Informed Consent and Free Speech: Are CPCs causing harm in young women with low health literacy by not giving them all the options?

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Abstract

Reproductive autonomy in the United States is being challenged. The 2022 overturn of *Roe v. Wade* brought more media attention to crisis pregnancy centers (CPCs) and other anti-abortion movements, leading to more cases that limit access to abortion through pathways like focusing on informed consent, ultimately leading to lessened bodily autonomy. The overturn of Roe serves as a crucial turning point in reproductive health resource access in the United States, and legislative backlash towards the provision of abortion nationwide indicates the urgency of this issue. CPCs imitate licensed health centers with limited services and aim to prevent women from seeking abortions. CPCs attract vulnerable pregnant individuals with the promise of free medical help but it is unclear if they provide enough information about all the options available, limiting a woman's right to make an informed decision about their healthcare.

A literature review on CPCs found that although CPCs engage in many medically inaccurate practices while providing free pregnancy testing and ultrasounds, CPCs spread misinformation about reproductive health, such as abortion, emergency contraception, and STIs. CPCs are protected from court challenges on the grounds of freedom of speech, which doesn't address the malpractice issues commonly found in CPCs. These findings show a trend for judicial and legislative bodies to prioritize freedom of speech over ensuring the correctness of medical information provided in healthcare settings. Further review of the current North Carolina legislature about CPCs and abortion, and content review of CPC websites in Wake County, NC, found that CPCs are often supported by the state even though their misinformation challenges the bodily autonomy of women in North Carolina. It is recommended that, at minimum, the state of NC should reduce its support and medicalization of CPCs and increase the representation of abortion providers in state resource directories. Further, North Carolina could reduce the harm caused by unlicensed ultrasound use to further CPCs' anti-abortion agenda by creating a licensing or certification process for sonographers.

Introduction

With the overturn of *Roe v. Wade* in June 2022, reproductive freedoms in the United States have been limited. While this decision sparked widespread attention and debate, this is just one in a string of lesser-publicized rulings that infringe on reproductive freedoms. The overturn of *Roe v. Wade* lets states decide how to provide, classify, and discuss abortion—as a medical procedure versus an inherently political and moral act—and allows many states to outright ban abortion, turning others into political battlegrounds. One such battleground is North Carolina.

Since abortion became legal in the US in the 1970s, crisis pregnancy centers, or CPCs, across the country have dissuaded pregnant individuals from seeking abortion care. CPCs imitate licensed health centers offering free services but do not appear to provide women with all the options available. Further, state and national governments often appear to protect the rights of CPCs over pregnant individuals or abortion providers, impeding efforts to combat reproductive health misinformation (Hill, 2015; Reines, 2016). This literature review explores documentation on CPCs, including how CPCs may endanger public health, current laws protecting CPCs, and how to make their practices more ethical. A website content review of the CPC services and messaging in Wake County, NC estimates how prevalent CPCs are in North Carolina. Additional examination outlines what specific legislative actions can be used in NC to address the dissemination of inaccurate information by CPCs.

Methods

Literature on CPCs and misinformation was collected in July 2022 via the North Carolina State University (NCSU) Summon database, which pulls from all academic databases that NCSU can access. Keyword identification was refined and combined with the term ‘crisis pregnancy center’ to capture relevant documentation. Keywords included ‘Carolina,’ ‘NC,’ ‘misinformation,’ ‘disinformation,’ ‘state,’ ‘informed consent, ‘testing,’ ‘court,’ and ‘freedom.’ Sources met the following criteria to be eligible: (1) peer-reviewed; (2) full text online; (3) included ‘crisis pregnancy center’ and at least one other keyword as listed above; (4) published in the last ten years; (5) pertained to CPCs in the United States. If a source met all the criteria and was relevant to the topic of study, then it was included in the review. Four main

searches were conducted, as seen in Table 1.

Table 1: Literature Search Diagram

Search Term	Initial results	Criteria Met	Relevant	Final results
(crisis pregnancy centers) AND ((Carolina) OR (NC))	38	22	6	6
(crisis pregnancy centers) AND ((misinformation) OR (disinformation) OR (state) OR (informed consent))	555	321	50	6
(crisis pregnancy centers) AND ((misinformation) OR (disinformation) OR (state) OR (informed consent)) NOT (abortion)	371	230	11	3
(crisis pregnancy centers) AND ((testing) OR (court) OR (freedom))	124	59	21	9

Of the initial 1088 search results, 632 met inclusion criteria. Removing duplicates and those without topic relevance yielded 24 citable sources. Most sources were from the databases ScienceDirect, ProQuest, and Springer Link. After analyzing each of the 24 sources, four overarching themes were identified: what is a CPC, CPCs and medical misinformation, freedom of speech and CPC legislation, and legal attitudes toward CPCs vs. abortion providers. Additional sources from NC governmental websites were used to understand current laws on abortion and CPCs in NC and analyze if NC had any state-endorsed misinformation or CPCs. The findings from the literature review were then used to create a content review of CPC websites for CPCs based in Wake County, NC.

Results

What is a CPC

Current US estimates indicate that crisis pregnancy centers outnumber abortion providers three to one (Hutchens, 2021). CPCs are staffed by volunteers and occasionally licensed medical providers (Montoya et al., 2022), but engage in misinformed practices. The CPC's primary goal is to prevent abortions and attract women with the promise of free medical help, such as ultrasounds, only to give them biased information on top of the services they may have accessed (Borrero et al., 2019; Hutchens, 2021;

Kelly, 2012; Montoya et al., 2022). CPCs further try to prevent abortions via pushing single pregnant women to get married, promoting abstinence, and encouraging people to convert to evangelical Christianity (Kelly, 2012).

In their advertising—such as on websites and via the phone—CPCs tend to conceal their opposition to abortion to appeal to people who would avoid CPCs if they knew contraception and abortion services were not provided (Faria, 2012). Most CPCs are religious-based organizations (DiPietro, 2022) and while many CPCs claim independence, they are affiliated with anti-abortion groups, such as National Institute for Family and Life Advocates (NIFLA), Care Net, and Heartbeat International (Kelly, 2012). These larger organizations aid CPCs by giving them funding, free ultrasound equipment, and information or scripts for their counseling services (Kelly, 2012). However, many CPCs also receive grants from state governments for health and prevention services, as well as family planning services, despite not providing either (Borrero et al., 2019; Montoya et al., 2022; Society for Adolescent Health and Medicine, 2019; Thomsen, 2022). They are often found in state resource directories and framed as accessible, and licensed, medical providers for pregnant individuals (Hutchens, 2021; Society for Adolescent Health and Medicine, 2019; Thomsen, 2022).

Despite CPCs existing since the 1970s, most literature to date is from 2020, indicating that CPCs' practices have come under more scrutiny as reproductive rights have been challenged. The consensus is that they are unethical establishments, spreading medical misinformation and undermining women's bodily autonomy while posing as accessible and comprehensive clinics, but forgoing informed consent; CPCs have been denounced by numerous medical organizations, including the Society for Adolescent Health and Medicine, the North American Society for Pediatric and Adolescent Gynecology, and the American Medical Association (Queen, 2020; Society for Adolescent Health and Medicine, 2019). In recent years, many CPCs have tried to become more medicalized, offering ultrasounds and a licensed medical provider on staff (Hutchens, 2021). However, ultrasounds, in particular, are leveraged to mislead pregnant women on gestational age and fetus viability. In addition, CPCs employ ultrasounds to emotionally manipulate women into rejecting abortions (Hutchens, 2021).

CPCs and Medical Misinformation

Almost all CPCs advertise on their websites that they provide pregnancy testing and pregnancy options counseling, but more than half fail to mention that they do not offer or refer for abortion services (Swartzendruber et al., 2018). Additionally, most CPCs do not mention or perform referrals for contraception; when they do, it is often limited to abstinence and natural family planning, which is unrealistic and highly ineffective (Montoya et al., 2022; Swartzendruber et al., 2018). Since the alleged goal of CPCs is to lower abortion rates, the "rejection of evidence-based medicine is counterintuitive" and causes harm to individuals that need free care and services (Polcyn et al., 2020, p. 225).

CPCs routinely share reproductive health misinformation, the most common falling into one of three categories: emergency contraception (EC), STIs, and abortion. CPCs often directly refer to emergency contraception as an abortifacient (Narasimhan et al., 2013; Swartzendruber et al., 2018). In an analysis of 254 CPC websites, 20% contained medically inaccurate information on EC, claiming it was an abortifacient (Narasimhan et al., 2013). In an analysis comparing 89 Georgia CPCs to 90 family planning clinics, 70% of legitimate clinics recommended EC use while only 7.9% of CPCs did; 46.1% of CPCs discouraged the use of EC, citing safety concerns and claiming it was an abortifacient (Solsmsn et al., 2021). Additionally, information about the timely initiation of EC was only provided by 10.1% of CPCs (Solsmsn et al., 2021). These findings indicate that many CPCs mislead individuals about the risks and effectiveness of EC, encouraging them to delay EC, thereby postponing patients' use of EC until it is no longer effective.

Of all the misinformation that CPCs engage in, abortion misinformation is the most prominent (Bryant et al., 2014). Most commonly, they engage in psychological tactics to confuse and scare women into not seeking an abortion (Hutchens, 2021). These include but are not limited to: claiming the pregnancy is probably not viable, incorrectly identifying gestational age, using words such as mom and baby when administering ultrasounds, giving inaccurate information about potential complications from abortion, and advertising abortion reversal procedures (ACOG Issue Brief, 2022; Hutchens, 2021; Polcyn

et al., 2020). Abortion reversal is not a medically proven procedure, but CPCs often purport that it is. Abortion reversal messaging targets women who have taken the first pill for a medical abortion but not the second and is done by administering an incredibly high dose of progesterone to counteract the initial medication. Advertising abortion reversal is another contradiction by CPCs since many of them claim that the comparatively lower dose of progesterone in EC is dangerous and can negatively affect one's body (ACOG Issue Brief, 2022; Narasimhan et al., 2013).

The most common misinformation on abortion links the procedure to mental health issues, breast cancer, and infertility (Bryant et al., 2014; Polcyn et al., 2020). A study done on CPCs in NC found that of the 32 CPCs that could be contacted by phone, 44% claimed to provide counseling on abortion and its risks, 16% linked abortion with breast cancer, 26% linked abortion with infertility and mental health problems, and 72% linked abortion to "post-abortion stress" or PAS (Bryant and Levi, 2012). CPCs perpetuate the myth of the mental disorder PAS, which is not recognized by the DSM (Bryant et al., 2014). CPCs claim that PAS occurs after abortion and is marked by regret, depression, and anxiety (Bryant et al., 2014). However, multiple studies have demonstrated that women denied abortion services are far more likely to have these negative mental health symptoms than women who got abortion services when they wanted them (Bryant et al., 2014**).**

Not providing accurate information on and testing for STIs, while simultaneously advocating for abstinence, and being against condom usage creates a very high-risk environment for vulnerable populations seeking care and medical advice from CPCs. As of 2019, CPCs can get Title X funding for family planning and reproductive health services (Swartzendruber and Lambert, 2020). Title X funding is intended to provide funding for family planning and reproductive health care services so these services can be accessed even when people may not have the ability to pay for them. For some patients, Title X funded clinics are their only source of healthcare and health education (HHS, n.d.). Providing clinics, such as CPCs, that spread misinformation with Title X funding allows CPCs to capitalize on individuals who lack the health literacy to understand their options. One vital service that Title X funding helps clinics provide, especially for organizations that target young people, is STI testing since young people

are at a disproportionate risk of getting STIs (Swartzendruber et al., 2020). However, in a study of 2,539 CPCs, only 11.8% advertised STI treatment on their websites, only 8.9% provided a referral for STI treatment, and even fewer provided HIV testing and referrals (Swartzendruber et al., 2020).

Freedom of Speech and CPC Legislation at the National Level

The most high-profile case regarding the regulation of CPCs is the 2018 Supreme Court case *National Institute of Family and Life Advocates (NIFLA) v. Becerra*. NIFLA is one of three large religious organizations that helps to fund and run many CPCs. The *NIFLA v. Becerra* case was about California's Reproductive FACT Act, which regulated clinics providing "pregnancy-related services," including crisis pregnancy centers. The act required licensed centers to notify women that California offers free or low-cost reproductive health services, including abortion, and required unlicensed crisis pregnancy centers to disclose that their services are not provided by licensed professionals (Parmet et al., 2018). After the FACT act was enacted, multiple CPCs associated with NIFLA challenged the law on first amendment grounds. The district and appellate courts denied the request because the FACT act regulated professional, not private, speech. However, when the case reached the Supreme Court, the ruling was reversed, and the court struck down the FACT act as unconstitutional (Parmet et al., 2018).

The American Medical Association (AMA) disagreed with the *NIFLA* decision because the state of California FACT Act was intended to regulate unethical medical practices by CPCs with licensed medical providers (Queen, 2020). The AMA's stance on professional speech regulation in medicine is that "strict scrutiny should be applied when governmental entities attempt to legislate speech acts between physicians and patients. Such regulations can further the government's political objectives… can interfere with a physician's right to speak, and can obstruct the AMA's self-regulatory efforts toward the ethics of medical practices" (Queen, 2020, p. 81). Protection of speech does not undermine the government's ability and duty to promote public health.

There is a certain duality of infringing on the free speech of abortion providers while protecting the dissemination of misinformation by CPCs, as exemplified by various cases in the past two decades.

Specifically, this phenomenon can be seen in two high-profile abortion provider buffer zone cases, *McCullen v. Coakley* and *Hill v. Colorado*.

In 2000, after many altercations between abortion opponents and proponents outside of abortion clinics, Massachusetts created a law to make an 18-foot buffer zone outside of abortion clinics where no one "could knowingly approach within six feet of another person – unless that person consented – for the purpose of passing a leaflet or handbill to, displaying a sign to, or engaging in oral protest, education, or counseling with such other person" (Reines, 2016). After complaints of this law being unenforceable, a 2007 revision was made, extending the buffer zone radius. Some opponents of abortion claimed this violated their first and fourteenth amendment rights, and thus the case of *McCullen v. Coakley* was created in 2008. Both the lower courts upheld that the law was constitutional; however, the Supreme Court reversed this decision claiming that it was not narrowly tailored in wording to the government's interest, the regulation burdened more speech than was necessary to further the government's interest, and Massachusetts had other options that would not have limited speech as much (Reines, 2016). Thus, in *McCullen v. Coakley,* the Supreme Court ruled in favor of pro-life protestors' right to free speech over patients' right to safety and security.

Hill v. Colorado is a similar case to *McCullen v. Coakley.* The state of Colorado passed a buffer zone law to protect patients visiting abortion providers from unwanted contact with protestors. However, unlike the decision in *McCullen v. Coakley*, when the Colorado law was challenged, the Supreme Court ruled that it was constitutional because its wording was more specific and narrowly tailored (Reines, 2016). The difference between these two cases shows that a law must be extremely carefully worded to pass the Supreme Court's first amendment scrutiny. These findings indicate that the lower courts prioritize safety concerns over broad free speech concerns. In contrast, the Supreme Court ruling indicates that, in cases dealing with controversial topics, more consideration was given to free speech than safety and bodily autonomy.

Informed Consent: CPCs vs. Abortion Providers

Government entities have repeatedly protected CPCs' right to spread their ideological misinformation, yet the same reasoning is used to erode access to comprehensive, evidence-based reproductive care (Gottesdiener, 2020). Under the guise of informed consent, state governments compel physicians' speech by requiring anti-factual pre-abortion scripts, called "Women's Right to Know Laws" (Hill, 2015). However, informed consent is a staple of modern medical practice. Its central premise is that physicians should give all relevant information to patients, including side effects and alternative procedures, to the best of their professional ability and medical standards (DiPietro, 2022). Decisions like *NIFLA* and the enactment of "Women's Right to Know Laws" demonstrate that unlicensed medical providers, such as CPCs, have more protection under the First Amendment than actual physicians, that are licensed by the state and trusted in many other areas to exercise sound professional judgment (Hill, 2015).

As stated by Reines (2016, p. 200), "the fact that the right to free speech is explicit in the text while reproductive rights are implicit cannot be used as a valid justification for weighing free speech concerns more strongly than reproductive rights. To do so would dismantle… the basis for much of American law." Reines (2016) statement indicates that privileging one group's right to free speech while that group is actively trying to undermine another group's right to bodily autonomy is not just. Further, abortion is healthcare, and *NIFLA* using free speech claims to justify protecting CPCs over medical professionals, makes it seems as if the court and legislature do not see reproductive health procedures as healthcare.

State-Funded Harm in NC

The reproductive rights of North Carolinians are in jeopardy. In NC in 2012, CPCs outnumbered abortion providers by a ratio of four to one, although the ratio disparity may vary on a county level and may have since increased (Bryant and Levi, 2012). Since 2011, NC has had the "Woman's Right to Know Act" in place, the baseline goal of which is to ensure pregnant individuals give informed consent for the procedure. Its provisions include a 72-hour waiting period between consultation and abortion procedures, a requirement that an ultrasound must be performed and described at least four hours before the

procedure, and listening to potential side effects that are not medically accurate ("Woman's Right to Know Act," 2011). It is also notable that the text of the bill uses the term “unborn child” instead of fetus when describing the pre-abortion “informed consent” requirements, further using emotionally evocative, rather than medically accurate, language. This bill also allowed the state government to support CPCs, called pregnancy care centers in the bill. These provisions are supposed to ensure that women obtaining an abortion have provided informed consent, but the motivation is to dissuade women from seeking the procedure and to encourage them to not get an abortion (Kelly, 2012). This bill uses compelled speech against licensed medical providers that perform abortions. Meanwhile, it encourages and legitimates the services provided by CPCs. Since the bill's implementation, CPCs have been listed in the state resource manual for pregnant individuals. However, family planning clinics that offer comprehensive care, including abortion, are excluded from the state resource manual, which implies that the intent of the bill is not informed consent, but actually about dissuading women from seeking an abortion. In the 22-23 fiscal year, North Carolina intends to provide over $5 million of grant funding allotted to CPCs (NC General Assembly, 2021), thereby directly funding organizations that may provide misinformation regarding personal medical decisions, potentially harming its constituents.

Following the implementation of the "Woman's Right to Know Act," the NC DHHS pregnancy and abortion pamphlet was created. This pamphlet uses much of the same misleading information that is commonly provided by CPCs. The first 19 pages of the pamphlet are dedicated to an in-depth breakdown of fetal development from fertilization to parturition. This breakdown contains many details about the fetus at every stage of development, for instance, the formation of fingerprints and fingernails is mentioned at 12 weeks, as well as the formation of the uterus and ovaries in female fetuses (N.C. DHHS, 2015). The pamphlet also claims that at ten weeks gestation “the embryo’s heart rate peaks at about 170 beats per minute. The heart is nearly fully formed” (N.C. DHHS, 2015). As stated by the American College of Obstetricians and Gynecologists (ACOG), using the term fetal heartbeat is inaccurate “until the chambers of the heart have been developed and can be detected via ultrasound (roughly 17-20 weeks of gestation)” (ACOG Guide to Language, 2022). By comparing the heart rate at 10 weeks cited in the NC

DHHS pamphlet versus the ACOG guidelines for fetal heart development (17-20 weeks), the NC DHHS pamphlet is reporting a heartbeat upwards of five weeks earlier than is medically accurate (ACOG Guide to Language, 2022).

The purpose of the pregnancy and abortion pamphlet is to meet the informed consent requirements set out in the "Women's Right to Know Act" (N.C. DHHS, 2015; "Woman's Right to Know Act," 2011). According to the pamphlet, the 72-hour waiting period is to "give you the chance to ask questions about all of your options and also the risks and benefits of the different medical and surgical procedures you may be able to choose from" and the ultrasound requirement is to "show how far along you are, if you are early enough in your pregnancy to be a candidate for medical abortion," and to ensure there isn't an ectopic pregnancy (N.C. DHHS, 2015). However, the pamphlet leaves out the "Women's Right to Know Act" requirement that the doctor must have the patient listen to the fetal cardiac activity and describe in detail what fetal features the ultrasound shows (N.C. DHHS, 2015; "Woman's Right to Know Act", 2011). The pamphlet examination also shows that it shares some of the same post-abortion claims as CPCs, claiming, without citation, that women undergoing abortion should be informed about the consequent risk of depression and the risk of future pregnancies ending in premature births (N.C. DHHS, 2015). The misinformation and framing of information in the DHHS pregnancy and abortion pamphlet demonstrates that, like the CPCs the state funds, state information materials were created to dissuade women from seeking an abortion.

The recent overturn of *Roe* has inspired the proposal of many new bills about abortion in the current legislative session in NC. While two of the proposed bills aim to protect abortion services and women's autonomy, four proposed bills seek to limit or ban abortion. The proposed bills are broken down in Table 2 in Appendix A. To summarize Table 2, there are seven proposed bills addressing abortion services in the most recent NC legislature session. H453, which prohibits eugenic abortion was ratified. Three bills—H31, S404, and H51—seek to limit abortion under various circumstances. H188 and H1119, seek to protect abortion services under the law. Bill H1126 seeks to protect abortion up to 20 weeks and prohibit the use of state funds by CPCs.

Due to the legislation already in place in NC and the nature of the proposed bills in this legislative session, NC seems to be at high risk of banning abortion services. The inaccuracies and misunderstandings of developmental biology may also be indicative of a lack of reproductive health knowledge across the board, specifically on how reproduction, pregnancy, and fetal development work. If North Carolinians wish to retain their rights to bodily autonomy and reproductive freedom, something must be done to curb the state-endorsed misinformation, reduce reliance on CPCs, and directly protect, by law, women's right to make decisions about their bodies.

Reproductive Rights in Wake County

Statewide legislation regulating CPCs is not feasible for many reasons; however, it may be possible to successfully regulate CPCs by scaling down to the county level. Wake County is the most populous county in NC and contains the state capital. Unlike some counties in NC, Wake has both abortion providers and crisis pregnancy centers, making it the ideal location to pilot test legislation regulating CPCs. In Wake County, there are two abortion providers, and at least six CPCs, meaning the ratio of CPCs to abortion providers in Wake County is 3 to 1. The CPCs in Wake County were located using the CPC Map and Finder, a web page designed to raise awareness about where CPCs are located (Swartzendruber & Lambert, 2020). The CPCs in Wake County are as follows: in Raleigh, Gateway Women's Care, Your Choice Pregnancy Clinic, The Women's Clinic, and Birthchoice; in Knightdale, iChoose Pregnancy Support Services; in Fuquay-Varina, Your Choice Pregnancy Clinic (*Crisis Pregnancy Center Map & Finder - CPC Map*, 2018). The website of each of these clinics was visited and assessed for the quality of information present. The results are depicted in Tables 3 and 4 below. Just as the literature on CPCs suggests, the CPCs in Wake County show up in web searches for abortion clinics, locate near legitimate medical providers, use potentially deceptive names, and utilize the same misinformation seen in studies on other CPCs. The CPCs in Wake County meet all the criteria of using harmful practices to dissuade women from seeking abortion and undermine their bodily autonomy.

Table 3 was created to assess the general practices that CPCs in Wake County were engaged in.

Among these were determining if the CPC was listed in the state's DHHS pregnancy resource directory, determining the proximity of the CPC to other women's health providers, what services they provided, and what reproductive health topics they provided (mis)information about. Categories were coded as "yes", for engaging in the listed activity; "no", for not engaging in the activity; and not applicable, or "NA" if the activity was not mentioned on the CPC's website.

Half of the CPCs in Wake County were included in the DHHS directory. Additionally, four of the six CPCs were located within one mile of a legitimate reproductive health provider or abortion clinic. All six CPCs provided pregnancy testing, limited ultrasounds, and advertised abortion reversals, but none provided referrals for abortion or contraception. Five of the six CPCs offered STI testing, but information about specific tests was limited. All the CPCs engaged in some form of abortion misinformation, and those that mentioned emergency contraceptives or miscarriage engaged in misinformation on the subject. These findings demonstrate that all of the CPCs in Wake County engage in disseminating at least one form of misinformation and attempt to draw vulnerable women in with the offer of free pregnancy testing and ultrasounds.

Table 3: General Assessment of CPC Websites in Wake County

Name of CPC	Your Choice, Fuquay	Your Choice, Raleigh	iChoose	Raleigh Women's Clinic	Birthchoice, Raleigh	Gateway Women's Care	Total engaged in activity
In the DHHS directory?	No	No	Yes	No	Yes	Yes	3/6
STI Testing?	Yes	Yes	Yes	Yes	No	Yes	5/6
Pregnancy Testing?	Yes	Yes	Yes	Yes	Yes	Yes	6/6
Limited ultrasounds?	Yes	Yes	Yes	Yes	Yes	Yes	6/6
Abortion Referral?	No	No	No	No	No	No	0/6
Contraception referrals?	No	No	No	No	No	No	0/6

Licensed medical provider on staff?	Yes	Yes	Yes	No	No	Yes	4/6
Abortion misinformation?	Yes	Yes	Yes	Yes	Yes	Yes	6/6
STI misinformation?	No	No	No	No	NA	NA	0/4
Miscarriage misinformation?	NA	NA	NA	Yes	NA	Yes	2/2
Contraceptive misinformation?	NA	NA	NA	No	NA	NA	0/1
EC misinformation?	Yes	Yes	Yes	Yes	NA	Yes	5/5
Advertises abortion pill reversal?	Yes	Yes	Yes	Yes	Yes	Yes	6/6
Located near a medical provider?	No	Abortion clinic	No	REX hospital	Abortion clinic	Planned Parenthood	4/6
Provide parenting resources?	No	No	No	No	No	Yes	1/6

Table 4 examines whether the CPCs in Wake County engage in the most common myths perpetuated by CPCs (Bryant et. al., 2014). Only myths about emergency contraception as dangerous to one's health were pervasive in most of the CPCs. Half of the CPC websites claimed that women who have an abortion are more likely to have depression and mental health issues. Two of the CPCs falsely claimed that abortion is often unnecessary since 20% of pregnancies end in miscarriage, the other three did not mention miscarriages. Only one website mentioned contraception, claiming that hormonal contraceptives are ineffective and detrimental to the user's health. These findings could be indicative of the medicalization of CPCs and more subtle anti-abortion tactics than in the past. This could further indicate moving away from posting direct misinformation on their websites, or a shift toward slightly more accurate, but misleadingly worded information.

Table 4: Common inaccuracies propagated by CPCs, broken down by CPCs in Wake County							
Myth About	Your	Your	iChoose	Raleigh	Birthchoice,	Gateway	Total

Reproductive health	Choice, Fuquay	Choice, Raleigh		Women's Clinic	Raleigh	Women's Care	engaged in activity
Abortion causes breast cancer	No	No	No	Yes	No	Yes	2/6
Abortion is likely to cause permanent physical harm or death	No	No	No	Yes	No	Yes	2/6
Women who have an abortion are more likely to have mental health issues than those who don't	No	No	No	Yes	Yes	Yes	3/6
There is a 20% of miscarriage in the first trimester, so you may not need to pay for an abortion if you miscarry	NA	NA	NA	Yes	NA	Yes	2/2
Emergency contraception is unnecessary or dangerous to your health	Yes	Yes	Yes	Yes	NA	Yes	5/5
Emergency contraception is an abortifacient	No	No	No	Yes	NA	Yes	2/5
Hormonal contraceptive methods harm your health or are ineffective	NA	NA	NA	Yes	NA	NA	1/1

As Table 4 illustrates, the Wake County CPC websites provide inaccurate abortion information and don't mention necessary services such as contraceptive referrals and material perinatal support, which is critical for the underserved women that CPCs attract. It is likely from the findings of the website content review that CPCs in Wake County do not provide accurate information about the options available to benefit residents that fall pregnant and need free or reduced-cost reproductive health services.

Discussion

While abortion providers have faced continual scrutiny and restrictive legislation, CPCs have been expanding and thriving despite being unaccredited and purveying medical misinformation (Polcyn et al., 2020). For years, state and municipal governments have attempted to regulate CPCs and their use of misinformation; however, when taken to court, these measures have typically been cast aside as laws

persecuting and violating the free speech of CPCs. National and state governments have been quietly eroding access to science-based, medical care facilities specializing in reproductive healthcare for decades and actively protecting organizations aiding the spread of uninformed, politically-motivated, propaganda. With the overturn of *Roe*, it is essential to remember the bigger picture—that abortion is a form of healthcare and abortion bans are heavily political and do not always center on providing evidence-based medical care. It is crucial to use the overturn of *Roe* as a catalyst for permanent change, including educating people on recognizing and refuting the organizations attempting to undermine bodily autonomy and reproductive freedom.

Despite unethical practices, CPCs are not intrinsically malevolent, some are moderately beneficial and transparent, but that is the exception. In Wake County, no CPC indicated their pro-life stance or affiliations with pro-life organizations. Most provide some services that are critically lacking in the US, such as free pregnancy tests, prenatal ultrasounds, and limited material support for new mothers (Kelly, 2012**).** However, to receive material support, CPCs often require women to attend seminars with biased curricula or bible study classes (Kelly, 2012). The negative impacts they make through their practices outweigh any positive impact they may have in communities (ACOG Issue Brief, 2022). While existing research focuses on the practices of CPCs nationally, it fails to address how drastically the healthcare and political landscape vary from state to state. To better understand CPCs and how to combat their unethical practices, more research must be conducted at both the state and local levels. Future research also needs to explore how usage of CPCs changes when people are aware of CPC malpractice and when other more medically sound options and services are available for free in the same locale.

The misinformation spread by CPCs impacts public health because CPCs do not provide all the medically viable options to vulnerable individuals, explicitly targeting adolescents and individuals with low health literacy. Adolescents and young adults have the highest rates of unintended pregnancy in the US (Solsmsn et al., 2021) and CPC websites use pictures and colors specifically chosen to lure in younger individuals (Swartzendruber et al., 2020). In 2021, a survey of 1000 women, 38% of whom were in the southern US, were asked to differentiate between CPC and abortion websites. It was found that the

websites of CPCs were more difficult to correctly identify than abortion clinic websites. This finding implies that CPC websites are often mistaken for websites of abortion-providing clinics. Women with limited knowledge on CPCs, abortion, and low health literacy were at a higher risk of misidentifying CPC websites (Swartz et al., 2021).

Misinformation on vital health topics can cause lifelong harm to patients. CPCs erode trust in actual medical providers by presenting themselves as legitimate sources of medical information. Having a poor or misleading experience with a CPC may make it harder for vulnerable patients to seek legitimate healthcare in the future. There is no empirical evidence that CPCs reduce the rate of unintended pregnancy and abortion; yet, they reject evidence-based, comprehensive care that has been proven to decrease abortion incidence (Polcyn et al., 2020). Advocacy groups and medical providers widely criticize CPCs as being deceptive and misleading about their services; however, most individuals do not know what CPCs are or the dangers they pose to autonomy and health. Educating and spreading awareness about what CPCs are is essential for successful avoidance. Many state governments, including NC, list CPCs in their resource directories, which might give legitimacy to the information provided by CPCs (Bryant-Comstock et al., 2016). Governments should only fund and endorse evidence-based medical practices—not nonprofits masquerading as medical facilities.

The *NIFLA v. Becerra* case exemplifies how the court treats professional and private speech differently. Professional speech, made by doctors and lawyers, is under the broader umbrella of commercial, rather than private, speech. In the majority decision, the Supreme Court claimed that professional speech could only be regulated when it applies to "factual, noncontroversial information," and abortion is controversial, so the speech could not be regulated (Parmet et al., 2018). Before *NIFLA,* 'uncontroversial' meant factually uncontroversial. By categorizing speech as controversial just because it pertained to a controversial topic—in this instance abortion—the case created a new precedent for using unregulated speech on 'uncontroversial' grounds. Thus, the *NIFLA* ruling created an atmosphere ripe for misinformation to spread and be untouchable for regulation by government entities.

The claim that professional speech can only be regulated when it applies to "factual,

noncontroversial information" also creates a problem because many states, NC included, have mandated "informed consent" laws, pre and post-abortion scripts that physicians must read from even though they are filled with medically inaccurate claims about the risks of abortion (Hill, 2015; Parmet et al., 2018). Courts have upheld the constitutionality of these scripts on the same grounds used in *NIFLA* to strike down state laws regulating professional speech.

The *NIFLA* ruling has larger implications than just reproductive healthcare; its reasoning jeopardizes many other health and consumer safety laws. Should *NIFLA* be used as a precedent, it puts stringent scrutiny on state regulation of CPCs, but by that same logic, states should also apply strict scrutiny to the regulation speech of abortion providers (Parmet et al., 2018). While the immediate impact of *NIFLA* may have been detrimental to the state of reproductive rights, as it provided states with very little agency to regulate (mis)information spread by CPCs, it may prove beneficial in the long term. The reasoning used in *NIFLA* may open the door to reexamining physician speech as protected by professional speech doctrine (Gottesdiener, 2020).

Informed consent is crucial in allowing patients to weigh their medical options and make the best decision for their health and their life. The medicalization of CPCs should then also come under more scrutiny using informed consent standards. Most CPCs fail to get informed consent from patients because they do not provide unbiased and accurate information about subjects like contraception and abortion; therefore, CPCs undermine the patient's ability to autonomously decide what is best for them (DiPietro, 2022). Most of the time, informed consent is regulated by the medical profession with little intervention by government entities. However, when it comes to abortion providers, suddenly, governments intervene and intensely regulate physician-patient interactions and what constitutes informed consent. With "Women's Right to Know Laws," the same logic applies—these scripts force the medical provider to give non-pertinent and inaccurate information designed to dissuade the patient from getting their abortion, and in doing so, the state itself undermines informed consent and bodily autonomy.

Conclusion

Through their spread of misinformation, legitimization by the state, and use of public funding despite their links to conservative anti-abortion organizations, CPCs are an immense public health risk. At a time in the United States when reproductive health services are under attack and misinformation is rampant, it is crucial to hold accountable institutions that exacerbate the problem. CPCs do offer important reproductive services, like ultrasounds, pregnancy tests, and material support, for free; however, one could argue that this is indicative of a greater issue in the affordability of healthcare and maternal support in the US, not altruism on the part of CPCs. CPCs could be improved if they were more strictly regulated or consistently used evidence-based medical information. The judicial system has failed to curb CPC misinformation by categorizing it as an issue of free speech instead of professional speech. Until an immense change is undertaken in how CPCs operate and are held accountable, they threaten individuals' autonomy and access to unbiased medical information. Providing citizens, especially adolescents, with better health literacy and reproductive education can also help to prevent the spread of misinformation by CPCs. The risk of negative and coercive interactions with them is mitigated by educating people on what CPCs are and what misinformation they spread. Holding organizations such as CPCs accountable is crucial so every person can make the best choices for themselves.

Policy Proposal

Based on the findings of my literature review, two potential strategies to minimize the harm to North Carolinians caused by CPCs are presented.

1. Currently, NC does not require sonographers to be licensed by the state, but it does require doctors to be licensed by the North Carolina Board of Medicine. Since almost all CPCs use free ultrasounds as a strategy to attract patients, I suggest that sonographers should 1) be licensed or certified, 2) display that certification where they perform ultrasounds, 3) state that they are unlicensed if they do not have state licensing. If that is not feasible, then sonographers should also have their own version of the North Carolina Board of Medicine license before they can practice.
2. The NC DHHS has a pregnancy resource directory that includes state health centers, adoption

agencies, some Planned Parenthoods, and many CPCs (marked as pregnancy resource centers in the directory); however, it does not include any abortion clinics or private comprehensive health clinics. To make the pregnancy resource directory unbiased and more comprehensive so that women truly do have informed consent and are given all their options, the state should add free or low-cost comprehensive clinics to the list and mark them as referring for or providing abortion services.

Appendix A

Table 2: NC Legislature Proposed Abortion Bills

Bill Name and Status	Short Title	Summary	Inaccuracies
H31 Proposed, Edition 1	Detected Heartbeat/ Prohibit Abortion	Prohibit abortion when there is a detectable human heartbeat	In the bill human heartbeat is defined as fetal cardiac activity, not an actual heartbeat, meaning abortion would effectively be banned after approximately six weeks.
S404 Proposed, Edition 1	A Second Chance for LIFE	Require physicians who perform medical abortions to give the patient written information about abortion reversal procedures	Endorses abortion reversal, which is not medically proven as effective or safe
H510/ S405 Proposed, Edition 1	Born-Alive Abortion Survivors Protection Act	The bill defines born-alive as having cardiac activity, umbilical cord pulsation (before and after being cut), or breathing. Any abortion that results in the birth of a live infant results in counting the infant as a legal person entitled to life-saving medical care.	Active infanticide is already illegal in all states. The number of induced abortions that result in a 'live birth' is less than 1%. This bill fails to account for cases where the infant has birth defects incompatible with life. In such cases, comfort care, rather than aggressive life-saving care is often chosen by the medical team and parents as the most humane treatment.
H453 Ratified	Human Life Nondiscrimination Act/No Eugenics	Women cannot seek an abortion on the following eugenic grounds • Presumed race of unborn child • Sex of unborn child • Presence of down syndrome	• There is no way to tell the skin color of a fetus, nor is presumed skin color a prominent reason for women to obtain an abortion. • The CDC reports that 93.1% of abortions occur before 13 weeks gestation. However, fetal sex is typically confirmed between 18-20 weeks gestation. It is unlikely that any significant number of abortions are due to sex selection as the majority happen before knowing the sex.
H1126 Proposed, Edition 1	Abortion Law Revisions	• Child support begins in the first month that the child was conceived • Prohibit the use of state funds for CPCs • Allow for abortion up to 20 weeks	No misinformation found
H188/ S167 Proposed, Edition 1	Remove Barriers/Gain Access to Abortion Act	• Reduce barriers to abortion access • Allow more health professionals, such as nurse practitioners and midwives to fulfill informed consent requirements for abortion • Have the state healthcare plan provide coverage for complications after abortion	No misinformation found
H1119 Proposed, Edition 1	Reproductive Freedom Act	• Codify Roe v. Wade and Planned Parenthood v. Casey into law • Repeal restrictions on abortion • Use DHHS funds of $2 million per year to clinics that provide contraceptives	No misinformation found

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