Response to Senator Grassley's questions

1. Some of the witnesses in this hearing testified that recently enacted health and safety standards for abortion clinics are unnecessary.

    a. Do you think health and safety standards are needed for abortion clinics?

    I believe that for a number of reasons health and safety standards are needed for abortion clinics, just as for any facility where outpatient surgery is performed. Surgical induced abortion is defined as a type of surgery.

    First, health and safety standards are designed to protect patients and staff, and to allow staff and emergency workers to do their job. There is a mandatory obligation on the part of clinicians and facility administrators to ensure that procedures are performed safely, that women are not exposed to infectious or other hazards, and that patients can quickly receive appropriate emergency care. Similarly, staff must be protected from infectious and other hazards.

    In addition, emergency workers must be able to enter a building quickly, as needed, to care for patients before, during and after a medical emergency, or to transfer to a hospital. This is especially true because once the emergency response system has been activated, minutes count in the care of a patient. In the case of complications from abortion, delays in emergency treatment can result in serious injury, loss of fertility or death for a patient. The width of hallways, for example, is important because emergency response teams must have adequate space to roll a stretcher down a hall with one person pushing the stretcher and another providing emergency care (e.g. administering medications, giving oxygen, etc.). Hallways which are cluttered or cannot accommodate a stretcher and 2 persons walking alongside pose a significant hazard, as do entry/exit doors that are too narrow or which are locked. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandates minimal hallway widths in health facilities, and during JCAHO inspections, hallway width and the absence of hallway clutter are rigorously scrutinized.

    The importance of adequate emergency access was graphically demonstrated during the trial of Philadelphia abortionist Kermit Gosnell, when emergency workers could not reach a dying patient due to locked exit doors and substandard-sized, cluttered hallways.

    Second, health and safety standards are not an unnecessary burdens; rather, they are an essential part of meeting a standard of care which protects both patients and staff, and which are assumed as a matter of course to be an integral part of a facility's operations. For example, a recent publication from India states that "Liposuction can be performed safely in an outpatient day care surgical facility, or a hospital operating room. The day care theater should be equipped with facilities for monitoring and handling emergencies. A plan for handling emergencies should be in place with which all nursing staff should be familiar. A physician trained in emergency

medical care and acute cardiac emergencies should be available in the premises. It is recommended but not mandatory, that an anesthetist be asked to stand by"(Mysore et al, 2008). It is noteworthy that these precautions are recommended and considered appropriate in a developing country for a low-risk procedure (tumescent liposuction) that, unlike surgical abortion, does not enter a body cavity, and that it is taken for granted that these precautions are needed.

Third, abortion, like many surgical procedures, carries significant risks, and despite every precaution, whenever a procedure is done, there is always a possibility that a woman will suffer complications such as hemorrhage, infection, loss of fertility or even death (the safety of abortion procedures is discussed in detail below). This is why informed consent must be obtained prior to abortion. It is therefore incumbent on state regulatory agencies to establish standards and to monitor and enforce their use.

The Office of the Inspector General, US Department of Health and Human Services, published 2 documents in 1992 (attached) that address the issues surrounding state regulation and licensure of outpatient surgery facilities. The first, "Surgery in Outpatient Settings: A Four-State Study" had as its purpose "To determine the types of surgical procedures which are commonly performed in outpatient settings and the extent to which such outpatient settings are subject to licensure or accreditation". The authors noted the following:

- A substantial portion of the facilities studied performed procedures that were classified as high risk based on their anesthesia risk alone, i.e. whether they used intravenous sedation or general anesthesia during these procedures. In particular, abortion was among the 3 most common procedures for which intravenous sedation or general anesthesia were used. These types of anesthesia are considered high risk because they purposely inhibit protective breathing and airway reflexes in patients and can affect heart rate and blood pressure. As such they are associated with risk for severe complications. A cursory search on the Internet of types of anesthesia provided by abortion clinics confirms that intravenous sedation and general anesthesia are often used for this procedure, in fact, the availability of these types of anesthesia is marketed to women seeking an abortion.

- The majority of facilities in this study were neither licensed nor accredited. More than half of the facilities that performed procedures classified as high risk (including abortion) were not licensed. For many facilities, "licenses are no different than for a restaurant, hardware store or barber shop…Even when facilities are licensed, standards and monitoring vary. Of the licensed or accredited facilities, 59 percent of the licensed facilities *do not have specific requirements for staff, equipment or the physical facility. Only about one-third (35 percent) of the licensed facilities were inspected regularly…States are not consistent in their regulation of freestanding medical facilities.* [emphasis added]." It is clear from this sentence that the OIG inspectors felt that such

requirements and inspections were reasonable expectations that were integral to patient safety.

- A majority of facilities did not have emergency plans or equipment. "Medical emergency equipment and procedures are not routinely available...over half of the sampled facilities have no written medical emergency procedures or could not produce them during an on-site visit…Regarding preparedness for emergency response, 19% of the facilities employ at least one physician who does not have admitting privileges at a local hospital." The presence of a physician with admitting privileges at a local hospital was identified as part of appropriate emergency preparedness.

- The OIG's recommendation was that "States should examine their licensure rules to ensure quality of "high-risk" procedures performed in outpatient settings. *States nationwide should examine their rules for licensure and procedures for oversight and make any necessary changes to ensure the quality of surgery performed in outpatient settings, particularly in those facilities performing "high-risk" procedures*" [emphasis added]. **Of note, abortion was categorized as a high risk procedure.**

b. What kind of health and safety standards are warranted?

A second study from the Office of the Inspector General, US Department of Health and Human Services, "Surgery in Outpatient Settings: Forms of Oversight", directly addresses this question. Briefly, this study examines different types of oversight for outpatient surgery facilities. (**Abortion is categorized in this report as a major procedure, in contrast to minor procedures such as performing skin biopsies**). The report provides a list of standards for health and safety which are warranted for outpatient surgery clinics, including abortion clinics. The report notes that "There are a number of standards that promote quality of care in a health setting. These standards are utilized by several State health facility licensure agencies, medical boards, and a podiatry board…The following is a summary of the chief types of standards that exist". 13 standards are described:

- Patient complaints
- Legal limits (guidelines for care)
- Peer review
- Training of ancillary personnel
- Credentialing process
- Infection control procedures
- Medical training standards
- Transfer agreement
- Minimum staff requirement
- Emergency equipment and trained personnel
- Minimum record-keeping standards
- Anesthesia standards

- Equipment standards

Other warranted standards include: mandatory reporting of abortion statistics and complications (as part of record keeping); requiring a provider to have privileges at a local hospital; mandatory ultrasound protocols to establish the location of pregnancy and its gestational age; requirements to screen for abuse or exploitation, especially for adolescents and possible human trafficking victims; and adherence to the *Guidelines for Hospitals and Outpatient Facilities*, which provides minimum standards for the design and construction of hospitals and outpatient facilities. Mandatory ultrasound, in particular, is essential and ultrasound is part of the standard of care for prenatal care; in fact, Adrienne Schreiber, an official at Planned Parenthood's Washington office stated, "That's just the medical standard…To confirm the gestational age of the pregnancy, before any procedure is done, you do an ultrasound" (http://www.lifenews.com/2012/02/22/planned-parenthood-rape-myth-debunked-99-do-ultrasounds/). Unless they do not receive prenatal care, all women receive antenatal ultrasound. This is because confirming the location and gestational age of a pregnancy is of the utmost importance. Pregnancies can be located in the uterus or outside the uterus (ectopic pregnancy). Undetected and untreated ectopic pregnancy is one of the leading causes of maternal mortality, and in fact at least 4 women have died over the last few decades when undiagnosed ectopic pregnancies ruptured following an abortion procedure (Angela Satterfield, age 23, Sherry Emry, age 26, Gladyss Delanoche Estanislao, age 28, and Yvette Poteat, age 26) Ultrasound also helps to estimate gestational age, this is important because the risks associated with abortion increase dramatically with gestational age.

To summarize, health and safety standards are universal in outpatient surgery clinics. It is clear that self-policing by abortion providers does not guarantee safety, and that even where standards are in place, authorities can choose to ignore them rather than enforcing them, resulting in tragedies such as the Gosnell case. Safety does not increase with less regulation. Rather, regulations exist to improve safety and protect patients.

c. In your professional opinion, is there any justification for regulating abortion clinics differently than other medical clinics? If so, why?

In my opinion, there is adequate justification for regulating abortion clinics differently from other medical clinics.

Induced abortion is unique in that it is performed on 2 uniquely vulnerable classes of people. Pregnant women and unborn children are recognized in research, ethics and regulatory spheres (for example, institutional review boards) as vulnerable populations which need special protection. This is recognized in virtually every area of life, commerce and health care. It is therefore clear that greater protections are needed for them.

The United States Supreme Court has repeatedly acknowledged that "abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." *Harris v. McRae*, 448 U.S. 297, 325 (1980). The Court has also held that the "abortion

decision has implications far broader than those associated with most other kinds of medical treatment." *Bellotti v. Baird* (*Bellotti II*), 443 U.S. 622, 649 (1979). Some of these implications include:

- The use of abortion as a means of concealing statutory rape, domestic violence and abuse, rape, incest, prostitution and human trafficking;
- Denial of paternity (i.e. a father is deprived of his child);
- The use of abortion for eugenic purposes or sex selection, i.e. to selectively terminate pregnancies based on characteristics of a fetus such as a genetic disease, disability, or female sex.

Abortion is unique among surgical procedures in that women's motivations for undergoing this procedure differ from all other surgeries (or drug therapies, in the case of medical abortion). The emotional factors associated with the abortion decision cannot be overstated. Many women turn to abortion in desperation. When women are desperate, they may choose to undergo abortion in clearly substandard, abusive or dangerous conditions because they feel they have no choice. They are also vulnerable to being manipulated into thinking that abortion will solve their problems, without considering alternatives. Coercion is also a significant risk with abortion. With the possible exception of sterilization and female genital mutilation, no other elective procedure is as likely to be associated with coercion. Informed consent for other procedures, especially for example sterilization, is carefully carried out (and monitored) to ensure that women undergoing procedures clearly understand the possible alternatives to the procedure and to attempt to prevent coercion.

Abortion is also unique in that it is the only invasive procedure that is performed in minors without their parents' consent and without institutional and court involvement. Minors are especially vulnerable to sexual exploitation, statutory rape, molestation and high-risk sexual behaviors, and due to their status as children may easily be coerced or forced to have an abortion to cover up these situations.

Abortion differs from other medical procedures in that the negative incentives for substandard care, physician malpractice, abandonment and lack of surveillance are rarely if ever felt by abortion providers. This is in part due to the guilt and shame felt by women who undergo abortion, and partly due to the fact that abortion providers do not in general manage the complications of the procedure they perform; abortion providers themselves often work outside the boundaries of standard medical practice. There is no other setting where a physician may perform an invasive procedure without a state license, or can fly in from a different state to perform invasive procedures without having either privileges at a local hospital or a transfer agreement in place with his or her colleagues. While it is standard practice for out-of town physicians to travel to cover their colleagues' practices, with reciprocal privileges being granted in some states, traveling physicians must be credentialed and obtain privileges at a local hospital.

Finally, abortion differs from all other medical procedures in the matter of rights of conscience. As has been well demonstrated, physicians and nurses refusing to perform or participate in abortions have been subjected to disciplinary actions and discrimination in employment.

Response to Senator Grassley's questions
Monique Chireau, M.D., M.P.H.

> Nancy Northrup stated in pages 5-6 of her written testimony that "abortion is one of the safest medical procedures" and that it is absurd to assert women's health as a rationale for abortion regulations. Do you agree with Northrup's statements? Why or why not?

I strongly disagree with Ms. Northrup's statements. As stated in my testimony, a substantial body of literature indicates that induced abortion is associated with significant risks and potential harms to women. Induced abortion is an elective procedure, and therefore the safety standard should be higher for abortion than for non-elective or emergency procedures.

The risks of abortion are known to include infection, bleeding, uterine perforation with damage to bowel or bladder, loss of long-term fertility, mental health issues and death.

A number of studies have documented these risks in detail in the peer-reviewed scientific literature. For example, a study by Niinimaki et al of all women who underwent induced abortion (42,000 women) in the nation of Finland noted that 20% of patients undergoing medically induced abortion (i.e. with medications) and 5.6% of women undergoing surgical abortion experienced an adverse event (including bleeding, hemorrhage, injury). 16% of women undergoing medical abortion, and 2% of women undergoing surgical abortion, experienced hemorrhage, while 2% of either surgical or medical abortion were complicated by infection**. Of note, the first trimester abortion mortality rate (for medical and surgical abortion combined) was estimated at 14 per 100,000.** This is a high rate of mortality for an elective procedure. These statistics represent a significant burden of disease; if applied to the United States, where 1.3 million abortions are performed annually, this translates to 260,000 adverse events per year. While these statistics are troubling, they are impossible to verify in the United States, where abortion surveillance is incomplete and inadequate. CDC stated in their most recent report on abortion in the United States that California, Maryland and New Hampshire did not report data, and that incomplete data were available for a number of other analyses including the age and ethnicity of women undergoing abortion.

Other research has demonstrated that the risks associated with abortion increase dramatically with gestational age. An important study on abortion mortality and morbidity by Bartlett et al found that the risk of mortality "increased exponentially by 38% with each additional week of gestation". When the risk for death from abortions performed at greater than 21 weeks was compared with the risk of death from abortion at 8 weeks or less, this study noted that women at later gestational ages were 77 times more likely to die from the procedure. These findings not only emphasize that abortion is not a benign procedure, but also provide support for establishing regulations regarding ultrasound dating of pregnancy. Use of the last menstrual period date to establish the gestational age of the pregnancy is notoriously unreliable (as is physical examination), especially in adolescents, and the use of ultrasound for dating pregnancy is part of the standard of care.

Other complications can occur following abortion. Bhattacharya et al, 2012 found that induced abortion in a first pregnancy increased the risk of preterm birth. Surgical abortion increased the risk of subsequent preterm delivery compared with medical abortion (Bhattacharya et al, 2012. Reproductive outcomes following induced abortion: a national register-based cohort study in Scotland, British Medical

Journal). Klemetti et al, in a study of abortion in Finland, found increased odds for very preterm birth (<28 weeks) in all subgroups of women who underwent abortion: 1.19 after 1, 1.69 after 2, and 2.78 after 3 abortions. Increased odds for preterm birth and low birthweight were seen with > 3 abortions. Most abortions were surgical (88%) and done for social reasons (97%). These statistics are of special interest in the United States, since African American women not only undergo abortion more than three times as often as Caucasian women, but also experience preterm birth at 1.6 times the rate of Caucasian women.

A robust literature exists on mental health problems following abortion. Coleman (2011) performed a meta-analysis which included 22 studies and 877,181 women. An 81% increase in mental health problems including depression, anxiety, substance abuse and suicide was noted in women who had induced abortion. The risk for mental health problems was increased 55% in women who had induced abortion compared with those who gave birth.

In conclusion, abortion is clearly not one of the safest medical procedures. The statement that it is absurd to assert women's health as a rationale for abortion regulations is shown to be incorrect based on sound data about abortion's risks to women; evidence of a lack of regulations, standards and oversight at abortion facilities; the public health and safety consequences of the lack of standards and regulation; and abortion providers practicing outside the bounds of established medical practice, all of which have led to poor outcomes, death and disability for women.

Abortion Risks

A review of the scientific literature

Abortion Epidemiology

- There are a number of adverse short-term outcomes with induced abortion
  - Maternal morbidity
    - Infection
    - Bleeding
    - Uterine perforation with damage to bowel or bladder
  - Maternal mortality

Complications of Abortion

- Long-term complications
  - Spontaneous abortion
  - Preterm birth
  - Mental health issues
  - Autoimmune disease

Abortion Epidemiology

- The study by Bartlett et al, of abortion-related mortality provided perhaps the best data, but may have underestimated abortion mortality
- This study suggests a **76-fold increase in mortality** between early and late abortion
- Stated another way, the risk of death from abortion increases exponentially by 38% for each additional week of gestation
- This is not true for pregnancy

Bartlett et al, Risk factors for induced abortion mortality in the United States. *Obstet Gynecol* 2004:103:729-737

Risk Factors for Legal Induced Abortion–Related Mortality in the United States

Linda A. Bartlett, MD, MHSc, Cynthia J. Berg, MD, MPH, Holly B. Shulman, MS, Suzanne B. Zane, DVM, Clarice A. Green, MD, MPH, Sara Whitehead, MD, MPH, and Hani K. Atrash, MD, MPH

OBJECTIVE: To assess risk factors for legal induced abortion–related deaths.

METHODS: This is a descriptive epidemiologic study of women dying of complications of induced abortions. Numerator data are from the Abortion Mortality Surveillance System. Denominator data are from the Abortion Surveillance System, which monitors the number and characteristics of women who have legal induced abortions in the United States. Risk factors examined include age of the woman, gestational length of pregnancy at the time of termination, race, and procedure. Main outcome measures include crude, adjusted, and risk factor–specific mortality rates.

RESULTS: During 1988–1997, the overall death rate for women obtaining legally induced abortions was 0.7 per 100,000 legal induced abortions. The risk of death increased exponentially by 38% for each additional week of gestation. Compared with women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes. to 87% of deaths in women who chose to terminate their pregnancies after 8 weeks of gestation may have been avoidable if these women had accessed abortion services before 8 weeks of gestation.

CONCLUSION: Although primary prevention of unintended pregnancy is optimal, among women who choose to terminate their pregnancies, increased access to surgical and nonsurgical abortion services may increase the proportion of abortions performed at lower-risk, early gestational ages and help further decrease deaths. (Obstet Gynecol 2004; 103:729–37.

LEVEL OF EVIDENCE: II-2

Legal induced abortion is one of the most frequently performed surgical procedures in the United States. With approximately 1.2 million legal induced abortions performed in 1997,[1] minimizing risk for women who choose to terminate their pregnancies is of clear public health importance.

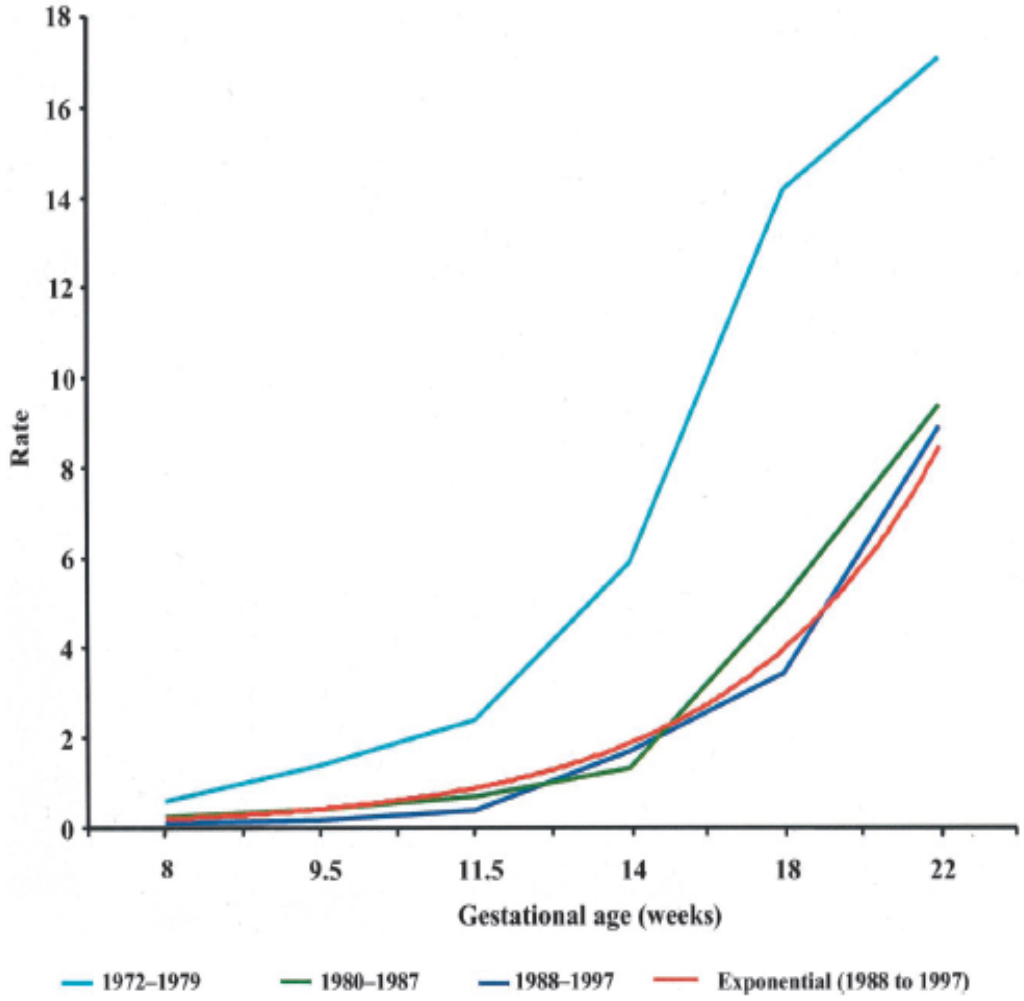

Figure 1. Legal induced abortion mortality rates with plot of exponential model, by gestational age—United States, 1972–1979, 1980–1987, and 1988–1997.

Bartlett. Abortion-Related Mortality. Obstet Gynecol 2004.

Table 2. Legal Induced Abortion–Related Deaths, Mortality Rates, and Relative Risks, by Selected Characteristics—United States, 1988–1997

Characteristic	1988–1997		
	Legal induced abortion–related deaths (*n*)	Mortality rate*	Relative risk (95% confidence interval)
Gestational age (wk)			
First trimester			
≤ 8	8	0.1	Referent
9–10	5	0.2	1.4 (0.5, 4.2)
11–12	6	0.4	3.4 (1.2, 9.7)
Second trimester			
13–15	15	1.7	14.7 (6.2, 34.7)
16–20	19	3.4	29.5 (12.9, 67.4)
≥ 21	15	8.9	76.6 (32.5, 180.8)
Unknown	26	Not applicable	Not applicable
Race			
White	38	0.5	Referent
Black or other	56	1.1	2.4 (1.6, 3.6)
Time period			
1972–1979	163	2.2	3.1 (2.4, 4.0)
1980–1987	80	0.8	1.1 (0.8, 1.4)
1988–1997	94	0.7	Referent
Age (y)			
≤ 19	20	0.7	1.2 (0.6, 2.2)
20–24	29	0.7	1.1 (0.6, 2.0)
25–29	18	0.6	Referent
30–34	16	0.9	1.5 (0.7, 2.9)
≥ 35	10	0.8	1.3 (0.6, 2.9)
Parity			
0	16	0.3	Referent
1–2	27	0.5	1.9 (1.0, 3.5)
≥ 3	7	0.5	2.1 (0.9, 5.2)
Unknown†	42	Not applicable	Not applicable

* Legal induced abortion mortality rate is the number of legal induced abortion–related deaths per 100,000 legal induced abortions.
† Denominators for calculating rates by parity use previous live births from abortion surveillance data; deaths with unknown parity are excluded.

Immediate Complications After Medical Compared With Surgical Termination of Pregnancy

Maarit Niinimäki, MD, Anneli Pouta, MD, PhD, Aini Bloigu, Mika Gissler, BSc, PhD, Elina Hemminki, MD, PhD, Satu Suhonen, MD, PhD, and Oskari Heikinheimo, MD, PhD

OBJECTIVE: To estimate the immediate adverse events and safety of medical compared with surgical abortion using high-quality registry data.

METHODS: All women in Finland undergoing induced abortion from 2000–2006 with a gestational duration of 63 days or less (n=42,619) were followed up until 42 days postabortion using national health registries. The incidence and risk factors of adverse events after medical (n=22,368) and surgical (n=20,251) abortion were compared. Univariable and multivariable association models were used to analyze the risk of the three main complications (hemorrhage, infection, and incomplete abortion) and surgical (re)evacuation.

RESULTS: The overall incidence of adverse events was fourfold higher in the medical compared with surgical abortion cohort (20.0% compared with 5.6%, $P<.001$). Hemorrhage (15.6% compared with 2.1%, $P<.001$) and incomplete abortion (6.7% compared with 1.6%, $P<.001$) were more common after medical abortion. The rate of surgical (re)evacuation was 5.9% after medical abortion and 1.8% after surgical abortion ($P<.001$). Although rare, injuries requiring operative treatment or operative complications occurred more often with surgical termination of pregnancy (0.6% compared with 0.03%, $P<.001$). No differences were noted in the incidence of infections (1.7% compared with 1.7%, $P=.85$), thromboembolic disease, psychiatric morbidity, or death.

CONCLUSION: Both methods of abortion are generally safe, but medical termination is associated with a higher incidence of adverse events. These observations are relevant when counseling women seeking early abortion.
(Obstet Gynecol 2009;114:795–804)

LEVEL OF EVIDENCE: II

Termination of pregnancy is one of the most common gynecologic procedures. For instance, in the

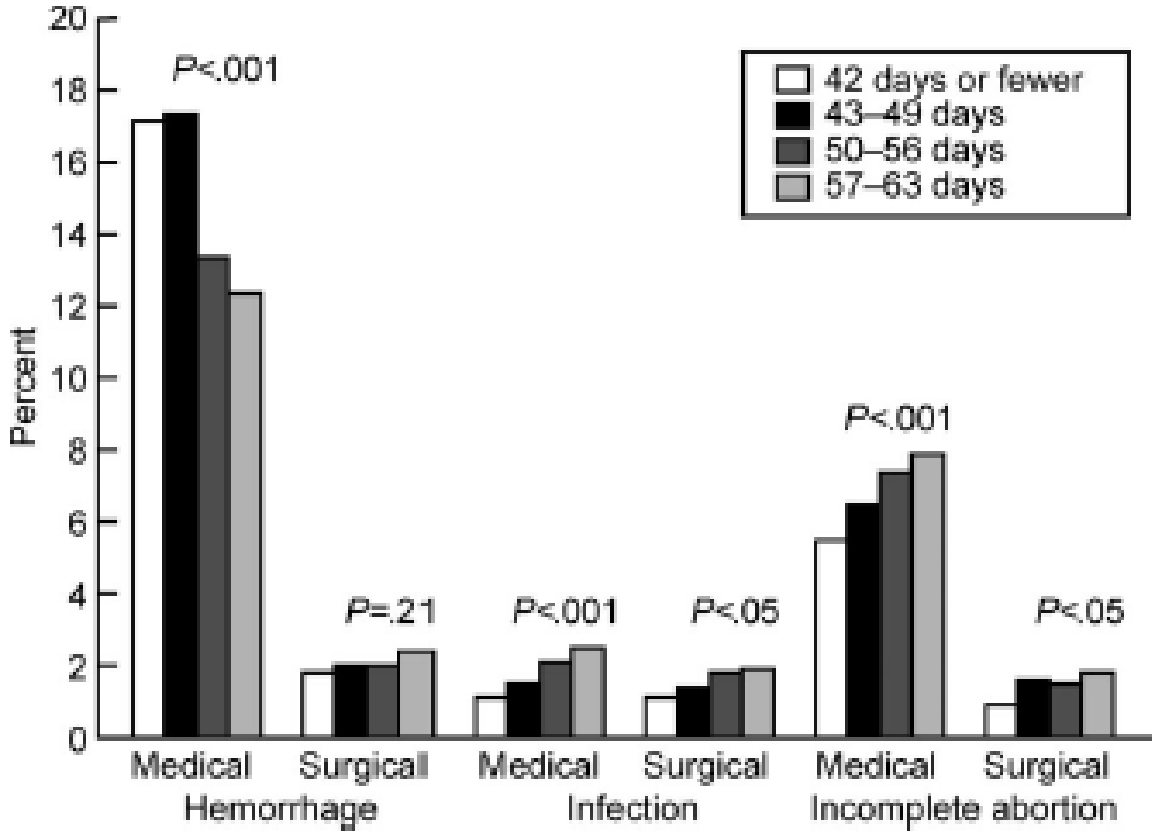

Fig. 1. Complications according to the duration of gestation in the medical and surgical cohorts (%).

Niinimäki. Complications After Medical and Surgical Abortion. Obstet Gynecol 2009.

Table 2. Incidence of Adverse Events in the Cohort

	Medical Abortion (n=22,368)	Surgical Abortion (n=20,251)	P*	Adjusted OR† (95% CI)
Hemorrhage	3,487 (15.6)	433 (2.1)	<.001	7.93 (7.15–8.81)
Hemorrhage with surgical (re)evacuation	645 (2.9)	173 (0.9)	<.001	
Infection	383 (1.7)	342 (1.7)	.85	1.15 (0.98–1.34)
Infection with surgical (re)evacuation	172 (0.8)	122 (0.6)	.02	
Incomplete abortion	1,495 (6.7)	323 (1.6)	<.001	5.37 (4.49–6.28)
Incomplete abortion with surgical (re)evacuation	1,320 (5.9)	77 (0.4)	<.001	
Injury	6 (0.03)	122 (0.60)	<.001	NA‡
Thromboembolic disease	18 (0.08)	17 (0.08)	.90	NA
Psychiatric morbidity	2 (0.009)	1 (0.005)	.62	NA
Death	2 (0.009)	4 (0.020)	.35	NA
Women with adverse events	4,479 (20.0)	1,127 (5.6)	<.001	4.23 (3.94–4.54)
Surgical (re)evacuation	1,320 (5.9)	363 (1.8)	<.001	3.58 (3.18–4.03)
Number of adverse events per woman				
0	17,889 (80.0)	19,124 (94.4)	<.001	
1	3,624 (16.2)	1,021 (5.0)		
2	796 (3.6)	97 (0.5)		
3	59 (0.26)	9 (0.04)		

OR, odds ratio; CI, confidence interval; NA, not applicable.
Data are n (%) unless otherwise specified.
* Chi-square test for comparison between medical and surgical cohort.
† Surgical cohort as a reference adjusted for age, parity, previous abortion, social status, marital status, type of residence, and duration of gestation.
† Not applicable owing to small number of patients in one or both groups.

Short-term complications of surgical abortion

- Infection (18.5%, *Am J OB GYN* 1977)
- Bleeding
- Damage to the uterus and cervix (perforation) 2%
- Damage to other organs such as the bladder, intestines or rectum
- Need for repeat procedure (0.2-2%)

Short-term complications of medical abortion (higher gestational ages)

- Bleeding
- Infection
- Uterine rupture
- Retained fetal products necessitating dilation and curettage; damage to bowel or bladder at the time of dilation and curettage

What does this mean?

- Abortion is clearly less safe at later gestational ages
- In addition, characteristics of women seeking abortion at later gestational ages are different

Long-term complications of abortion

- Pelvic adhesions
  - These form when uterine perforation occurs
  - More common in second trimester abortions
  - Also occur as a result of infection following abortion

Long-term complications of abortion

- Bhattacharya et al, 2012 found that induced abortion in a first pregnancy increased the risk of preterm birth
- Surgical abortion increased the risk of subsequent preterm delivery compared with medical abortion

Bhattacharya et al, 2012. Reproductive outcomes following induced abortion: a national register-based cohort study in Scotland. *BMJ*

Human Reproduction, Vol.27, No.11 pp. 3315–3320, 2012

Advanced Access publication on August 29, 2012 doi:10.1093/humrep/des294

human reproduction

ORIGINAL ARTICLE *Reproductive epidemiology*

Birth outcomes after induced abortion: a nationwide register-based study of first births in Finland

R. Klemetti[1], M. Gissler[1,2], M. Niinimäki[3], and E. Hemminki[1]

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Induced abortion and preterm birth (Klemetti *et al*)

- Most abortions were surgical (88%) and done for social reasons (97%)
- Increased odds for very preterm birth (<28 weeks) were seen in all subgroups: 1.19 after 1, 1.69 after 2, 2.78 after 3 abortions
- Increased odds for preterm birth and low birthweight were seen with > 3 abortions

Abortion and Mental Health

- A robust literature exists on mental health problems following abortion
  - Coleman (2011) performed a meta-analysis which included 22 studies and 877,181 women
  - An 81% increase in mental health problems including depression, anxiety, substance abuse and suicide was noted in women who had IAb
  - The risk for mental health problems was increased 55% in women who had IAb compared with those who gave birth

Coleman P. Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. *Br J Psych* 2011(199), 180-186..

Abortion and Mental Health

- Another review by Bellieni and Buonocore (2013) examined mental health following abortion, childbirth, miscarriage and unplanned pregnancy with childbearing
- Outcomes studied were depression, anxiety (including PTSD) and substance abuse

Abortion and Mental Health

- A higher proportion of studies showed an increased risk for mental health problems in women who underwent induced abortion (Iab) compared with those who gave birth, had a miscarriage or had an unplanned pregnancy and gave birth

Abortion and Mental Health

- They concluded that *fetal loss exposes women to a higher risk for mental health issues than childbearing*, and that in some studies abortion was a more powerful risk factor for mental health problems than miscarriage

Bellieni CV, Buonocore G. *Psychiatry Clin Neurosci*. 2013 Jul;67(5):301-10

Another harm to women? Non-physicians performing abortions

- In an effort to circumvent state abortion restrictions, abortion rights organizations are advocating for and training non-physicians to perform medical and surgical abortions
  - **This is a violation of State law, as well as scope of practice laws**
- Patients with complications are told to “go the emergency room, but don’t tell them you had an abortion, just that you’re miscarrying”

Another harm to women? non-physicians performing abortions

- There are active efforts to promote these activities nationwide
  - One possible goal is to undermine state antiabortion laws and provide impetus for their repeal, or for expansion of scope of practice laws
- However, NO data are collected on these practitioners
- This represents a resurgence of clandestine abortion

Non-physicians: performing abortions to circumvent state abortion laws (from apctoolkit.org)

- "However, in a number of states, including those with physician-only laws, APCs [advanced practice clinicians] with additional training are providing medication and, in some cases, aspiration [surgical] abortions as a result of Attorney General opinions, regulatory clarifications, and other mechanisms (Joffe & Yanow, 2004; Advancing New Standards in Reproductive Health, 2007).

Non-physician induced abortion (from apctoolkit.org)

- “This demonstrates that even in states where abortion is restricted by law to licensed physicians, nonlegislative strategies have provided APCs with opportunities to incorporate abortion services into their practices.”

Another harm to women? Non-physicians performing abortions

- In an effort to circumvent state abortion restrictions, abortion rights organizations are advocating for and training non-physicians to perform medical and surgical abortions
  - **This is a violation of State law, as well as scope of practice laws**
- Patients with complications are told to “go the emergency room, but don’t tell them you had an abortion, just that you’re miscarrying”

Another harm to women? Non-physicians performing abortions

- Emergency room physicians therefore lack critical information
- This shows disregard for patient welfare through patient abandonment as well as refusal to take responsibility for women's care
  - *These practitioners have much in common with back-alley abortionists, who forced women to lie about their real reason for coming to the hospital*
    - Women are often too fearful or ashamed to tell what really happened and are therefore victimized again through emotional blackmail

Another harm to women? non-physicians performing abortions

- There are active efforts to promote these activities nationwide
  - One possible goal is to undermine state antiabortion laws and provide impetus for their repeal, or for expansion of scope of practice laws
- However, NO data are collected on these practitioners
- This represents a resurgence of clandestine abortion