underhanded approach taken by the Senate to passing the bill, or by the language of the bill itself, expressed his disagreement. Threatening to veto the measure, he said that parts of the bill were clearly aimed at restricting access to abortion, rather than improving the safety of the procedure. Since it became clear to the legislature that the Governor was not going to sign HB 695 with the abortion provision attached, the bill was not put to a further vote, and was removed from the legislative calendar three days later.

With the legislative session set to end on July 26, 2013 and the abortion initiative essentially squandered with HB 695, the North Carolina Senate picked up a new piece of legislation. The legislation, Senate Bill 353, was a bill on motorcycle safety that had passed a first reading in the Senate in April. While the Bill was being considered in the House, a Senate recommendation was added. The new recommendation included similar restrictions on abortion

224 Binker, “Abortion law breaks McCrory promise.”
that were seen earlier with HB 695. In the Bill, the state Department of Health and Human Services (DHHS) was directed to revise the rules for abortion clinics.\textsuperscript{225} The discretion of the DHHS was outlined in Section 4 of the Bill; “the Department is authorized to apply any requirement for the licensure of ambulatory surgical centers to the standards applicable to clinics certified by the Department to be suitable facilities for the performance of abortions.”\textsuperscript{226} In addition to authorizing the application of ASC standards, the legislation ensured that the Department would address the on-site recovery phase of patient care at the clinic, protect patient privacy, provide quality assurance, and ensure that patients with complications receive the necessary medical attention.\textsuperscript{227} Although it was left to the discretion of the DHHS to set the standards for the clinics, some of the same regulations that apply to ambulatory surgical centers would apply to the clinics. This would impose burdensome structural requirements that were irrelevant to patient safety and abortion procedures, such as door and hallway widths, guaranteed square footage per operating room, and mandatory water fountains in waiting facilities.\textsuperscript{228}

The House passed its final version of SB 353 with the provision related to the DHHS on July 11, 2013. This time, the Governor voiced no immediate opposition. The Bill returned to the Senate for its final vote, and was passed on July 25, 2013, one day before the end of the legislative session. Four days later, Governor McCrory signed the bill into law. By allowing the DHHS to use ambulatory surgical center standards for abortion clinic inspections, the lawmakers successfully reframed abortion as a public health issue. The law was pushed forward by a Republican majority in the legislature first under the guise of a bill concerning religion in family courts, and second as a bill related to motorcycle safety.

\textsuperscript{225} Blake, “Asheville abortion clinic to close.”
\textsuperscript{227} Ibid.
Given the entire legislative process and the non-public last minute changes to the bill, the enactment of Senate Bill 353 was received with significant criticism, since it seemed to deliberately subject abortion clinic inspections to unnecessary standards. North Carolina Democratic Senator Floyd McKissick said, “The only thing this bill does is to try in every legal way that’s conceivably possible to deny a woman the right to choose…we’re trouncing upon the rights and the options of women in this state and in my mind, it’s unconstitutional.”\(^{229}\) Also acknowledging the detrimental impact of the law was Representative Rick Glazier, who explained that for most women in North Carolina, “there’s a pretty strong fear that it’s going to shut down most access to abortion services in the state.”\(^{230}\) Yet despite the clear indications that the law goes beyond the scope of what is necessary for inspecting abortion clinics, Republican legislators continue to defend it.

Immediately after its enactment, the Governor and several conservative congressmen, like Republican Representative Ruth Samuelson, tried to defend the law against these accusations, claiming that the law was in fact aimed at improving women’s health and safety, and not just an attempt to apply burdensome standards in the hopes of shutting down the clinics. Samuelson said, “this is really about protecting the health and safety of women…we are not out here trying to shut down every abortion clinic in North Carolina.”\(^{231}\) Her sentiment reflected that of Governor McCrory, who said of the legislation that he “wasn’t limiting access to the procedure, but rather was signing a measure that would result in safer conditions for North Carolina women.”\(^{232}\)

\(^{230}\) Ibid.
In an attempt to defend his actions, the Governor only further solidified his alliance with the conservative Republican strategy aimed at restricting abortion through onerous and unrelated legislation. In a post legislative session news conference he said, “Because of the veto threat [on HB 695], that bill was changed to our satisfaction... We're not going to limit access in those facilities. We're going to increase the safety...” McCrory even went so far as to say, “[SB 353] does not further limit access and those who contend it does are more interested in politics than the health and safety of our citizens.”

His response to SB 353 received especially strong criticism because of his campaign pledge during the gubernatorial election eight months earlier, in which he said he would not sign any further restrictions to abortion. He also had declared that he would veto House Bill 695, but then went ahead and signed Senate Bill 353. The two bills, although slightly different, would have the same effect in restricting access to clinics. McCrory attributed his change to the fact that HB 695 would have required clinics to meet the ASC standards, as compared to SB 353, which only required the DHHS to use the ambulatory surgical rules as a guide, “while not unduly restricting access” to abortion.

The difference that McCrory was referring to was a slight change to the designation of responsibility, which in practical application would make no difference to those operating any of the 16 North Carolina abortion facilities. The use of the ASC standard was not completely eliminated.

Depending on what regulations are drafted by the DHHS under SB 353, it could still force expensive upgrades that abortion clinics may find too costly or physically impossible to comply with because of their locations. According to Drexdal Pratt, director of DHHS' Division of Health Service Regulation, an ambulatory surgical center costs about $1 million

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233 Binker, “Abortion law breaks McCrory promise.”
234 “North Carolina Governor Signs Abortion Rules Bill.”
235 Binker, “Abortion law breaks McCrory promise.”
236 Ibid.
more to build than a regular clinic.\textsuperscript{237} If the DHHS decides to apply all requirements of ambulatory surgical centers to clinics, only one clinic will meet the outpatient surgery requirements necessary to remain open, Femcare Inc. in Asheville. Governor McCrory’s shift in support for a law related to ambulatory surgical center standards revealed his true intentions with respect to restrictive abortion legislation. The coordinated conservative effort to enact such legislation does in fact relate to the way that conservative, pro-life governors will vote, and it is important because it can cause a detrimental impact on women’s access to reproductive services.

\textbf{The Department for Health and Human Services and Femcare Inc.}

Given the deceptive way in which the law was passed and the way in which the Governor flipped on his campaign promise, it is necessary to look at the impact of SB 353. Less than a month after SB 353 was signed into law, the North Carolina Department of Health and Human Services suspended the license of Asheville abortion clinic, Femcare Inc., citing safety violations that were discovered in a recent inspection. The inspection was conducted on July 18\textsuperscript{th} and 19\textsuperscript{th} in 2013,\textsuperscript{238} just nine days before the new restrictive legislation was officially enacted. The suspension report cited violations that included a failure to maintain anesthesia delivery systems in good working condition, a failure to ensure weekly checks on emergency equipment, a failure to have a resuscitator available, as well as a failure to have an agreement or contract with a registered anesthetist and registered pharmacist.\textsuperscript{239} Immediately after the clinic was suspended, Lorraine Cummings released a statement on behalf of FemCare Inc. stating,

\begin{flushleft}
\textsuperscript{239} Ibid.
\end{flushleft}
Standards that were acceptable when we were last inspected have changed and, as soon as we were notified of them two weeks ago, we began the process of meeting each one of them. We have had no patient infections using our former protocols. We expect to be in compliance soon with the required standards and will return to serving our patients as soon as possible.\textsuperscript{240}

Also, the DHHS noted that Femcare Inc.’s last inspection was on January 16, 2007.\textsuperscript{241} This speaks to the plausibility of a deceptive Republican legislative strategy, considering that the enactment of strict TRAP laws, with provisions for ASC requirements on clinics, has been gaining significant traction since 2010.\textsuperscript{242} Since there were no DHHS inspections conducted in the years since 2007, and then suddenly an inspection was conducted the week before SB 353 was officially enacted, it is likely that the Republican officials deliberately targeted the clinic.

Femcare Inc. was willing to comply with the new standards, but it is important to reiterate that Femcare Inc. is the only abortion clinic in North Carolina that is also an ambulatory surgical center.\textsuperscript{243} In other words, Femcare Inc. is the only clinic that is actually able to comply with the new standards. For all other abortion providers who do not meet ambulatory surgical center standards, the new DHHS requirements would require major, costly renovations, or would force the clinic to shut down. Since SB 353 grants the DHHS broad discretion to utilize ASC standards in their investigations, it is noteworthy that Femcare Inc. was the first abortion clinic to be cited publicly for failing the inspection. NARAL Pro-Choice North Carolina executive director Suzanne Buckley pointed to the license suspension as yet another sign that the current system of clinic regulations was already effective,

\textsuperscript{240} Ibid.
\textsuperscript{241} Ibid.
\textsuperscript{242} Gold and Nash, “TRAP Laws Gain Political Traction While Abortion Clinics and the Women They Serve-Pay the Price.”
The DHHS citations reinforce our position that the current regulations are working and SB 353 is unnecessary… Some have suggested that timing of the citations is suspicious and politically motivated. It certainly deserves further inquiry. Our efforts will continue to be focused on advancing and protecting access to reproductive healthcare for all North Carolinians.\(^\text{244}\)

Given the political implications, the threat to women’s health and safety seems to be a legislative means to another end; eliminating abortion. After all, Femcare Inc. was given DHHS approval to reopen on August 21, 2013, less than a month after its license was revoked.\(^\text{245}\) If the DHHS was clearly concerned about atrocious, unacceptable clinic conditions that were threatening to women’s health, one would think that a sustained effort to keep the clinic closed would take place on behalf of the inspectors and their Republican counterparts. After all, the director of the Division of Health Service Regulation for DHHS, Drexdal Pratt said, “We take rule violations very seriously, and when necessary, take firm action to prevent harm to patients and clients in the facilities that we license, regulate and inspect.”\(^\text{246}\) The fact that Femcare Inc. was only briefly suspended indicates that the legislation’s goal is political, and not part of a concerted effort to improve health standards. The assertions defending most TRAP laws, as seen in Texas and North Carolina, are based on the idea that the laws make abortion safer for women’s health. Yet, there is no evidence that shows that the new requirements do in fact enhance women’s health or safety.

As the health and safety of the woman continues to be pitted as the main concern for both pro-life and pro-choice advocates, it is worthwhile to understand the actual risks associated with the abortion procedure. According to a 2008 Guttmacher report, most abortions occur before nine weeks’ gestation, and the proportion of very early abortions (less than seven weeks) has


\(^{246}\) Robin Marty, “North Carolina Clinic License Suspended, But Clinic Expects to Reopen.”
increased substantially since 1994.\textsuperscript{247} As seen by the charts below, which represent a compilation of data from Guttmacher reports published in 2008 and 2014, the percent of women obtaining abortions has remained relatively steady since 2004.

<table>
<thead>
<tr>
<th>WHEN WOMEN HAVE ABORTIONS\textsuperscript{248}</th>
<th>Approximate Percentage of Women Obtaining Abortion</th>
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</thead>
<tbody>
<tr>
<td>Gestational Age (weeks)</td>
<td>2004</td>
</tr>
<tr>
<td>Less than 7</td>
<td>28</td>
</tr>
<tr>
<td>7 to 8</td>
<td>33</td>
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<tr>
<td>9 to 12</td>
<td>27</td>
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<tr>
<td>13 to 15</td>
<td>7</td>
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<tr>
<td>16 to 20</td>
<td>4</td>
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<tr>
<td>More than 21</td>
<td>1</td>
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<thead>
<tr>
<th>WHEN WOMEN HAVE ABORTIONS\textsuperscript{249}</th>
<th>Approximate Percentage of Women Obtaining Abortion</th>
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<tbody>
<tr>
<td>Gestational Age (weeks)</td>
<td>2004</td>
</tr>
<tr>
<td>12 or less</td>
<td>89</td>
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<tr>
<td>13 or more</td>
<td>11</td>
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From the data above, it is clear that a majority of women obtain abortions within the first 12 weeks of pregnancy. In fact, one third of abortion procedures are completed within the first seven weeks. According to the National Abortion Federation, serious complications arising from abortions obtained within the first 12 weeks are unusual, and of these women, 97% report no complications; 2.5% have minor complications that can be handled at the medical office or

\textsuperscript{248} Ibid.
\textsuperscript{249} Ibid.
abortion facility; and less than 0.5% have more serious complications that require an additional surgical procedure.\textsuperscript{250} The risk of death associated with abortion increases as the length of the pregnancy increases. The risk of death is one for every one million abortions at or before eight weeks, to one per 29,000 at 16-20 weeks, and one per 11,000 at 21 weeks or later.\textsuperscript{251} That being said, it is important to note that the Republican led efforts to pass restrictive legislation, both in North Carolina and in the United States in general likely exacerbates the health risks of women seeking to obtain an abortion, since the law likely makes it more difficult and untimely to access a clinic and schedule a legal procedure.

Femcare Inc. is just the first in what will likely be several DHHS inspections in North Carolina that results in either the suspension or the closing of a clinic. In Femcare Inc.’s case, the clinic was able to stay open, but there are several others in the state who will most likely be forced to close. For example, the Baker Clinic for Women, located in Durham County near Raleigh, also had its license revoked in July 2013. Since then it has announced that it will voluntarily turn over its license rather than attempt to meet new ambulatory surgical center requirements and reopen.\textsuperscript{252} Baker exemplifies the problematic nature of SB 353, especially with respect to women’s access to abortion. Clinics that are unable to meet the new standards will be shut down, and the conservative legislative efforts will be successful. As Representative Rick Glazier (D) explained, the final version of SB 353 was a “rewrite by moonlight” and consistent with the legislature’s rightward tilt since Republicans had taken complete control of North Carolina’s government. He characterizes the Republicans as “an extreme legislative majority bent on eliminating the right to choice, [to the legislative majority] everything looks like a health

\textsuperscript{251} “In Brief: Facts on Induced Abortion in the United States.”
\textsuperscript{252} Marty, Robin. “One North Carolina Abortion Clinic Reopens, Another Says It Will Turn Over Its License.”
regulation, ready to be used and abused to dismantle access to that choice." North Carolina experienced this rightward tilt in the 2010 elections, when Republicans swept the majority for both chambers of the General Assembly, allowing GOP majorities to be established in both the Senate and House. The legislature’s rightward tilt is not surprising for North Carolina, especially considering the ties between state office holders and the conservative American’s United for Life organization (AUL), which will be discussed next.

**Americans United for Life and the Conservative Movement**

Critics of the SB 353 have continuously asserted that the Bill has nothing to do with women’s safety, pointing out the fact that the model legislation for the Bill, the *Abortion Patient’s Enhanced Safety Act*, was drafted by AUL. Given the nature of AUL’s involvement with other state legislatures and restrictive abortion legislation, the pro-choice assertion is convincing. SB 353, pushed through by the Republican majority in the final days of the legislative session, follows similar actions by Republican controlled legislatures in other states, as seen in the previous chapter with Governor Rick Perry’s calling of a second special legislative session that resulted in the enactment of House Bill 2. AUL has recognized North Carolina’s efforts to enact stricter abortion legislation, contributing to public acknowledgement of Republican legislators’ role in passing the laws. In its 2014 Life List, meant to identify and rank states on the basis of how well they “protect life in law,” AUL named North Carolina as one of the year’s most improved states. By essentially applauding and granting public recognition to

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256 “AUL’s 2014 Life List.”
North Carolina for its legislative efforts in 2013, including SB 353, AUL is encouraging conservative Republicans to push forward with the restrictive strategy. Further evidence appears in AUL’s state “report card” page, which includes several model legislation recommendations and priorities for North Carolina.257

So long as AUL continues to publicize its support for the legislative efforts of conservative Republican legislatures, as seen with the annual “Life List” publications and the booklet of model legislation, pro-life advocates will continue to successfully redefine abortion as a public health concern that is necessary for the reproductive safety of women. North Carolina is just one example of the increasingly large collection of pro-life states adopting this strategy. Hal C. Lawrence, vice president of the American Congress of Obstetrician and Gynecologists explained, “As we’ve seen in several other states, legislators are getting between women and their doctors.”258 This intervention not only reflects legislative dominance, but an ideology that is almost entirely contrary to the medical necessities concerning abortion. As the legislative efforts continue to become clearer, pro-choice advocates are catching on. At a NARAL pro-choice rally, a protester explained the issue plainly; speaking of Republican legislators he said,

Tell them that some of us get it, that we know this is not really about abortion; it's about the critical America cornerstones of freedom and independence. It's about who knows best what's right for my family – my wife, my daughter, me? Or some politicians who think they know better. That's not what America is about.259

The protester was getting at the heart of an issue that began with the Christian Right, and manifested over time into a legislative strategy that reshapes abortion access by changing laws so as to limit access to the procedure. It is for this reason that men like John L. Rustin, the president of the North Carolina Family Policy Council, can say that he considers SB 353 to be a “common sense measure and very rational.” Yet, what seems to have been forgotten, or at least clouded by recent successful legislative enactments, is the impact that these laws will have further down the road. Senator Earline W. Parmo (NC-D) explained, “When we fail to allow access, women will find other ways...When we over regulate to this extent and make regulations so rigid that medical facilities can’t meet those standards, that’s the choice we leave our women.” The full impact that SB 353 will have on North Carolina clinics has yet to be seen, but the predictions of detrimental effects to women’s access to reproductive health services are entirely convincing.

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Conclusion

“For today, the women of this Nation still retain the liberty to control their destinies. But the signs are evident and very ominous, and a chill wind blows” - Harry Blackmun, U.S. Supreme Court, in Webster v. Reproductive Health Services (1989).

North Carolina and Texas are just two examples of states that have succeeded in their efforts to enact TRAP legislation. All of the pieces were set in place; a pro-life Republican governor, a pro-life senate and pro-life house, model legislation from Americans United for Life, and several abortion providers that would not quite meet the mark once the law’s new standards were in effect. Restrictive abortion legislation has come to fit a new mold. It is no longer an effort aimed at the woman who is making the decision, but rather at the clinician or facility that is providing the service. Simply put, the informed consent laws that dominated the early 1990s cannot be compared to the ambulatory surgical center requirements that have emerged since 2005. Although the former adds an emotionally charged obstacle for women deciding to obtain the abortion, it does not make the abortion procedure entirely inaccessible, as the latter has the potential to do. As legal correspondent Dhalia Lithwick explains,

The anti-choice strategy has been to close as many clinics as possible and to sideline as many providers as possible by crafting “abortion regulations” […] that force doctors to attempt to obtain ever-elusive hospital admitting privileges; and that force clinics to widen hallways and rejigger broom closets. And all of this has been done under…the theory that just a few more regulations, warnings, and inches added to the clinic corridors will make them safer and more comfortable in the cruel world of abortion mills.

What Lithwick refers to is the problematic sequence that has made the entire TRAP law strategy concerning. To start, the Republican legislators’ assertion that the laws will improve the health and safety of women is an empty claim. As seen in previous chapters, women’s health and safety


are not the main concerns of the Republican legislators pushing the restrictive laws forward. Instead, the concern is the effective closure of as many abortion clinics as possible, which is a step backwards in terms of protecting women’s reproductive health and safety. The fact that the strategy is not protecting women’s health and safety is clear. The fact that Republicans have succeeded in reframing the abortion debate in terms of public health is also clear. What is not clear, however, is the true intention of the Republicans who continue to vote for the restrictive laws. Yes, the main goal for pro-life organizations has always been centered upon the effective overturning of Roe, but can the same be said for state Republican legislators? Are these Republicans really supporting the TRAP laws because they have the potential to eliminate abortion, or do they have other objectives?

From the examples provided by Texas and North Carolina, it is clear that having an executive and legislative branch that are dominated by pro-life Republicans makes the entire passage of TRAP laws much easier. The laws enacted, despite claims for making the procedure safer, are not responsive to women’s health care needs. These ideologically driven laws mirror the pro-life ideology of conservative legislators, and it is not a coincidence. TRAP laws are the mechanism for preventing abortions and ultimately overturning Roe v. Wade.

In the past two decades, abortion rights activists have had to pick their battles against restrictive abortion laws carefully, “attempting to challenge only the measures they were reasonably confident of defeating at the high court, or at least wouldn’t make significantly worse.”264 The meticulous selection of legal challenges is exacerbated in part because of the Supreme Court’s reluctance to overturn Roe v. Wade and grant control of legalized abortion to the states. As Lithwick observes, “like King Kong perched atop the Empire State building, the Court itself has batted away challenge after challenge, content to leave Republican-controlled

264 Ibid.
state legislatures to do all the heavy lifting, as one state after another has tried to make it all but impossible to legally terminate a pregnancy." 265 Whether the Court’s reluctance to accept abortion cases is intentional is beyond the scope of this paper, and a difficult claim to prove nonetheless. What is important to understand, however, is that attempts to return the issue to the Supreme Court and overturn Roe v. Wade have been put on the backburner, and as a result, pro-life activists are looking for an alternative. What they have found is an entirely different but potent legislative strategy.

In the years since Planned Parenthood v. Casey, this strategy has increasingly gained popularity. As Lithwick writes, “after almost six years of being frozen into a sort of WWKD (what would Justice Kennedy do?), the reproductive rights landscape seems to have shifted so quickly that it almost doesn’t matter what Justice Kennedy would do anymore.” 266 The fact that the courts are no longer relied upon for change signifies the radical shift in the type of restrictive legislation being pushed forward. Since the Court has avoided overturning Roe v. Wade, pro-life legislators have adopted a strategy that takes Court precedent out of the equation, targeting those who provide the abortion, as opposed to those seeking it. As empirical evidence shows, the newfound TRAP law strategy does in fact create an environment where the constitutional right to make the decision to have an abortion may be moot, because there are too few providers to perform the procedure. 267 In other words, “the enactment of a TRAP law represents a substantive, as opposed to a merely symbolic, measure of a state’s restrictive abortion policy.” 268

The consequences of TRAP legislation are apparent in the cases of Texas and North Carolina. Moreover, the reality of the TRAP law in those states is confirmed by clear empirical evidence.

265 Ibid.
266 Ibid.
267 Medoff and Dennis, 968.
268 Ibid.
Empirical Evidence

Two of the leading researchers who study the TRAP movement are Marshall Medoff and Christopher Dennis. In his research, Medoff raises a point that is crucial to properly assessing the impact of TRAP laws, namely that they are a recent phenomenon. Despite the recent flood of legislation aimed at abortion providers, very little research has examined the impact of those types of restrictive state abortion laws. Medoff emphasizes that this is not due to a lack of information or data, since the Guttmacher Institute periodically conducts a thorough survey of the number of abortion providers. Rather, he argues, since the research related to providers is mainly descriptive and documents changes over time, the impact has been difficult to analyze. More importantly, though, is the fact that numerous clinics have already been closed due to the new laws. This speaks to the profound impact the new strategy has on access to abortion. This causal link is strengthened by the results that both Medoff and Dennis have found in their research between the decrease in providers and the increased legislative action.

In looking to their analysis, it is important to recall that the new state restrictive abortion laws are not directed at a women’s “right to choose,” which was upheld in Casey. Nevertheless, the new laws substantially obstruct a woman’s access to abortion. For Medoff and Dennis, the two dominant ways in which a law could impede or alter a woman’s pregnancy decision are by increasing the out of pocket or emotional costs of obtaining an abortion, or by reducing the number of providers. As Medoff and Dennis explain, virtually all of the research on the impact of restrictive abortion laws has focused on the emotional side related to the women’s right to choose. After analyzing the less examined side aimed at the providers, they explain why restrictive state abortion laws and the subsequent decline in abortion providers merits study.

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269 Medoff, 226.
270 Medoff, 225.
271 Medoff, 225.
Most importantly, however, they note that the available empirical evidence finds that TRAP laws make it more difficult and costly for abortion providers to supply abortion services as a consequence of complying with the TRAP laws.\textsuperscript{272}

TRAP laws, enacted under the guise of protecting women’s health, are designed to regulate all aspects of the business operations of abortion providers. The intent of TRAP laws is to deter physicians from becoming or remaining abortion providers. TRAP laws impose on abortion providers medically unnecessary requirements and regulations that are calculated to drive abortion providers out of practice or make abortions so prohibitively expensive and increasingly difficult to obtain that women will no longer be able to afford them or find a provider offering abortion services.\textsuperscript{273}

Reiterating the evidence seen in both Texas and North Carolina, among other states that have adopted restrictive TRAP laws, Medoff and Dennis imply that TRAP laws do not in fact serve the purpose of making reproductive health in clinics safer for women. Instead, the real purpose of the laws is to regulate business operations in a targeted way and drive out abortion providers. What merits further investigation, however, is the resulting impact. That is to say, can the decline in abortion providers be causally linked to the decline in reported abortion incidence? If so, will the TRAP laws continue to result in a precipitous decline in providers? Also, if there are fewer legal providers, are women likely to return to illegal or self-induced forms of abortion? Medoff and Dennis claim that through TRAP laws, abortion opponents can effectively overturn the Supreme Court’s \textit{Roe v. Wade} decision legalizing abortion.\textsuperscript{274} Assuming they are right, a new legislative strategy could effectively lead to the longstanding goal of pro-life activists.

Although Medoff’s and Dennis’ studies cannot provide a direct causal connection between abortion providers and the true objectives of legislators who support TRAP laws, their

\\textsuperscript{272} Medoff and Dennis, 956.
\textsuperscript{273} Ibid.
\textsuperscript{274} Ibid.
analysis of several theories presents a convincing argument that mirrors the evidence seen in states like Texas and North Carolina. First, Medoff and Dennis counter a 1957 study that linked the behavior of policymakers to the preferences of their constituents. Instead, they measure the enactment of TRAP laws though observations of partisan political party abortion ideology in conjunction with partisan political control of state government and conclude, after controlling for other variables, that “lawmakers are not influenced by the abortion attitudes of their constituents in enacting a TRAP law.”275 This is important, because it shows that the restrictive TRAP laws that are being enacted reflect not a conservative political constituency within a state, but represent the independent motives of state office holders. This was the case in North Carolina. Although 80 percent of North Carolina voters objected to including abortion restrictions in a motorcycle bill, and 35,000 North Carolinians signed a petition urging Governor McCrory to veto the restrictive legislation, the Governor signed the bill.276 Governor McCrory and Lieutenant Governor Tillis are both ideological opposed to abortion, and their indifference to the public’s general opposition shows that ideological opposition to abortion is independent of the beliefs of the majority of a state’s constituents. In other words, defeating pro-life legislation becomes all the more difficult when the majority of those who support it identify as pro-life in a Republican controlled pro-life state.

The evidence both at the state level and in empirical studies indicates a larger conservative Republican ideological goal: to prevent abortion. To reiterate Medoff and Dennis’ findings, the implicit or explicit intent of TRAP laws is to “effectively overturn the Supreme Court’s Roe v. Wade decision legalizing abortion by driving abortion providers out of practice and making it extremely difficult for women to exercise their legal right to choose to have an

275 Ibid., 965.
abortion.” This is precisely what was seen in Texas’s lower Rio Grande Valley, in which over 200,000 women of reproductive age are now forced to travel over eight hours if they wish to simply access an abortion provider. The problematic nature of TRAP legislation makes clear that the laws are not being promoted as a means to making abortion safer. As Medoff and Dennis explain, “the enactment of TRAP law by states represents an ambiguous, direct, unmistakable, and substantive measure of a state’s restrictive abortion policy.” Considering that abortion is a major social and political electoral issue for both Republicans and Democrats, it makes sense that the Republican Party would choose to use its control of state government to enact the restrictive laws. Furthermore, the empirical evidence supports this:

The anti-abortion ideology of the Republican Party, in conjunction with the institutional control of the legislative and executive branches of the state government, suggest that the enactment of TRAP laws is more likely when the Republican Party controls both houses of the state legislature and the governor’s office.

Full Republican control of state government facilitates the passage of laws that are ideological driven and not responsive to any real healthcare needs.

**Looking Forward**

The most recent “Abortion Incidence and Service Availability in the United States” report released by the Guttmacher Institute shows a steady decline in the abortion rate from 2008

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277 Medoff and Dennis, 968.
279 Medoff and Dennis, 957.
280 Ibid, 960.
to 2011, about 4-5% per year, or 13% over the entire 3 year span.\textsuperscript{281} In 2011, the year with the lowest rate since 1973, there were 1.06 million abortions, and the abortion rate was 16.9 per 1,000 women.\textsuperscript{282} Given the fact that there were four restrictive TRAP laws aimed at abortion providers in 2005,\textsuperscript{283} as compared to the 27 laws that were enacted by 2013,\textsuperscript{284} it is reasonable to conclude that the decline in abortion incidence from 2008 to 2011 is largely attributable to the subsequent increase in TRAP laws. Although Guttmacher does not go so far as to directly link the decline in abortion incidence to the influx of TRAP laws, the report considers several related factors.

For example, the researchers for the report, Rachael K. Jones and Jenna Jerman, explain that “the closure of even one facility that is unable to meet TRAP regulations has the potential to affect several hundred, or even several thousand women.”\textsuperscript{285} They explain that while the number of facilities did not change drastically between 2008 and 2011, the disruption in services may have contributed to the 19% decline in abortion incidence. In other words, if a facility’s clinicians were unable to obtain hospital-admitting privileges, it is possible that scheduling legal abortion procedures would become increasingly difficult. The procedure would become less accessible for the woman, and she would then have to wait longer for an appointment. This hypothetical scenario is not far off from the impact that House Bill 2 had on Texas, as described in Chapter 3.

Of course, the report also cites Oregon and Illinois as states in which abortion incidence has largely decreased, despite any new restrictions being enacted.\textsuperscript{286} Given that both of these

\begin{footnotesize}
\footnote{281} Rachael K. Jones and Jenna Jerman, “Abortion Incidence and Service Availability In the United States, 2011,” \textit{Perspectives on Sexual and Reproductive Health} 46 no. 1 (2014): 3. \\
\footnote{282} Jones and Jerman, 5. \\
\footnote{283} Brown, “The TRAP: Targeted Regulation of Abortion Providers.” \\
\footnote{284} “State Policies in Brief: Targeted Regulation of Abortion.” \\
\footnote{285} Jones and Jerman, 6. \\
\footnote{286} Ibid.
\end{footnotesize}
states have predominantly pro-choice legislatures, the lack of restrictive legislation could potentially be explained by a lack of conservative leadership. The Oregon and Illinois examples support the notion that Republican legislators have come to play the most crucial role in restricting access to abortion. Although the report does not make a direct causal connection between restrictive legislation and the decline in abortion incidence, the apparent connection should be understood to be an influential factor, especially looking forward. The report, published in 2014, tracked the abortion incidence leading up to the first half of 2011. Given that a majority of restrictive legislation was passed in 2011, primarily in the second half of the year, it would not inform data in the incidence report for 2011. Therefore, the true impact of the new restrictive TRAP laws may be predicated upon the next published incidence report for the Guttmacher Institute.

For legislators in support of abortion, efforts have been made to stop the influx of TRAP laws. Pro-choice legislation has been proposed at the federal level to counteract the restrictive abortion law strategy. In November of 2013, Senators Richard Blumenthal and Tammy Baldwin, and Representatives Judy Chu, Lois Frankel and Marcia Fudge, all Democrats, introduced a bill called the Women’s Health Protection Act. The bill was an effort to reaffirm Roe and Casey “by pre-empting state efforts to enact measures like heartbeat bills, fetal pain legislation, and regulations that result in clinic closures, added expenses, and unnecessary delays,” and would force states to prove that their legislation actually had a significant health reason for its enactment. Despite the evident optimism that the bill represents for pro-choice advocates, the bill is estimated to never pass the GOP-controlled House. Yet, as Dahlia Lithwick explains, “what’s important is that it represents Democrats, including male Democrats, “taking a strong,

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287 Ibid, 3.
long-overdue stand against state efforts to simply nullify *Roe v. Wade* with legislation that assumes *Roe* has already been overruled.”  

Democratic action counters the apparent, coordinated effort that pro-life Republicans embrace. TRAP legislation has replaced laws aimed at limiting a woman’s right to choose as the new potent and effective strategy adopted by pro-life advocates and legislators in states controlled by those who are ideologically opposed to abortion. The impact of this strategy has yet to be measured but as seen in Texas and North Carolina, is expected to have a resounding impact on women’s access to clinics. If all of the provisions are enacted as scheduled and fully applied, Texas will be left with a mere five clinics, and North Carolina one. This will affect not only access to abortion, but also other essential reproductive health services provided by the clinics. As AUL publicist Kristin Stone Hamrick noted, “A lot of people assume Roe is untouchable, and we disagree...we have a template of legislation that will roll back *Roe*.”  

The same can be said for conservative politicians who have reveled in the success of their legislative efforts, like Governor Rick Perry of Texas and Mississippi Governor Phil Bryant. The intentions are becoming increasingly clear, but the ability to stop the movement is not. As pro-choice researcher and journalist Abby Scher aptly suggests “the well-oiled machine that is the anti-abortion movement in the states will only really be stopped in two ways: in the courts or by retaking the state legislatures.”

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289 Ibid.
290 Scher, "Anti-Abortion Forces on the March."
291 Ibid.
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Sheppard, Kate. “Wham, Bam, Sonogram! Meet the Ladies Setting the New Pro-Life Agenda.” Mother Jones, September/October 2012.


**Court Cases and Congressional Bills**


ABORTION PATIENTS’ ENHANCED SAFETY ACT

[Drifter’s Note: The best candidates for this legislation have an established record of enacting protective legislation such as comprehensive informed consent requirements, parental consent, ultrasound requirements, and comprehensive and specifically-targeted abortion clinic regulations. Moreover, several issues will need to be carefully considered before introducing this legislation including whether or not the administration of abortion-inducing drugs such as RU-486 will be specifically covered or excluded. Moreover, states that have abortion clinic regulations already on the books may also want to consider enacting specific ambulatory surgical center standards to remedy noted deficiencies in the existing regulations. Please contact AUL for assistance on this legislation.]

HOUSE/SENATE BILL No. ______
By Representatives/Senators ____________

Section 1. Title.

This Act may be known and cited as the “Abortion Patients’ Enhanced Safety Act.”

Section 2. Legislative Findings and Purposes.

(a) The [Legislature] of the State of [Insert name of State] finds that:

(1) The [vast majority] of all abortions in this State are performed in clinics devoted solely to providing abortions [and family planning services]. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion either before or after the procedure and they do not return to the facility for post-surgical care. In most instances, the woman’s only actual contact with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.

(2) For most abortions, the woman arrives at the clinic on the day of the procedure, has the procedure in a room within the clinic, and recovers under the care of clinic staff, all without a hospital admission.


(4) Abortion is an invasive surgical procedure that can lead to numerous and seri-
ous medical complications. Potential complications for first trimester abortions include, among others, bleeding, hemorrhage, infection, uterine perforation, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, fertility problems, emotional problems, and even death.

(5) The risks for second trimester abortions are greater than for first trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.


(8) Moreover, the State of [Insert name of State] has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient.” *Roe v. Wade*, 410 U.S. 113, 150 (1973).

(9) Since the Supreme Court’s decision in *Roe v. Wade*, courts have repeatedly recognized that for the purposes of regulation, abortion services are rationally distinct from other routine medical services, because of the “particular gravitas of the moral, psychological, and familial aspects of the abortion decision.” *Greenville Women’s Clinic v. Bryant*, 222 F.3d 157, 173 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001).

(10) An ambulatory surgical center (ASC) [or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)] is a health care facility that specializes in providing surgery services in an outpatient setting. ASCs generally provide a cost-effective and convenient environment that may be less stressful than what many hospitals offer. Particular ASCs may perform surgeries in a variety of specialties or dedicate their services to one specialty.
Patients who elect to have surgery in an ASC arrive on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff, all without a hospital admission.

(b) Based on the findings in subsection (a) of this Act, the purposes of this Act are:

(1) To define certain abortion clinics as “ambulatory surgical centers” \[or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)]\ under the laws of this State, and to subject them to licensing and regulation as such.

(2) To promote and enforce the highest standard for care and safety in facilities performing abortions in this State.

(3) To provide for the protection of public health through the establishment and enforcement of a high standard of care and safety in abortion clinics.

(4) To regulate the provision of abortion consistent with and to the extent permitted by the decisions of the Supreme Court of the United States.

Section 3. Definitions.

As used in this Act only:

(a) \textbf{"Abortion"} means the act of using or prescribing any instrument [, medicine, drug, or any other substance, device, or means]${}^2$ with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use [, prescription, or means] is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

(3) Remove an ectopic pregnancy.

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\[^2\text{This language is used when state officials intend the regulations prescribed herein to apply to the provision of chemical abortions (such as the use of RU-486).}\]
(b) “Abortion clinic” means a facility, other than an accredited hospital, in which five or more first trimester abortions in any month or any second or third trimester abortions are performed.

(c) “Department” means the [Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities] of the State of [Insert name of State].

Section 4. Statutory Definition of “Ambulatory Surgical Center” [Or Other Appropriate Term] Modified to Include Certain Facilities Performing Abortions.

(a) The term “ambulatory surgical center” [or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)] as used in [Insert specific reference(s) to state statute(s), administrative rules, or other regulatory material(s) governing ambulatory surgical centers or similar state-regulated entities] shall include abortion clinics which do not provide services or other accommodations for abortion patients to stay more than twenty-three (23) hours within the clinic.

(b) All ambulatory surgical centers [or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)] operating in this State, including abortion clinics, must meet the licensing and regulatory standards prescribed in [Insert specific reference(s) to state statute(s), administrative rules, or other regulatory material(s) providing licensing and regulatory standards for ambulatory surgical centers or similar state-regulated entities].

Section 5. Criminal Penalties.

Whoever operates an abortion clinic as defined in this Act without a valid ambulatory surgical center [or other appropriate term as used in existing state statute(s), administrative rules, or other regulatory material(s)] license issued by the Department is guilty of a [Insert proper penalty/offense classification].

Section 6. Civil Penalties and Fines.

(a) Any violation of this Act may be subject to a civil penalty or fine up to [Insert appropriate amount] imposed by the Department.

(b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.
(c) In deciding whether and to what extent to impose fines, the Department shall consider the following factors:

(1) Gravity of the violation including the probability that death or serious physical harm to a patient or individual will result or has resulted;

(2) Size of the population at risk as a consequence of the violation;

(3) Severity and scope of the actual or potential harm;

(4) Extent to which the provisions of the applicable statutes or regulations were violated;

(5) Any indications of good faith exercised by licensee;

(6) The duration, frequency, and relevance of any previous violations committed by the licensee; and

(7) Financial benefit to the licensee of committing or continuing the violation.

(d) Both the Office of the Attorney General and the Office of the District Attorney [or other appropriate classification such as “County Attorney”] for the county in which the violation occurred may institute a legal action to enforce collection of civil penalties or fines.

Section 7. Injunctive Remedies.

In addition to any other penalty provided by law, whenever, in the judgment of the Director of the [Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities], any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this Act, the Director shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the Director that such person has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

Section 8. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.
Section 9. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

Section 10. Severability.

If any provision, word, phrase, or clause of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this Act which can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this Act are declared severable.

Section 11. Effective Date.

This Act takes effect on [Insert date].
ABORTION PROVIDERS’ PRIVILEGING ACT

HOUSE/SENATE BILL No. ______________
By Representatives/Senators ____________

Section 1. Title.

This Act may be known and cited as the “Abortion Providers’ Privileging Act.”

Section 2. Legislative Findings and Purposes.

(a) The Legislature of the State of [Insert name of State] finds that:

(1) The [vast majority] of all abortions in this State are performed in clinics devoted primarily to providing abortions and family planning services. Most women who seek abortions at these clinics do not have any relationship with the physician who performs the abortion either before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman’s only actual contact with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.

(2) In some cases, abortion providers travel into [Insert name of State] from other states [or locations] to perform abortions at abortion clinics in this State. These physicians typically do not live in or remain in this State when not providing abortions or abortion-related care.


(4) Abortion is an invasive, surgical procedure that can lead to numerous and serious (both short- and long-term) medical complications. Potential complications for abortion include, among others, bleeding, hemorrhage, infection, uterine perforation, uterine scarring, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, organ damage, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, and even death.
(5) The risks for second trimester abortions are greater than for first trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparate surgery, or a blood transfusion.


(9) The State of [Insert name of State] has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient.” *Roe v. Wade*, 410 U.S. 113, 150 (1973).

(b) Based on the findings in subsection (a), it is the purpose of this Act to provide for the protection of public health generally and of women’s health and safety specifically through the establishment and enforcement of an admitting privileges requirement for physicians providing abortions in [freestanding] abortion clinics in this State.

**Section 3. Definitions.**

As used in this Act only:

(a) **Abortion** means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

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2 The bracketed language is used when state officials intend the requirements prescribed herein to apply to the administration or provision of abortion-inducing drugs (such as RU-486).
(3) Remove an ectopic pregnancy.

(b) **Abortion clinic** means a facility, other than an accredited hospital, in which five (5) or more first trimester abortions in any month or any second or third trimester abortions are performed.

(c) **Admitting privileges** means the right of a physician[, by virtue of membership with a hospital's medical staff,] to admit patients [from an abortion clinic] to a particular hospital for the purposes of providing specific diagnostic or therapeutic services to such patient in that hospital.

(d) **Physician** means a person licensed to practice medicine in the State of [Insert name of State]. This term includes medical doctors and doctors of osteopathy.

Section 4: Admitting Privileges Requirement.

On any day when any abortion is performed in an abortion clinic, a physician with admitting privileges at an accredited hospital in this State and within thirty (30) miles of the abortion clinic must remain on the premises of the abortion clinic to facilitate the transfer of emergency cases if hospitalization of an abortion patient or a child born alive is necessary and until all abortion patients are stable and ready to leave the recovery room.

Section 5. Civil Penalties and Fines.

(a) Any violation of this Act may be subject to a civil penalty or fine up to [Insert appropriate amount] imposed by the [state Department of Health or other appropriate department or agency].

(b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

(c) In deciding whether and to what extent to impose fines, the [state Department of Health or other appropriate department or agency] shall consider the following factors:

1. Whether physical harm to a patient or a child born alive has occurred;
2. Severity and scope of the actual or potential harm;
3. Any indications of good faith exercised by the abortion clinic involved in the violation to comply with the requirements of this Act;
(4) The duration, frequency, and relevance of any previous violations of this Act by the abortion clinic; and

(5) Financial benefit to the abortion clinic of committing or continuing the violation.

(d) Both the Office of the Attorney General and the Office of the District Attorney [or other appropriate title or designation] for the county in which the violation occurred may institute a legal action to enforce collection of civil penalties or fines.

Section 6. Injunctive Remedies.

In addition to any other penalty provided by law, whenever in the judgment of the [Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency], any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this Act, the [Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency] shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the [Director [or other appropriate title or designation] of the Department of Health or other appropriate department or agency] that such person has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

Section 7. Construction.

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

Section 8. Right of Intervention.

The [Legislature], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.
Section 9. Severability.

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

Section 10. Effective Date.

This Act takes effect on [Insert date].