'The Biggest Problem With Access': Provider Reports of the Effects of Wisconsin 2011 Act 217 Medication Abortion Legislation

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ABSTRACT

Introduction: Abortion legislation in the United States determines people's access to services, including the abortion modality of their choice. In 2012, Wisconsin legislators passed Act 217, banning telemedicine for medication abortion and requiring the same physician to be physically present when patients signed state-mandated abortion consent forms and to administer abortion medications over 24 hours later.

Objective: No research documented real-time outcomes of 2011 Act 217 in Wisconsin; this study documents providers' descriptions of the effects of Wisconsin abortion regulations on providers, patients, and abortion care in the state.

Methods: We interviewed 22 Wisconsin abortion care providers (18 physicians and 4 staff members) about how Act 217 affected abortion provision. We coded transcripts using a combined deductive and inductive approach, then identified themes about how this legislation affects patients and providers.

Results: Providers interviewed universally reported that Act 217 negatively affected abortion care, with the same-physician requirement especially increasing risk to patients and demoralizing providers. Interviewees emphasized the lack of medical need for this legislation and explained that Act 217 and the previously enacted 24-hour waiting period worked synergistically to decrease access to medication abortion, disproportionately affecting rural and low-income Wisconsinites. Finally, providers felt Wisconsin's legislative ban on telemedicine medication abortion should be lifted.

Conclusions: Wisconsin abortion providers interviewed underscored how Act 217, alongside previous regulations, limited medication abortion access in the state. This evidence helps build a case for the harmful effects of non–evidence-based abortion restrictions, which is crucial considering recent deferral to state law after the fall of *Roe v Wade* in 2022.

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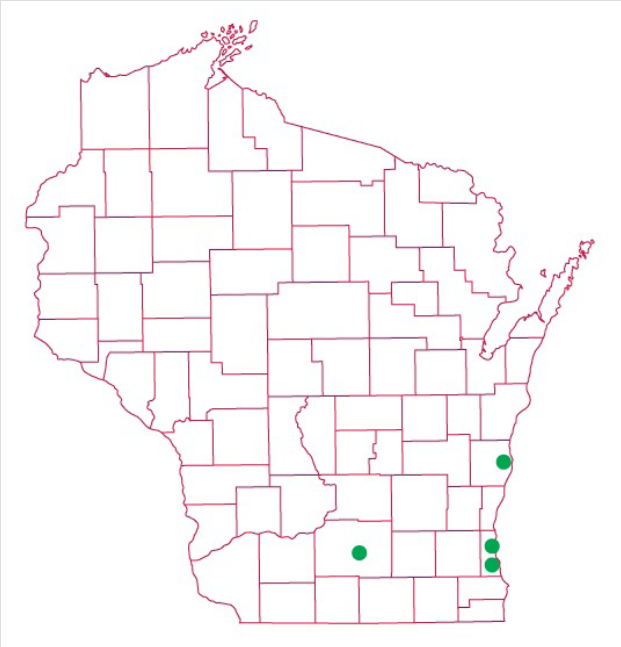
INTRODUCTION

Abortion care in the United States is at a crossroads amid changing national precedent. Increasingly, state laws rather than federal laws dictate circumstances under which people can obtain abortions.[1] Research must document how state-specific legislation affects abortion access:[2] Wisconsin's case can reveal consequences of specific medication abortion regulations.

Medication abortion using misoprostol and mifepristone is safe and effective.[3] In some settings, patients can choose between in-clinic "surgical" abortion (though in-clinic abortion does not involve surgery) and medication abortion. Few have estimated US patients' true preferences amidst limited options,[4,5] but in 2014, 45% of abortions in the United States were medication abortions, a proportion that has likely increased over time.[6] When legal and accessible, the mortality risk for abortion overall is at least 14 times lower than childbirth.[7] Over 99% of medication abortions and in-clinic abortions before 13 weeks of gestation have no adverse effects.[6,8] Federal mandates restrict pharmacists from dispensing medication abortion.[1] However, medication abortion can be administered safely through telemedicine[9]—key in states with high COVID rates, few abortion providers, and widely dispersed populations. In Wisconsin, some of the most restrictive legislation in the country has dictated how patients and providers experience abortion care.

In 2012, Wisconsin legislators passed and enacted *2011 Act 217*, containing multiple stipulations about how providers could offer medication abortion care. The bill's sponsor said it would

Figure. Locations of Clinics That Provided Abortion Services in Wisconsin, 2019



protect the "health and safety of women;" however, no evidence supports this claim.[10] Act 217 followed several other abortion restrictions enacted after Wisconsin's 2010 election, laws that contributed to closures of 40% of Wisconsin abortion clinics between 2010 and 2017.[11] In 2019, 4 abortion clinics remained, clustered in the southern quarter of Wisconsin; 3 provided medication abortion (see Figure). Act 217 compounded existing regulations by requiring the same physician be physically present when state-mandated abortion consent forms were signed and to administer abortion medications over 24 hours later. No corollary law existed for physicians providing in-clinic abortions. Act 217 also banned medication abortion provision via telemedicine; in 2020, 17 other states also required a physical clinician to provide medication abortion, although research suggests telemedicine is safe, effective, and often patient-preferred.[3,9,12,13]

No research to date examines how Wisconsin regulations specifically affected medication abortion care and access. Studies documenting the impact of all abortion restrictions are important; our team turned to Act 217 given its relative severity. While many other states impose non–evidence-based restrictions on medication abortion care, Wisconsin's law involved considerable stipulations. Wisconsin legislation created one of the most restrictive medication abortion environments nationwide at the time. Thus, evidence about this law's effects could be useful in the context of changing restrictions about medicine, from telemedicine to abortion. We documented Wisconsin abortion care providers' reports of how Act 217 influenced patient care.

METHODS

Because this study focused on the understudied effects of legislation on abortion provision, we chose a qualitative methodological approach to ask why, how, and under what circumstances.[14] Between May and October 2020, 3 researchers recruited health care professionals who were currently providing or had recently provided abortion care in Wisconsin. Using snowball sampling and professional networks, the team invited providers via phone, email, or text message to participate in an interview. While recruitment focused on physicians since only physicians could provide abortions in Wisconsin in 2020, the team also recruited other abortion health care providers. Many interviewees had abortion care experience in Wisconsin before the implementation of Act 217, providing comparative perspectives.

Our orientations and experiences, as an MD abortion provider, PhD researcher with decades of experience in abortion research, and two health professions students with experience working at abortion clinics, informed research design, analysis, and triangulating findings. This team compiled the interview guide to elicit providers' descriptions of how Act 217 and intertwined legislation in Wisconsin affected abortion provision, particularly of medication abortion. The semistructured interview guide included questions about abortion care, medication abortion, abortion policy, COVID-19 in abortion care, and *Roe v Wade*. A trained interviewer conducted and recorded all interviews over WebEx. She obtained informed consent before every interview, took notes throughout, and prepared 2- to 3-page post-interview memos. Interviews lasted 30 to 60 minutes, and participants received a $75 gift card upon completion. The team ceased recruitment after reaching theoretical saturation.

Each participant received a unique study number and pseudonym. A professional transcription service transcribed interview recordings. Using NVivo 12 (QSR International Pty Ltd, Australia, 2019), 2 independent coders built consensus themes using a combined inductive-deductive approach. To ensure methodological rigor and research integrity, we completed the Standards for Reporting Qualitative Research checklist.[15]

RESULTS

The final sample included 22 abortion care providers: 18 physicians, 2 nurses, and 2 surgical technicians. All providers and staff members worked at freestanding abortion clinics; the majority of providers worked there part time. Interviewees lived across Wisconsin when they provided services. Further identifying information is not provided here for participant anonymity. Interviewees universally expressed that Act 217 and its contingent regulations negatively affected abortion care. The research team identified the following 4 main themes about related but distinct effects of this policy.

1. Providers found the same-physician requirement especially burdensome.

Act 2017 required that the same physician consent the patient and then provide and watch the patient take the medication, 24 or more hours later. Many providers expressed that, at the time of their interview, the same-physician restriction was the most burdensome abortion restriction in Wisconsin. One noted that it

both required patients to base the timing of their care on one provider's availability and was inconsistent with other care:

"To use the pill, the same doctor has to be the same person doing it; whereas if a woman decides to have the surgical, any of the other doctors can do that procedure. So what, where's the consistency in that? And so I would say that it's the [...] single biggest problem."

Another provider highlighted how, instead of protecting pregnant people, the law limited their autonomy. Since different providers could consent and later provide in-clinic abortions, some patients "would be forced" to have in-clinic abortions due to provider timing, despite having originally wanted medication abortions:

"People would come in on the day of counseling, and they would actually wish that they could get a medication abortion, but their schedule wouldn't line up to come back and see me, and so they would be forced to choose an in-clinic […] it really limited their access to medication abortion."

Many providers worked only one full or half day per week at an abortion clinic. The same-physician law meant patients were required to wait until that provider returned to the clinic, a timeline that could vary from one to many weeks. Such delays in care put some patients outside of the gestational age range for medication abortion:

"I saw many times that women were obligated to having [sic] a surgical procedure when they really had hoped to have a medical procedure because there wouldn't be a provider there twice before they became too far in gestational age to qualify for the medication abortion."

Finally, one provider expressed the burden of the same-physician law on physicians and staff:

"We have tried to minimize the impact on the patient. But that's often really at the expense of the physician and the health care staff trying to do whatever they can. I've had days when I'm post-call that then I try to come in to see a patient so they can have their pill."

This provider, among others, described going above and beyond normal duties, including working on days they are not scheduled to ensure that their patients receive care. Ultimately, providers painted a picture of overwork, frustration, and burnout from the same-physician law specifically and Act 217 overall.

2. Providers emphasized the lack of medical evidence or clinical rationale for Wisconsin's abortion restrictions.

Many providers explained that, in addition to causing burden, the same-physician restriction was not evidence-based or best medical practice:

"Two separate visits. Not evidence-based. Not necessary to provide safe care, as evidenced by all the other states that [don't] have it, as evidenced by the state of Wisconsin before that law was enacted."

Interviewees often mentioned the inconsistency of the same-physician requirement in abortion care, as other medical procedures do not require the same physician to both consent for and provide care. One provider expressed how Act 217 and contemporaneous regulations led to longer waits for abortions, undermining safety and quality of care:

"All of these regulations, none of them make sense. None of them are useful or promote a more safe procedure or a healthier procedure. It would clearly be better if the day the woman walked into the clinic, [...] she could have an abortion that day, she would have a safer abortion than if you make her wait."

Finally, one provider explained how Wisconsin abortion restrictions, including Act 217, did not aim to ensure best medical care:

"I think about some of the restrictions on providing that care safely that did not seem to be really about providing the best medical care but were obvious barriers to women and impositions from the legislature into the patient-doctor relationship. The intent was to interfere with the patient-doctor relationship, and it was being hidden under the guise of caring about women."

3. Providers reported that alongside the mandated 24-hour waiting period, Act 217 decreased access to medication abortion, especially for rural and low-income Wisconsinites.

Providers expressed that Act 217 and previously instated restrictions disproportionately affected rural and low-income pregnant people. One stated:

"For women who have to drive sometimes 2, 3, even 4 or 5 hours to a clinic appointment, need to take time off work, need to find childcare, need to explain to family and friends why they need to do these things, it really is a barrier to being able to access a safe form of abortion that I think could be more accessible to women if there weren't legislative barriers."

Providers knew the hours added up for rural Wisconsinites, especially since abortion care in Wisconsin was available only in one corner of the state.

"[Act 217] presents a tremendous, not just inconvenience, but a barrier for women who drive 3 and 4 hours [...]to sign a consent and then come back and take a pill and then [...] have to come back a third time for a follow-up."

Another provider outlined how they saw marginalized people in Wisconsin, including poor people, rural residents, and people of color, struggle the most under abortion restrictions:

"There's so many barriers for poor women. Women of color are disproportionately affected as well, because they make up a disproportionate amount of poor women. In terms of accessing care, paying for care when insurance doesn't cover it, childcare, and work, taking time off work and having to make multiple visits... Rural women [..] are terribly affected."

Some providers mentioned their concern that people who "are pregnant and in dangerous situations," including abuse, also had a more difficult time accessing high-quality care under Act 217:

"They have to balance so many factors, from the legal end of what we're telling that patient, of when she has to return and what she has to do, to when she may be able to leave the house or fit that in or be able to make that happen in a safe way. [Accessing abortion may be] the key for her to be able to get out of the relationship."

4. Providers argued that the telemedicine ban on medication abortion provision should be lifted, especially during the COVID-19 pandemic.

Interviews were conducted before COVID vaccines were available; providers shared that COVID-19 revealed ways that limitations on medication abortion provision harmed both patients and providers, particularly given unnecessary requirements for multiple in-person appointments. One interviewee summarized:

> *"[The impact of Wisconsin abortion restrictions] was especially highlighted during COVID-19. [... I feel] the pressure of gosh, I have a cold. How bad is that cold? Should I just go to work? During COVID-19 [...] you shouldn't go to work. [...] But if I don't go to work, that means the women that I saw a week ago—who are counting on me to be able to have their medication abortion—can't have it. So it's a terrible place to be in as a provider, to feel like I can't not go to work."*

This provider experienced moral distress: abortion legislation shaped their ability to provide medical care. Another interviewee explained that legislators could solve this moral distress by lifting the ban on telemedicine for medication abortion provision. They explained how telemedicine would confer benefits to women's health, amidst COVID and generally:

> *"Providing quality medication abortion services by physicians and other trained providers via a telehealth platform would be something that would be a real positive force in public and population health in Wisconsin... if we really want to take care of women, it would be important to them to work to be able to make these services more accessible."*

Finally, providers argued that the prohibition on telemedicine, in conjunction with other Wisconsin regulations, prevented clinics from providing abortion care in the safest way possible during a pandemic:

> *"Our 24-hour, same physician, our physician only, our ultrasound law, our parental consent—all of these things. Whereas other states have been able to not only protect their patients and their staff and everyone else by working towards less contact during a time of COVID, we haven't been able to do any of that because our laws force us to do what has now become inherently unneeded but unsafe things to continue to abide by medically unnecessary restrictions."*

DISCUSSION

Findings from this study indicate that Act 217, alongside previously instated regulations, limited physicians' ability to provide evidence-based abortion care in Wisconsin. Participants argued that people from racial and ethnic groups who have been historically oppressed, as well as rural and low-income residents, bore the brunt of this legislation, which providers underscored as non–evidence-based. No provider indicated that Act 217 specifically, or Wisconsin's abortion restrictions generally, improved or protected patient care or health. Interviewees also emphasized that Act 217's telemedicine ban caused unnecessary barriers to care.

Wisconsin's Act 217 implemented some of the most restrictive medication abortion regulations in the country at the time. State-level abortion policy is especially important given changing national precedent and subsequent deferral to state law; evidence is needed in judicial responses to changing state laws.[16] Rich research has elucidated effects of state-specific abortion legislation in other states,[1,13,17,18] but few studies have been qualitative[19–21] and none to date studied providers and legislation in Wisconsin. This research contributes empirical details about providing abortion care amidst restrictive legislation, which may help inform research and practice in areas where new or shifting laws affect abortion provision in unexpected ways.

Our findings underscore telemedicine's key role in medication abortion provision, especially considering the ongoing COVID-19 pandemic and dwindling number of abortion clinics. Interviewees emphasized that, when they were interviewed, many Wisconsin residents already traveled 100 miles or more to access abortion.[22] The effect of distance, providers explained, fell disproportionately on disadvantaged Wisconsinites, especially those in rural areas. Telemedicine is widely used for other medical care, yet despite the preponderance of evidence on the safety and efficacy of telemedicine for medication abortion,[3,9,12,17,23] Wisconsin and 17 other states prohibited it.[24] Overturning these non–evidence-based laws would facilitate safe, effective, and equitable telemedicine medication abortion services.

While evidence from our study indicates that one act significantly limited abortion care, results also underscore the cumulative effect of Act 217 and previously existing abortion restrictions, making accessing abortion care difficult for many—especially those oppressed due to race, geography, and socioeconomic status. While for legislative purposes we researched the effects of one unstudied law, further research should focus on legislation's holistic effects.

Results highlight the consequences of abortion restrictions on providers themselves and the health care workforce. Providers often tried to protect patients from antichoice legislative sequelae, but this had emotional and physical tolls. Future researchers should study provider dropout and burnout amid state-based abortion restrictions.

Limitations and Strengths

Limitations of this research include our oversampling physicians, which limited our conclusions about abortion care teams overall. Scholarship suggests that different types of providers have differing relationships to and opinions about abortion care work;[25] researching other providers' perspectives would be beneficial. However, because Wisconsin legislation only permitted physician provision of abortion in 2020, oversampling reflected who provided abortion care in Wisconsin. Data collection timing—during the first 6 months of the COVID pandemic—likely affected providers' perspectives but carried attendant advantages, revealing intersections of the pandemic with abortion restrictions.

Strengths include the timeliness of delineating some of the effects of Wisconsin abortion restrictions, especially Act 217, given pending lawsuits at the time of data collection. We sought

provider perspectives; health care professionals are exposed to day-to-day effects of legislative barriers, and we additionally asked providers how they thought laws affected patients. Finally, while we focused on one specific law, our study narrates what at the time were maximal legislative barriers, which can help researchers and clinicians across the United States plan for abortion provision in changing legal landscapes.

CONCLUSIONS

In this study, Wisconsin abortion providers detailed how Act 217, in conjunction with previous regulations, dramatically limited medication abortion access in the state. Providers described how people who had already struggled to access abortion—like people with low incomes, people of color, and rural Wisconsinites—experienced even more obstacles as a result of this law. This study provides evidence that Act 217 and overlapping legislation, often justified by suggesting they protect the "health and safety of women" but are not based in scientific evidence,[10] worsened patients' abortion access and care. Act 217 prevented Wisconsin physicians from following medical best practice for their patients or following their patients' preferences in abortion modality. Our research, which describes the impact of state-specific legislation on abortion access and provision, is paramount considering recent changes to national precedent and subsequent deferral to state law. The fall of *Roe v Wade* in 2022 means that abortion care has ceased in Wisconsin for the immediate future, but legal challenges will continue. Findings from this study and others can help build a crucial, implementable evidence base as policy change unfolds.

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