Women's Health Issues 22-5 (2012) e415–e420

WOMEN'S HEALTH ISSUES
www.whijournal.com

Policy matters

Knowledge of State-Level Abortion Laws and Policies among Front-Line Staff at Facilities Providing Abortion Services

Laura E. Dodge, MPH [a], Sadia Haider, MD, MPH [a,b], Michele R. Hacker, ScD, MSPH [a,b,c,*]

[a] Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center, Boston, Massachusetts
[b] Department of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Boston, Massachusetts
[c] Department of Epidemiology, Harvard School of Public Health, Boston, Massachusetts

Article history: Received 13 January 2012; Received in revised form 9 July 2012; Accepted 10 July 2012

A B S T R A C T

Objective: To determine the accuracy of information regarding state-level abortion laws and policies received by a simulated patient from front-line staff at facilities providing abortion services.
Methods: U.S. states were ranked by restrictiveness of access to abortion, and a simulated patient made calls to the five most and six least restrictive states. Three scripts were used to simulate the following three patients: a 17-year-old minor, a married woman, and a woman at 15 weeks of gestation. Each facility was called three times. Accuracy of the information provided was assessed using a list of laws published monthly by the Guttmacher Institute.
Results: Of 138 calls, 72 (52.2%) were made to least restrictive states, and 66 (47.8%) were made to most restrictive states. Information provided by front-line staff was generally excellent, with over 90% accuracy regarding spousal and parental involvement, presence of, and length of mandatory waiting periods. Most inaccuracies were owing to responses of "I don't know." Despite providing highly accurate information regarding the existence of parental involvement laws, only 55.6% of front-line staff members in states with parental involvement laws informed the simulated minor patient of her right to a judicial bypass.
Conclusion: Information regarding state abortion laws and policies provided by front-line staff members at facilities that provide abortion services is highly accurate, with the exception of judicial bypass for parental involvement. Resources should be developed for reproductive health care providers and their staff to ensure that all information provided to patients is accurate and comprehensive.

Introduction and Background

Induced abortion is highly controversial in the United States and is becoming increasingly legislated. In 2011, state legislatures introduced more than 1,100 reproductive health and rights-related provisions (Guttmacher Institute, 2012). By the end of 2011, 135 of these new provisions had been enacted, of which 68% sought to restrict access to abortion (Guttmacher Institute, 2012). This is nearly four times more than the previous record of 34 abortion restrictions enacted in 2005 and nearly six times more than the 23 restrictions enacted in 2010 (Guttmacher Institute, 2012). The 92 new restrictive provisions enacted this year were enacted in 24 states. The new restrictions take several approaches to limiting abortion access and place additional burdens on both abortion providers and patients. These restrictions include mandated counseling and waiting periods, bans on abortion coverage in new insurance plans, and a ban on the use of telemedicine to provide medication abortion in areas without any abortion providers (Guttmacher Institute, 2012). Additional restrictions have banned abortion at and after 20 weeks post-fertilization owing to the belief that the fetus may feel pain, despite evidence that challenges this belief (Lee, Ralston, Drey, Partridge, & Rosen, 2005). These restrictions may conflict with the Supreme Court ruling that bars states from placing an undue burden on women seeking abortion before viability.

With nearly half of unplanned pregnancies ending in induced abortion, it is estimated that one in three women will have an induced abortion in her lifetime (Jones & Kooistra, 2011). Although induced abortion is among the most common operative procedures performed in the United States, accessing abortion services remains difficult for many women (Guttmacher Institute, 2008). Information is an integral part of access, and

Conducted with grant support from the Harvard University William F. Milton Endowment.
* Correspondence to: Michele R. Hacker, ScD, MSPH, 330 Brookline Avenue KS 328, Boston, MA 02215. Phone: (617) 667-2933; fax: (617) 667-5011.
E-mail address: mhacker@bidmc.harvard.edu (M.R. Hacker).

1049-3867/$ - see front matter
http://dx.doi.org/10.1016/j.whi.2012.07.002

navigating an ever-changing array of state laws and policies is likely to become more difficult for both health care professionals and patients as the number of laws and policies increase (Guttmacher Institute, 2012). Although research has shown that nearly all women (92%) decide to have an abortion before calling for an appointment, and are thus not calling to receive options counseling, these women may still require information regarding the legal restrictions on abortion services (Moore, Frohwirth, & Blades, 2011). It is unlikely that a woman seeking an abortion will speak with a clinician before she presents for an appointment, in which case her sole source of information may be the front-line staff member who answers the telephone. Inaccurate information about abortion restrictions may discourage or prevent her from seeking the care she desires. It is unknown whether staff members at facilities that provide abortion services are able to accurately communicate to women the abortion laws and policies in their states. Without accurate information, women seeking induced abortion may not receive the services they are seeking in an effective or timely manner, which may limit their choices and endanger their health.

The primary aim of this study was to assess the accuracy of the information regarding state-level abortion laws and policies received by a simulated patient from front-line staff members at facilities providing abortion services. This study is the first, to our knowledge, to examine the knowledge of state-level abortion laws and policies among health care professionals in the United States.

Methods

Selection of Facilities

States were categorized as most restrictive or least restrictive based on the number of abortion laws and policies present in those states as of February 2010 (Guttmacher Institute, 2010), as described elsewhere (Dodge, Haider, & Hacker, forthcoming). Briefly, the monthly Guttmacher Institute publication *State Policies in Brief: An Overview of Abortion Laws* was used to choose the six least restrictive and five most restrictive states (Guttmacher Institute, 2010). The number of states in each category was chosen to balance the number of abortion providers between the two groups. The laws and policies present in the least restrictive and most restrictive states at the time of classification are shown in Table 1. Almost all of the most restrictive states contained all the laws or policies examined. Four of the five had mandatory 24-hour waiting periods, which was the maximum waiting period in any U.S. state at the time of the study; the other had a shorter waiting period that is not identified owing to privacy concerns.

States were classified as least restrictive or most restrictive for the purpose of investigating regional differences in the accuracy of information provided, with the hypothesis that staff in states that pass more laws and policies may either provide more accurate information because they are more aware of changing laws, or less accurate information because the changes in laws are difficult to follow. Laws regarding the targeted regulation of abortion providers, which impose burdensome requirements on abortion providers that are not imposed on providers of any other medical procedures, were not taken into account when classifying the states.

The phone calls took place from May 2010 through January 2011 and were conducted by a single investigator acting as a simulated patient. All of the study states remained in the least restrictive or most restrictive categories throughout the study period. Because of the small number of National Abortion Federation (NAF) members in some of the study states, all results are reported in aggregate to protect the identity of the study clinics.

Table 1
Number of States with Laws and Policies, by Level of Abortion Restriction

Law or Policy for Classification Purposes	Most Restrictive	Least Restrictive
Abortions must be performed by a licensed physician	5	0
Abortions must be performed in a hospital in certain cases	5	0
A second physician must participate in the abortion in certain cases	5	0
Abortion is prohibited in certain cases except for life or health endangerment	5	0
Individuals may refuse to participate in abortion services	5	2
Institutions may refuse to participate in abortion services	5	2
State-mandated counseling must be performed before an abortion	3	1
A mandatory waiting period must be observed before an abortion	5*	1
Abortion for a minor requires parental consent	5†	0
Abortion for a minor requires parental notification	1†	1
Mean ± number of laws and regulations	9.6 ± 0.5	1.0 ± 1.1

* Four states had 24-hour waiting periods; one state had a shorter waiting period that is not identified owing to privacy concerns.
† One state required both parental consent and notification.

A list of abortion providers in each of the eleven study states was compiled from the NAF website (NAF, 2010). Membership in NAF is voluntary; not all abortion providers are NAF members, and are thus not listed on the website. Every NAF member listed on the website in February 2010 in each of the study states was contacted. NAF members consist of private physicians, hospitals, and independent abortion clinics. If it was discovered that one central number handled appointments for multiple locations, the central number was treated as one facility and the other locations were excluded. The practice type was not recorded at the time of the telephone call. At the time of manuscript preparation, the practice types of the providers currently listed in the study states on the NAF website were classified.

Assessment of Accuracy of Information

A single investigator acting as a simulated patient used three telephone scripts to simulate the experiences of a minor, a married woman, and a woman at 15 weeks of gestation. The three scripts are shown in Figure 1. The scripts were designed to be indistinguishable from an actual patient call and aimed to evaluate accuracy of information provided regarding as many of the following laws and policies as was possible during the conversation: Parental involvement (consent and/or notification), option of a judicial bypass, spousal involvement, presence of a mandatory waiting period, length of a mandatory waiting period, presence of a gestational age limit, and gestational age at gestational age limit. Each facility was called three times over a period ranging from 3 to 18 weeks, with calls taking place at least 1 week apart. The simulated patient asked standardized questions as specified in the scripts of the staff member who

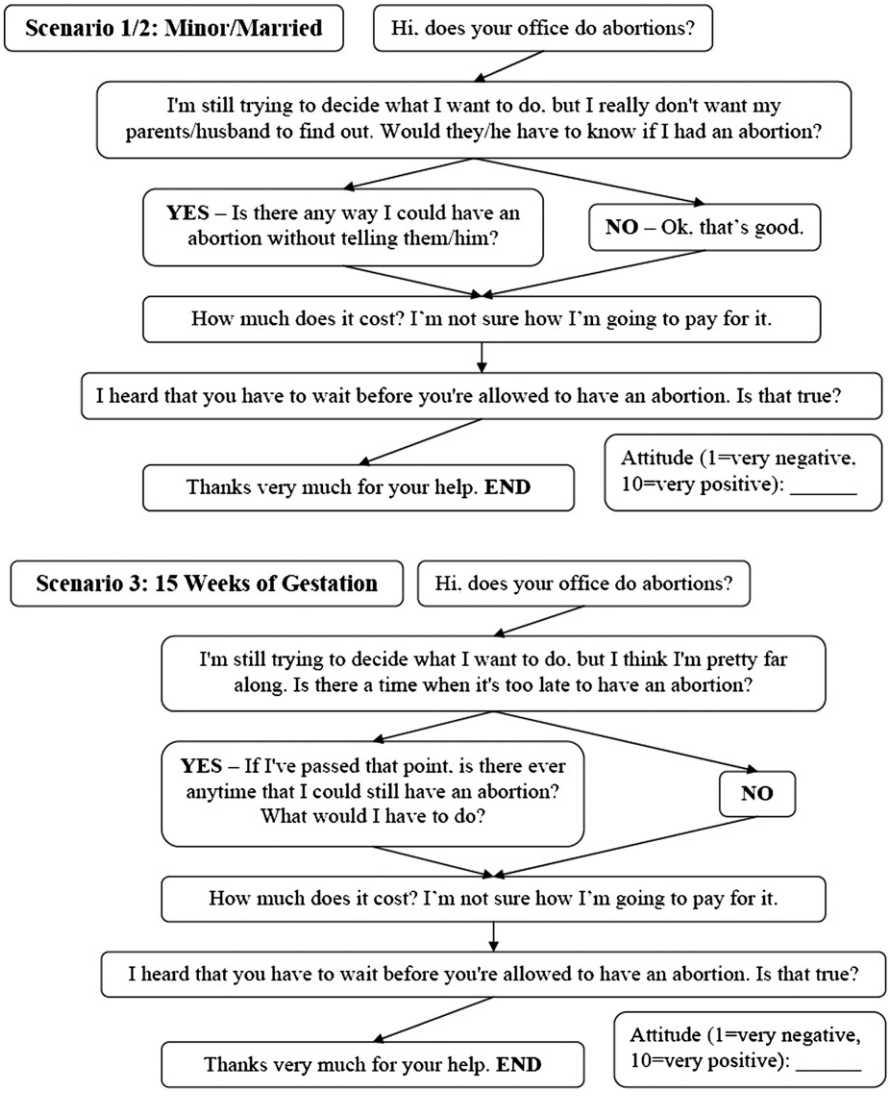

Figure 1. Three telephone scripts were used to simulate the experiences of a minor, a married woman, and a woman at 15 weeks of gestation.

answered the telephone. As a minor and as a married patient, the simulated patient indicated that she was worried about her parents or her husband finding out if she had an abortion. If the staff member indicated that the simulated patient would need parental or spousal consent, the simulated patient reiterated that she did not want to involve her parents or her husband and asked if there was any way she could have an abortion without their or his consent. The information provided was later scored as correct, incorrect, or indeterminate using Guttmacher Institute's *State Policies in Brief: An Overview of Abortion Laws* (Guttmacher Institute, 2010). A response of "I don't know" was considered to be incorrect. Indeterminate responses occurred when the question was addressed by the simulated patient, but the information provided by the staff member was not specific enough to be determined to be correct or incorrect (e.g., in response to the question about the mandatory waiting period in a state with a 24-hour waiting period, the staff member may have told the simulated patient that she needed to come in for three separate visits, but did not specify how far apart each visit must be).

The simulated patient used a set of facts that remained the same for each scenario, which were only volunteered if she was asked directly. The simulated minor patient was 17 years old, approximately 7 weeks of gestation, and worked part time at an after school job. The simulated married patient was also at approximately 7 weeks of gestation and worked full-time at a desk job for under $40,000 per year. The simulated patient at 15 weeks of gestation had the same personal details as the married patient. All simulated patients lived in the same state as the contacted provider and were insured by BlueCross BlueShield, although the minor and married patients told the clinic that they did not want to use their insurance owing to concerns that their families would find out about their abortion. Each simulated patient asked about the cost of the procedure and the length of time typically needed to obtain an appointment. Finally, the simulated patient recorded a subjective measure of the front-line staff member's attitude towards her on a scale of 1 to 10, with 1 being extremely hostile and 10 being extremely helpful.

After all calls were completed, a debriefing letter was sent to all facilities that were contacted. The letter informed the facility that they were contacted as part of the study and described the objectives and methods of the study. The letter did not include any study results and informed the facilities that all of their

identifying information had been destroyed after the letters were addressed and mailed.

Data Analysis

Data analysis was conducted using SAS 9.2 (SAS Institute, Cary, NC). Data are presented as proportions or medians with the interquartile range (IQR). Comparisons between least restrictive and most restrictive states were made using chi-square, Fisher's exact, and Mann–Whitney *U* tests. All tests were two-sided; $p < .05$ was considered significant. The institutional review board at Beth Israel Deaconess Medical Center approved this study.

Results

We made 138 phone calls to 46 providers. Of these, 24 (52.2%) providers were in least restrictive states, and 22 (47.8%) providers were in most restrictive states. Although the practice types were not recorded at the time of the study call, at the time of manuscript preparation, among a total of 26 providers in the six least restrictive states, 54% of providers were Planned Parenthood facilities, 8% were hospitals, and 39% were other types of facilities. In the five most restrictive states, among a total of 23 providers, 17% were Planned Parenthood facilities, 4% were hospitals, and 65% were other types of facilities.

The accuracy of the information provided was generally high (Table 2). Information regarding the presence of spousal involvement laws, which have been declared unconstitutional by *Planned Parenthood v. Danforth* (1975) and *Planned Parenthood v. Casey*, (1993) was highly accurate. Nearly all staff members (97.8%) responded correctly when asked by the simulated patient if she would need to tell her husband about the abortion; the only incorrect responses were responses of "I don't know." Similarly, most staff members (91.1%) gave the simulated patient correct information regarding parental involvement laws; three (6.7%) staff members responded with "I don't know" and only one (2.2%) did not inform her of parental involvement laws in her state. Overall, accurate information regarding mandatory waiting periods was provided in more than 90% of calls.

Despite highly accurate information regarding parental involvement laws, only 56% of respondents gave the simulated patient information about judicial bypass as an option for minors who do not want to involve their parents. In the cases where the simulated patient was not informed of the option for judicial bypass, when the simulated patient asked the staff member if there was any way she could have an abortion without telling her parents, the staff member usually simply said "no." However, all the study states with parental involvement laws provide a judicial bypass option for minors.

This study was designed to assess the accuracy of information regarding gestational age limits in the study states, but it was difficult to obtain using the simulated patient method. Most practices cited the gestational age limit at their particular practice instead of the state law, even when asked by the simulated patient if having an abortion would be illegal in that state after that gestational age limit. In other cases, the staff member informed the simulated patient of the practical limit in the state, which was the latest gestational age at which an abortion provider would perform an abortion. For instance, several of the study states have no gestational age limits, but also no known providers who will perform an abortion past 14 weeks of gestation. In cases where the staff member indicated that the simulated patient was beyond the practical limit in that state, 79% informed the simulated patient of the option to travel out of state to have an abortion. It is important to note that in no cases did the staff member cite a gestational age that was greater than the legal limit in that state.

Table 2
Accuracy of Knowledge of State Abortion Laws and Policies among Abortion Providers

Law or Regulation	Total*	Least Restrictive	Most Restrictive	*p* Value†
Simulated married patient				
Spousal involvement				1.00
Correct	45 (97.8)	23 (95.8)	22 (100.0)	
Incorrect	1 (2.2)	1 (4.2)	0 (0.0)	
Don't know	1 (2.2)	1 (4.2)	0 (0.0)	
Inaccurate	0 (0.0)	0 (0.0)	0 (0.0)	
Presence of waiting period				1.00
Correct	35 (94.5)	15 (93.8)	20 (95.2)	
Incorrect	2 (5.4)	1 (6.3)	1 (4.8)	
Length of waiting period				.19
Correct	18 (90.0)	1 (50.0)	17 (94.4)	
Incorrect	2 (10.0)	1 (50.0)	1 (5.6)	
Simulated minor patient				
Parental involvement				.11
Correct	41 (91.1)	19 (82.6)	22 (100.0)	
Incorrect	4 (8.9)	4 (17.4)	0 (0.0)	
Don't know	3 (6.7)	3 (13.0)	0 (0.0)	
Inaccurate	1 (2.2)	1 (4.4)	0 (0.0)	
Presence of judicial bypass				—
Correct	10 (55.6)	—	10 (55.6)	
Incorrect	8 (44.4)	—	8 (44.4)	
Presence of waiting period				—
Correct	35 (100.0)	15 (100.0)	20 (100.0)	
Incorrect	0 (0.0)	(0.0)	(0.0)	
Length of waiting period				1.00
Correct	16 (94.1)	1 (100.0)	15 (93.8)	
Incorrect	1 (5.9)	0 (0.0)	1 (6.3)	
Simulated patient at 15 weeks of gestation				
Presence of waiting period				1.00
Correct	16 (94.1)	8 (100.0)	8 (88.9)	
Incorrect	1 (5.9)	0 (0.0)	1 (11.1)	
Length of waiting period				1.00
Correct	10 (90.9)	2 (100.0)	8 (88.9)	
Incorrect	1 (9.1)	1 (0.0)	1 (11.1)	

* Totals for each law and regulation do not sum to 46 because it was not possible to assess all components of knowledge during each call.

† The *p* values are for comparisons of correct and incorrect responses between least restrictive and most restrictive states.

Among seven (5%) calls that contained clearly inaccurate information (this excludes the assessment of gestational age limits in states that set the limit at viability, because the study design did not define viability at a specific gestational age), only one call led the simulated caller to believe that abortion was less restricted than it actually was; the other six led the caller to believe that abortion was more restricted.

There were no differences in the accuracy of information provided between the least restrictive and the most restrictive states. However, few of the least restrictive states had mandatory waiting periods, and this limited the comparison of accuracy of the length of the mandatory waiting period.

For the minor and married patients, both of whom reported being at approximately 7 weeks of gestation, the median cost of the procedure as reported by the staff member was $450 (IQR, $393–$485), with a range from $250 to $1,500. In most restrictive states, the reported cost was $413 (IQR, $382–$463), which was significantly lower than the reported cost in the least restrictive states ($475; IQR, $425–$500; $p = .01$). For the simulated patient at 15 weeks of gestation, the median reported cost was $750 (IQR, $600–$900), with a range from $398 to $4,200. The

reported cost at 15 weeks of gestation was lower in the least restrictive states ($650; IQR, $575–$875) compared with the most restrictive states ($817; IQR, $600–$945), although the difference was not significant ($p = .36$). In only eight calls (6%) did staff members offer any information about private abortion funds that could assist the simulated patient with paying for the abortion; three (4%) of these calls were to least restrictive states and five (8%) were to most restrictive states.

Overall, the median time needed to obtain an appointment was 2 days (IQR, 1–7), with one facility reporting a waiting time of 16 days. The median time was shorter in most restrictive states (2 days; IQR, 1–5) than in least restrictive states (3 days; IQR, 2–7), although this difference was not significant ($p = .07$). Overall, the median subjective attitude score was 7 out of 10 (IQR, 6–8). Three facilities received attitude scores of 5, which were considered to be negative attitudes toward the simulated patient; all were in least restrictive states. Despite this, the median attitude score was significantly better in the least restrictive states (7; IQR, 7–8) compared with the most restrictive states (7; IQR, 6–8; $p = .04$).

Discussion

Staff members provided highly accurate information regarding parental and spousal involvement laws, as well as highly accurate information regarding the presence and length of required waiting periods. This is expected, because parental involvement and waiting periods require documentation from facilities that provide abortion services. Accurate information regarding mandatory waiting periods is critical for abortion access, especially for women who live at greater distances from an abortion provider.

Surprisingly, despite providing highly accurate information regarding parental involvement laws, many facilities did not inform the simulated minor patient of her right to a judicial bypass. This study was unable to assess the impact this omission had on patient care. It is possible that not receiving this information caused minors to either not receive the care they desired or subjected them to dangerous situations when forced to involve a parent. This is especially important given the high incidence of unintended pregnancy among minors. In 2006, the estimated number of pregnancies among women aged 15 to 17 was 246,250 (Kost, Henshaw, & Carlin, 2010); 79% were unintended (Finer & Zolna, 2011).

Research by Helena Silverstein (2007), which is described in her book *Girls on the Stand: How Courts Fail Pregnant Minors*, has shown that the judicial bypass system is flawed. The bypass option was originally developed because it was recognized that some teens would be in danger if subjected to complete oversight of their reproductive choices by their parents. Although Silverstein states this compromise was made with good intentions, it assumes that the laws will be implemented in a reasonable way. This ignores the fact that the legal system is affected by politics and constitutes what Stuart A. Scheingold has called "the myth of rights." Unfortunately, Silverstein has proven that from a minor's perspective, her right to a judicial bypass is not apparent. Silverstein and her colleagues contacted all 222 county courts that handle petitions for judicial bypass in Alabama, Pennsylvania, and Tennessee between 1997 and 2002. Of these, 100 (45%) demonstrated substantial or complete ignorance about the bypass system, or expressed considerable doubt about its existence. Although it is possible that staff members omitted information about the option of judicial bypass because they are aware of its inherent problems, women should be informed about their right to a bypass, even if that means that the staff member explains that the process is difficult. The findings of this study suggest that women are not receiving information about the judicial bypass system, and thus efforts should be made to improve the information that is provided regarding judicial bypass.

Very few staff members (6% of calls) offered the simulated patient information about private abortion funds that could assist her in paying for an abortion. If asked, the simulated patient stated that she was covered by BlueCross BlueShield, although the minor and the married simulated patients stated that they did not want to use their coverage for privacy concerns. In these cases, information about private abortion funds should be offered. Although the simulated patient did not record whether she offered information about her insurance coverage, it is possible that in cases where she did, the staff member assumed that because she had private insurance coverage she would not qualify for abortion funds. Staff members should not make this assumption, especially in the most restrictive states where insurance coverage tends to be more limited, because abortion is increasingly concentrated among low-income women (Jones & Kavanaugh, 2011).

The median subjective attitude score was 7 out of 10, and only three phone calls were classified as negative by the simulated patient. In these cases, the staff member sharply corrected the simulated patient after she called the private office a 'clinic,' used an unkind tone of voice, or was unhelpful or seemed uninterested in the simulated patient. The staff members who scored the highest attitude scores were those who used a kind tone of voice and took the time to answer all the questions of the simulated patient and explain all aspects of the abortion process, were reassuring, and often gave their name and encouraged the simulated patient to call back if she had any additional questions or if there was anything else the staff member could help her with.

This study has several strengths. This study is the first, to our knowledge, to assess the accuracy of information provided to women seeking abortion services in the United States. By using a simulated patient, the study was able to imitate real-life experiences that otherwise would have been unobservable. The variation between calls was minimized by using a single caller posing as the simulated patient. In addition, three scripts were developed in an attempt to standardize the questions asked by the simulated patient.

This study is subject to several limitations. First, the practice types of facilities were not recorded to maintain provider privacy. Thus, the study could not assess whether accuracy of information differed by practice type. Second, all of the abortion providers that were contacted are members of NAF, and they may not be representative of all abortion providers in the country. Because of their membership in NAF, these facilities may be better equipped to provide accurate information about laws and policies than providers who are not members of NAF. Thus, these findings could overestimate the accuracy of information provided at facilities throughout the country. Third, some states passed new abortion laws and policies during the study period, which may have raised awareness of laws and policies throughout the state. This was not taken into account when comparing the least restrictive and the most restrictive states because this was a descriptive study designed to assess the information that patients receive in the real world. Finally, this study was not designed to assess the accuracy of knowledge provided by front-line staff of facilities that do not provide abortion services. It is

possible that staff members who work at these facilities may be less likely to provide patients with accurate information about abortion services, either because they are unaware of the laws and policies or because they do not support a patient's decision to have an abortion.

Implications for Practice and/or Policy

These findings are relevant to the concern that facilities that provide abortion services are not following laws and policies that restrict abortion services. In response to this concern, Americans United for Life is currently calling on Congress to "hold hearings into Planned Parenthood's operations, its use of taxpayer funding, and its potential violations of state and federal law" (Americans United for Life, 2011). Although there were a few cases where incorrect information was given, it is likely that these inaccuracies would have been corrected when the patient presented to the facility. In only one call was the simulated patient led to believe that the state laws and policies were less restrictive than they actually were; the remaining six calls containing inaccuracies implied that the laws and policies were more restrictive. In no cases did the staff member give any indication that the facility was willing to disregard state laws and policies for the benefit of the simulated patient.

To ensure that the ever-changing array of abortion laws and policies are followed, and that patients receive accurate information about the restrictions placed on their care, resources should be developed to assist reproductive health care providers. The number of abortion laws and policies introduced into state legislatures and subsequently enacted has grown enormously, and even individuals who are interested in these issues may struggle to follow the numerous developments. Thus, it is unlikely that individual patients will be aware of the state laws and policies concerning abortion before seeking services. Each time a state passes a new law or policy concerning abortion, reproductive health care facilities should be made aware of the new laws so that all clinicians, front-line staff members, and patients can be informed. This information could be provided in writing, especially for patients. For front-line staff, information on state laws and policies could be provided during routine training; for clinicians, information could be incorporated into credentialing. School counselors and social workers, who may work with young women who have unintended pregnancies, could also be provided with these resources.

No differences were found between the most restrictive and least restrictive states. Although staff members at facilities that provide abortion services are highly competent in providing accurate information regarding the state laws and policies, it cannot be concluded that dealing with new laws and policies is easy. The actual challenges that these laws and policies create for abortion providers remain unknown and are an area for future research. The political climate continues to focus on abortion, and there is no reason to believe that the pace of newly proposed laws and policies restricting access will slow in the near future.

It is important that women seeking abortion services receive accurate information from front-line staff so they are able to access services in a timely manner. Although clinicians, practice owners, and administrators are responsible for ensuring that their front-line staff can accurately communicate the relevant laws and policies to patients, receiving inaccurate information from front-line staff members does not imply that the laws are not being followed at those facilities. Instead, this work demonstrates that although overall information regarding state abortion laws and policies is highly accurate, there is room for improvement, particularly in the area of judicial bypass. Even in practices with accurate general information, staff members should be reminded of a minor's right to a judicial bypass in states with parental involvement laws. All clinicians, practice owners, and administrators at facilities that provide abortion services should ensure that their staff knows the laws and policies and is able to accurately communicate these laws to patients.

Acknowledgments

This project was conducted with grant support from the Harvard University William F. Milton Endowment. We are grateful to Dr. Milton Kotelchuck for his valuable assistance in the development of this project and to Aaron Sidney Wright for his thoughtful review of the manuscript.

References

Americans United for Life. (2011). *The case for investigating Planned Parenthood: AUL looks behind the closed doors of the nation's largest abortion provider*. Washington, DC: Author.

Dodge, L., Haider, S., & Hacker, M. (2012). Using a simulated patient to assess referral for abortion services in the United States. *Journal of Family Planning and Reproductive Health Care*. 2012 Jan 16. [Epub ahead of print].

Finer, L. B., & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception*, 84, 478–485.

Guttmacher Institute. (2008). An overview of abortion in the Unites States. Accessed from: http://www.guttmacher.org/

Guttmacher Institute. (2010). *State policies in brief: An overview of abortion laws*. Accessed from: http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf

Guttmacher Institute. (2012). States enact record number of abortion restrictions in 2011. Accessed from: http://www.guttmacher.org

Jones, R. K., & Kavanaugh, M. L. (2011). Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstetrics and Gynecology*, 117, 1358–1366.

Jones, R. K., & Kooistra, K. (2011). Abortion incidence and access to services in the United States, 2008. *Perspectives on Sexual and Reproductive Health*, 43, 41–50.

Kost, K., Henshaw, S., & Carlin, L. (2010). U.S. teenage pregnancies, births and abortions: National and state trends and trends by race and ethnicity, 2010. Accessed from: http://www.guttmacher.org/pubs/USTPtrends.pdf

Lee, S. J., Ralston, H. J., Drey, E. A., Partridge, J. C., & Rosen, M. A. (2005). Fetal pain: A systematic multidisciplinary review of the evidence. *JAMA*, 294, 947–954.

Moore, A. M., Frohwirth, L., & Blades, N. (2011). What women want from abortion counseling in the United States: A qualitative study of abortion patients in 2008. *Social Work in Health Care*, 50, 424–442.

Planned Parenthood of Central Missouri v. Danforth. 31 Jan 1975. (1975). *Federal Supplement*, 392, 1362–1379.

Planned Parenthood of Southeastern Pennsylvania v. Casey. (1993). *Federal Supplement*, 822, 227–239.

Silverstein, H. (2007). *Girls on the stand: How courts fail pregnant minors*. New York: New York University Press.

National Abortion Federation (NAF). (2010). How can I find a provider near me? Accessed from: http://www.prochoice.org

Author Descriptions

Laura E. Dodge, MPH, is a clinical research assistant in the Department of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center. She is currently pursuing a doctorate in epidemiology at the Harvard School of Public Health.

Sadia Haider, MD, MPH, is an obstetrician-gynecologist who specializes in family planning. Her domestic research interests include access to abortion and contraception, and her global research focuses on reproductive health and family planning, especially within conflict and post-conflict settings.

Michele R. Hacker, ScD, MSPH, directs the Program in Epidemiological Research in the Department of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center. She is also an Assistant Professor at the Harvard School of Public Health and at Harvard Medical School.