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S. HRG. 113–844

S. 1696, THE WOMEN'S HEALTH PROTECTION ACT: REMOVING BARRIERS TO CONSTITUTIONALLY PROTECTED REPRODUCTIVE RIGHTS

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JULY 15, 2014

Serial No. J–113–69

Printed for the use of the Committee on the Judiciary

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S. 1696, THE WOMEN'S HEALTH PROTECTION ACT: REMOVING BARRIERS TO CONSTITUTIONALLY PROTECTED REPRODUCTIVE RIGHTS

TUESDAY, JULY 15, 2014

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in Room SD–226, Dirksen Senate Office Building, Hon. Richard Blumenthal, presiding.

Present: Senators Blumenthal, Klobuchar, Franken, Coons, Hirono, Grassley, Hatch, Graham, Lee, and Cruz.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, A U.S. SENATOR FROM THE STATE OF CONNECTICUT

Senator BLUMENTHAL. Welcome to everyone. Thank you for joining us today. Thank you to our witnesses. Thanks to our Ranking Member, Senator Grassley, and most especially to Senator Leahy, the Chairman of the Judiciary Committee, for giving me this privilege of chairing this hearing.

We are convened today to hear testimony regarding the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights, and our first panel consists of a number of our colleagues who have positions and views on this issue. We welcome you this morning from the House, as well as my colleague Senator Baldwin of the Senate, who is my cosponsor in the measure that is now pending before the Senate and who has been a leader for a long time in this area.

We have support from more than 30 of our Senate colleagues, and my understanding is that the companion measure introduced by Representative Chu has 125 cosponsors in the House, or thereabouts.

The reason for this bill is essentially the cascading avalanche of restrictions on reproductive health care around the country. What we see increasingly is, in effect, an avalanche of measures that purportedly protect women's health care, but in reality restrict reproductive rights. This bill is about stopping laws that purport to be about health when really they interfere with the doctor-patient relationship and have the effect, the very practical impact of harming women and limiting constitutionally protected rights. Our goal, speaking for myself, our goal is to stop politicians from playing doctor and stop public officials from interfering in significant medical

decisions that should be made by medical experts and patients together.

This legislation would eliminate limitations on access to abortion services and eliminate the targeting and unwarranted restrictions against abortion providers and clinics, no matter where a woman may live. In fact, more than half the States now have these very unwarranted and unconstitutional restrictions, and the majority of women in our country live in those States. They have passed 92 restrictions on a woman's right to choose in those States, since 2011 more than 100, and in 2014 at least another dozen of these harmful laws have been enacted. So we are talking about serious harassment of reproductive health care providers, singling them out for regulations that apply to no other medical services, regulations that do nothing to improve a woman's health or safety, and, in fact, are more likely to harm them. These regulations are designed to shut doors of vital health care providers forever, and that purpose has been fulfilled across the country as the availability of these services has been restricted.

These regulations are in effect a pernicious charade, and one of the purposes that I see in this hearing is to remove the patina of respectability and show that they are, many of them, irresponsible and even reprehensible. Under the guise of protecting women's health care, they actually endanger it.

I want to thank again our witnesses and my fellow members for making this hearing happen. We may disagree on these issues, but I know that we are going to have a very enlightening and engaging hearing. And I want to turn now to the Ranking Member, Senator Grassley, for his remarks.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM THE STATE OF IOWA

Senator GRASSLEY. Thank you to our colleagues in the other body that are here, as well as the Senator from Wisconsin, and thank you for the succeeding panel that will be here.

Four and a half years ago, a woman walked into an abortion clinic with the expectations that she would have her pregnancy terminated and that she would walk out of that clinic without major side effects. She was 41 years old and 19 weeks pregnant. She had three children, and she was also a grandmother. She and her daughter entered the clinic, but she never left alive. Her name was Karnamaya Mongar. She was one of the many victims of Kermit Gosnell.

Kermit Gosnell operated a clinic in West Philadelphia for four decades. He made a living by performing abortions that no other doctor should ever do. The grand jury report charging Kermit Gosnell stated, "Gosnell's approach was simple: keep volume high, expenses low, break the law. That was his competitive advantage." Also according to the grand jury report: "Gosnell ran a baby charnel house. It smelled of cat urine. Furniture and blankets were stained with blood. Instruments were not sterilized, and medical equipment was broken. He provided same-day service. Required counseling was ignored. The bigger the baby, the bigger the charge. Ultrasounds were forged so that the government would never know how old aborted babies truly were. Babies were born alive, killed

after breathing on their own, by sticking scissors into the back of the baby's neck and cutting the spinal cord. These were live, breathing, squirming babies."

He did not care about the well-being of these aborted babies. He did not care about the health of the women. Women were put under because he disliked the moaning and groaning and screaming.

This practice and his disregard for the law led to the death of two women, including the one that I have already mentioned.

Now, Pennsylvania has a law against abortions after 24 weeks. It also has a very commonsense law that says women should receive counseling about abortion procedures and they must wait 24 hours after the first visit to the provider in order to fully consider the decisions that they are about to make.

While it is true that Kermit Gosnell ignored the law, these laws have saved lives. They have saved women from horrible, life-threatening procedures. They have saved babies.

If the bill we are discussing today, the Women's Health Promotion Act, were to become law, Pennsylvania's laws would be invalidated. Abortion providers would not be required to counsel their patients or give them 24 hours to consider what they were about to do. And, more importantly, it would lead to inhumane, unsanitary, heinous, dangerous, shocking, and unsafe abortions. The law that helped convict Kermit Gosnell would be wiped away.

This proposed legislation is an attempt to override U.S. Supreme Court precedent by severely restricting the ability of States to regulate abortion. It would invalidate hundreds of abortion-related laws, such as clinic regulations, admitting privileges requirements, regulations on abortion-inducing drugs, reflection periods, ultrasound requirements, conscience protections, sex-selection bans, and limitations on the use of State funds and facilities for abortion training.

Now, my home State of Iowa has laws on the books to protect the unborn and the health of the women. For example, an Iowa law stipulates that when inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided. That was enacted to ensure that women were not taking abortion-inducing drugs via webcam and then far from a medical provider who may save the life if a problem came about.

We also have a law on the books to protect the rights of medical professionals. Specifically, the law says: "An individual who may lawfully perform, assist, or participate in medical procedures which will result in an abortion shall not be required against that individual's religious beliefs or moral convictions to perform, assist, or participate in such procedures. A person shall not discriminate against any individual in any way, including but not limited to employment, promotion, advancement, transfer, licensing, education, training, or granting of hospital privileges or staff appointments, because of the individual's participation in or refusal to participate in recommending, performing, or assisting in an abortion procedure."

Iowa and many other States have taken action on their own to make sure that abortions are done safely. They have protected indi-

viduals from having to kill babies against their own religious beliefs.

Yet the bill before us would invalidate these laws and would allow abortion providers to set standards of care for their patients with no oversight from the States. It would allow health care workers to determine when a life is viable, ensuring that there are several and various standards across the country. The bill would invalidate laws enacted by 10 States since 2010, which declare that unborn children are capable of experiencing pain at least by 20 weeks of fetal age, and that generally prohibit abortion after that point.

If the bill before us were to be signed into law, the Federal Government would send a message to States that enacting laws to protect patients and regulate the health and welfare of their citizens is not one of their Tenth Amendment rights. It would allow Congress to intrude on States' rights and nullify such laws.

This bill is a weak political opportunity before the midterm elections. It is unfortunate that the majority is using this issue to appear compassionate and concerned about women's rights when, in reality, the bill disregards popular and commonsense laws enacted in various states aimed at protecting women and children across this country and stopping murders like Kermit Gosnell. Large majorities of Americans support strong abortion restrictions that this bill would overturn.

This bill will not become law because the American people will not support it. I thank the witnesses once again.

Thank you.

Senator BLUMENTHAL. Thank you, Senator Grassley.

We will now hear from our colleagues, and, again, my thanks to the Congresswomen who have come to join us. Let us begin with Senator Baldwin, if we may.

STATEMENT OF HON. TAMMY BALDWIN,
A U.S. SENATOR FROM THE STATE OF WISCONSIN

Senator BALDWIN. Thank you, Chairman Blumenthal and Ranking Member Grassley and members of the Committee, for this opportunity. I am encouraged that the Committee is pursuing a constructive conversation on this issue, and I am grateful for the opportunity to share my work on the Women's Health Protection Act.

I would also like to recognize the tireless advocacy of my Wisconsin State Representative Chris Taylor, who is here today and will be on the second panel to share her experience working to defend women's access to health care in Wisconsin. I thank her for her testimony today.

Americans across the country expect to have access to high-quality, dependable health care when they and their families need it. Indeed, my colleagues and I have worked to reform and improve health care, the entire health care system, to expand access to quality, affordable health care options so that all patients have health care that meets their needs.

Unfortunately, for women in this country, this access has come under attack. Over the last 40 years, politicians across the country have been increasingly chipping away at the constitutional rights guaranteed under *Roe v. Wade*, which affirmed that women have

the right to make their own personal health care decisions and have access to safe and legal reproductive care.

Since that landmark decision by our Nation's highest Court, too many States have been trying to turn back the clock on women's access to quality care.

In just the past 3 years, States across the country have enacted a total of 205 provisions that restrict women's access to safe abortion services. This year, 13 States have been busy working to erode women's freedoms and have already adopted 21 new restrictions designed to limit access to abortion.

In my home State of Wisconsin, we are now ranked as one of the worst States when it comes to women's reproductive rights thanks to the restrictive measures enacted by our Governor and our legislature.

To name just one, last year our Governor signed a measure forcing women—who are already required by law to make two separate trips to the clinic—to also undergo an invasive ultrasound 24 hours before receiving abortion care.

This same law also forces health care professionals to have unnecessary admitting privileges at a local hospital. If it were not for a Federal judge temporarily blocking this provision, two of Wisconsin's four abortion clinics would have been forced to shut their doors, and others would have been forced to reduce services, leaving many Wisconsin women out in the cold.

But women and their families should not have to rely on last-minute court decisions to be able to make the best decisions for themselves and their families.

I recently heard from a mother in Middleton, Wisconsin, who was not so lucky. When she found out her baby had a severe fetal anomaly and would not survive delivery, she had to endure the consequences of the Governor's new law before the Federal court judge blocked the provision.

She had to undergo an emergency termination, and a clinic in Milwaukee was the only place that would do the procedure. But because the Governor was set to sign the law imposing these unreasonable requirements on providers, the clinic was preparing to close its doors and would not schedule her procedure. She and her husband were forced to find child care for their two sons and travel out of State so she could receive the medical care that she needed.

The threat in Wisconsin and in States across the country is clear. Some politicians are doing this because they think they know better than women and their doctors. And the fact is that they do not.

Women are more than capable of making their own personal, medical decisions without consulting their legislator.

It is not the job of politicians to play doctor and to dictate how professionals practice medicine. Nor is it our job to intrude in the private lives and important health decisions of American families.

This is why I was proud to be a cosponsor of the Women's Health Protection Act with my colleagues Senator Blumenthal and Congresswoman Chu to put a stop to these relentless attacks on women's freedom.

Let me conclude by briefly describing the bill.

The Women's Health Protection Act would prohibit these laws that undermine and infringe on a woman's constitutional rights

guaranteed under *Roe v. Wade*. Specifically, our bill would outlaw any mandate or regulation that does not significantly advance women's health or safety. Our legislation also protects women by invalidating measures that make abortion services more difficult to access and restrictions on the provision of abortion services that are not imposed on any other medical procedures.

Congress is responsible for enforcing every American's fundamental rights guaranteed by our Constitution. Throughout history, when States have passed laws that make it harder—or even impossible—to exercise those rights, we have necessarily stepped in with Federal protections. The Women's Health Protection Act would ensure that every woman--no matter where she lives—has access to safe, quality reproductive health care without interference from politicians.

I thank you for your time.

[The prepared statement of Senator Tammy Baldwin appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Senator.

Representative Black.

STATEMENT OF HON. DIANE BLACK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Representative BLACK. Chairman Blumenthal, Ranking Member Grassley, and Members of the Committee, thank you for the opportunity to testify before you today. As has been said, my name is Diane Black, and I am privileged to have the honor of serving in the House of Representatives on behalf of Tennessee's 6th Congressional District.

Prior to entering public service, I built my career around the health care sector as a registered nurse. My career began as an emergency room nurse, where I spent the majority of my career, but I have also worked as a long-term care nurse and as part of an outpatient surgery team. I decided to run for office after I witnessed firsthand how poor public policy was directly impacting my ability to deliver health care and, more importantly, the unfortunate outcomes on the lives of my patients.

Today I am here to share with you, as a colleague in the House, and also as a mother, a grandmother, and a nurse, my grave concerns with the Chairman's legislation. Although called "The Women's Health Protection Act," this bill would nullify and declare unlawful any law at any level of the Government—whether Federal, State, or local—that presents what the bill deems to be an undue burden on women seeking an abortion. This legislation would effectively overturn the majority of State laws regulating abortions.

As a nurse, I can tell you that abortion is unlike any other medical procedure. This is an act that does not just involve the mother, but the child. It takes the life of an unborn child and in the process imposes many serious medical risks to the mother.

To be clear and transparent, I am unapologetically pro-life. And while I believe that the life of an unborn must be protected, I also believe that we must do everything in our power to protect any woman who decides to have an abortion, even though I may disagree with their choice.

During my time in the ER, a young woman came in after having complications with her abortion, which had been done at a clinic that was not regulated properly. When the complications occurred, there was no answer at the after-hours number that she called. And by the time she reached the hospital, she was dying and there was nothing that I or the doctors could do to save her life.

As a result of an abortion, the young woman lost her precious life. Her life could have been saved if proper regulations had been in place that protected her health and well-being and that held the abortionist accountable.

Now, infections occur in 1 to 5 percent of the abortions. Cervical lacerations, incompetent cervix, and other injuries can occur to the cervix and other organs during abortion procedures. Worse, minors are up to twice as likely to experience cervical lacerations during an abortion and overall are even more susceptible to short-term risks than are older women.

Women who have had abortions are at a 37 percent increased risk of pre-term birth in subsequent pregnancies, a 30 to 50 percent increased risk of placenta previa in subsequent pregnancies, and 18 percent more likely to develop breast cancer as opposed to the average of just 12 percent. In the case of women with a family history of breast cancer, this jumps up to 80 percent.

Abortions not only pose serious physical risks but endanger a woman's mental health as well. Studies show that after having an abortion, a woman is 81 percent more likely to develop a mental health issue, is at a 37 percent increased risk of depression, a 110 percent increased risk of alcohol abuse, and sadly, a 155 percent increased risk of suicide.

After the horrific case of abortionist Kermit Gosnell, Americans know that even though abortions are legal, these procedures that are risky and must be regulated. Perhaps this is why 39 States require that abortions be performed by a licensed physician and why 26 States require abortion clinics to meet the same clinic standards as ambulatory surgical care clinics. And just as important, 42 States prohibit abortion after a certain point in the pregnancy, and about 9 States prohibit abortions at 20 weeks, or at the start of the sixth month of pregnancy, when medical research affirms that unborn children can feel pain during an abortion. We are, after all, discussing a medical procedure that ends a human life.

Let us also not forget that the Supreme Court indicated in *Planned Parenthood v. Casey* that the Government has an interest in preserving fetal life. Senate bill 1696 represents a sweeping attempt to undermine dozens of measures enacted by States to protect women, all under the false pretense that abortions are safe and rare.

My hope today is that we can reach across party lines, realize our preconceived notions on this topic, and see abortion for what they really are. Abortion is brutal—to both the mother and the unborn child. It is not health care. To reference the Supreme Court, a dilatation and extraction abortion, which represents the majority of abortion procedures in America, is as generally gruesome as partial birth abortion. These abortion procedures are the most common for abortions performed in the second trimester of pregnancy, where the unborn child is literally torn apart limb by limb.

In considering this and the many health care risks that can occur as a result of abortions, I strongly urge you to reconsider advancing Senate bill 1696 and any other effort that would undermine current laws that exist to protect the health and well-being of women and unborn children at the Federal level, State, and local government level.

Thank you again for the opportunity to be here today, and I yield back.

[The prepared statement of Representative Diane Black appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Representative Black.

Representative Chu.

STATEMENT OF HON. JUDY CHU, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Representative CHU. Thank you, Chairman Blumenthal, Ranking Member Grassley, and Committee members for the opportunity to testify today. Every woman should have access to affordable and comprehensive health care coverage that protects her right to choose. This should be the case regardless of her income, the type of insurance she has, or the State she resides in so that she can make personal health decisions based on what is best for her and her family.

But we are witnessing an alarming moment in time. Attacks on reproductive rights are intensifying. Having lost in our court system with *Roe v. Wade*, opponents of reproductive freedom are trying to undercut our constitutional right and make it increasingly difficult to access a legal abortion. They are trying to take us back to a time before Roe, when 1.2 million women resorted to illegal abortions each year. Their goal is to take us back to a time when unlicensed doctors, in unsanitary conditions, performed abortions that led to infections, hemorrhages, and at times, death. They are taking us back to a time when many women knew the hazards, but risked all of this because they were desperate—and this was their only option.

The new trend is to shut down abortion services, but this time State by State.

This is happening all across the country. Individual States have signed into law restrictive regulations that single out abortion services. Between 2011 and 2013, more than two dozen States passed over 200 restrictions that block access to abortion services. This translates to more restrictions placed on women's health care in 3 years than in the entire preceding decade.

The effect of these laws is that a woman's constitutional right now depends on her address. The rights of women residing in my home State of California now vastly differ from the rights of women living in Texas or Mississippi. According to the Guttmacher Institute, 56 percent of women—over half of women in our country—now live in a State that is hostile to abortion.

These laws range from mandatory waiting periods to biased counseling requirements to the exact size requirements and corridor width for the offices in which the procedure is to take place.

They are laws like the recent one in Texas, which make no sense medically. They require doctors performing abortion procedures to

have formal admitting privileges at a hospital within 30 miles of their clinic, among other senseless requirements. We already see the effects. After the law passed, clinics began closing their doors. For women in Texas, this means longer waits, higher costs, and canceled appointments. Some have to travel over 150 miles to get to the nearest clinic. These obstacles have put many women in desperate circumstances, some of which may very well endanger their lives.

We need laws that put women's health and safety first—not politics. And that is why we introduced the Women's Health Protection Act this Congress. We recognized that without the ability to access it, the right to abortion is meaningless. This bill would outlaw the restrictive State laws that target abortion services and shut down clinics across the country. The bill would outlaw State-mandated medical procedures such as forced ultrasounds, restrictions on medication abortions, and other onerous TRAP laws. Simply put, this bill would end discrimination against abortion access for women based on their zip code.

I am so proud to be the lead sponsor of this bill in the House and to partner with Senators Blumenthal, Baldwin, and Congress Members Fudge and Frankel to push as hard as we can on this bill. We already have 124 cosponsors in the House.

Constitutional rights should never be subject to the personal whims or beliefs of political leaders. Nor should the safety of mothers, daughters, sisters, or wives be jeopardized in the process.

Thank you for the opportunity to testify, and thank you for holding this important hearing to discuss how we can protect the health, safety, and rights of all women.

[The prepared statement of Representative Judy Chu appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Representative Chu.

Representative Blackburn.

STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Representative BLACKBURN. Thank you, Mr. Chairman. I appreciate the opportunity to join you all. Senator Grassley, thank you for the invitation.

I think that it is fair to say that every one of us at this table, and certainly each of you, we all want what is best for women. We differ on what that is, and we differ on how to get there. And I am very appreciative of the opportunity to be here and to talk with you about this legislation, the Women's Health Protection Act.

In my opinion, it is something that is extraordinarily broad, it is loosely written, and through its wide-ranging words would, in my opinion, substitute the special interests of the abortion industry for both the well-being of women and the value of human life.

The legislation would jeopardize and nullify hundreds of laws, as has previously been mentioned at this table, laws that protect both mothers and their unborn children. Among my concerns with the bill—and Senator Grassley mentioned several of these—it would render impossible efforts by the States to limit abortions based on the sex of the child; it would put a double pressure on women, who

are often forced by familial or cultural pressures, to exercise male bias in pregnancy and eliminate a female child.

Furthermore, this legislation sets a dangerous precedent because it would place unconstitutional limits on a State's ability to assure the safety of medical facilities. Abortions are indeed invasive medical procedures and should be regulated by the States as such.

In addition, by considering this legislation, many of your constituents perceive that this body is out of touch with the consensus opinion in this country. Public opinion polls show time and again that the American people support limits on abortion. They support this. Sixty percent of Americans believe abortion should not be permitted in the second trimester, and an overwhelming 80 percent believe it should never happen in the third. Women hold these convictions at a higher percentage than men, and it is no wonder. We bear life—and we bear the burden when public policies fail to support women at a critical hour.

The Committee would be well advised to consider how far this bill goes in reversing and uprooting both a long-existing and rising consensus. S. 1696 would attack conscience exemptions that have existed since the 1973 abortion decision. It would bar laws that provide for periods of reflection and consideration before an abortion is chosen. It would even prevent a State from assuring that a physician is physically present when abortion drugs are given or even that only a physician may perform a surgical abortion. It would make the abortion process less safe.

What the Senate should be considering today is the Pain-Capable Unborn Child Protection Act which passed the House of Representatives on June 17, 2014, on a bipartisan vote, 228–196. The Pain-Capable Act is a piece of legislation that is supported by the American people. It is based in science and filled with compassion. The Pain-Capable Unborn Child Protection Act limits abortions after the 20th week of pregnancy except in the instances of rape, incest, or to protect the life of the mother. Our Nation is one of only about seven countries in the world to allow elective abortion to term, and this legislation would take one small but vital step to move us closer to the international norms.

Polls by Quinnipiac University, the Washington Post, and the Huffington Post have all shown that a strong majority of people support limiting abortion after the 20th week of pregnancy. Quinnipiac University's poll shows that women support a 20-week limit in even greater numbers than men—60 percent of women versus 20 percent in opposition—a 35-point margin.

Let me give you an example of why these have changed. You all have an exhibit from me, and I want to show you this. This is a 3-D ultrasound of my grandson. It was made on March 11, 2009, before his birth June 12, 2009. This is the wonder of science. And I have to tell you how exciting it was for me to see this ultrasound. I was thrilled. I could tell—I could tell—before he was born, 3 months before he was born, he had my eyes and nose. Now, for a grandmother, that is a really big deal. I could see his hands. I could see his arms. And I could see him peacefully resting in his mother's womb.

That is the wonder of science. That is life. Our Constitution does not put a qualifier on life. The pursuit of life, liberty, pursuit of

happiness, those protections, the right to life, liberty, pursuit of happiness, even in the mother's womb.

I urge this Committee to reconsider this legislation. We have mentioned today the horrors of the Kermit Gosnell trial, the Philadelphia-based abortionist who ran a dangerous, illegal, and ghastly so-called clinic. He was tried, rightfully convicted for the crimes he committed and the deaths that he caused in that terrible place. Yet the legislation that you are considering, the Women's Health Protection Act, could be used to validate the acts that placed him behind bars and to invalidate the bipartisan legislation put in place.

I find it so curious that your legislation is termed "The Women's Health Protection Act." In my opinion, it would be more accurately titled "The Removal of Existing Protections and Safety Measures for Women Undergoing Abortion Act."

I encourage you to reconsider your legislation, to take up the Pain-Capable Unborn Child Protection Act, and to be more in line with the consensus of Americans and the States who are making certain that abortion is indeed safe, legal, and rare.

I yield the balance of my time.

[The prepared statement of Representative Marsha Blackburn appears as a submission for the record.]

Senator BLUMENTHAL. Thanks to each of you, and we are going to move to our next panel. We really appreciate your being here this morning. Thanks for your excellent testimony.

Before you get too comfortable, I am going to ask you to stand because the custom of our Committee is to swear in our witnesses. If you would please rise? Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Ms. NORTHUP. I do.

Dr. CHIREAU. I do.

Dr. PARKER. I do.

Ms. TOBIAS. I do.

Ms. TAYLOR. I do.

Senator BLUMENTHAL. Thank you. Let me introduce our witnesses before they give their testimony.

We are going to begin with Nancy Northup, who is the president and CEO of the Center for Reproductive Rights. She has worked as a constitutional litigator and Federal prosecutor before her appointment at the Center for Reproductive Rights, which is a global human rights organization that has documented rights abuses, brought ground-breaking cases before Federal and State courts, U.N. committees, regional human rights bodies, and has built the legal capacity of women's right advocates in more than 55 countries.

Dr. Monique Chireau is an obstetrician/gynecologist in Durham, North Carolina, and affiliated with multiple hospitals in the area, including Duke University Hospital and Durham Veterans Affairs Medical Center. She is one of 250 doctors at Duke University Hospital and one of 5 at Durham Veterans Affairs Medical Center who specialize in obstetrics and gynecology.

Dr. Willie Parker, our third witness, has over 20 years of experience providing comprehensive women's medical care. He is board certified and trained in preventive medicine and epidemiology

through the Centers for Disease Control. Dr. Parker currently provides abortion care for women in Alabama and Mississippi.

Carol Tobias is president of the National Right to Life Committee. She has held various positions at the National Right to Life Committee since 1991.

Representative Chris Taylor represents Assembly District 76 in the Wisconsin Assembly. Representative Taylor has a long history of working with the State legislature even prior to her election in 2011, and she has led numerous State and local coalitions in various settings around the State of Wisconsin.

We welcome you all and thank you very, very much for being here this morning. Nancy Northup.

STATEMENT OF NANCY NORTHUP, PRESIDENT, CENTER FOR REPRODUCTIVE RIGHTS, NEW YORK, NEW YORK

Ms. NORTHUP. Thank you, Senator Blumenthal, and thank you, Ranking Member Grassley, for having us here today for this important hearing. I am Nancy Northup, and I am president and CEO of the Center for Reproductive Rights.

Today, one of our most basic protections of our Constitution—the right to make for ourselves the important decisions of our lives—is under assault for women throughout vast swaths of the Nation. There have been over 200 State laws passed in the last 3 years designed to make it harder or impossible for women to access abortion services in their communities. And we are not blocked by courts. This new wave of restrictions is shutting down clinics, closing off essential services, and harming women.

This is the newest tactic in a four-decade campaign to deprive women of the promise of *Roe v. Wade*. There have been during those four decades terrorizing physical attacks; clinics bombed, vandalized, and torched; doctors and clinic workers murdered; and clinics blockaded. Twenty-five years ago, I locked arms with members of my church and concerned citizens in Baton Rouge to form a human chain of protection around a reproductive health care clinic as hundreds of Operation Rescue protesters descended, intent on obstructing patients from entering. This scene was played out over and over again across the Nation. Federal action was needed and taken in 1994, with Congress' passage of the Freedom of Access to Clinic Entrances Act.

Today, women's access to abortion services is being blocked through an avalanche of pretextual laws that are designed to accomplish by the pen what could not be accomplished through brute force—the closure of facilities providing essential reproductive health care to the women of this country.

At an alarming rate, States are passing laws that single out reproductive health care providers for excessively burdensome regulations designed to regulate them out of practice under the false pretense of health and safety.

When Mississippi enacted such a law in 2012, a State Senator put it quite plainly: "There is only one abortion clinic in Mississippi," he said. "I hope this measure shuts that down." Right now, Mississippi's sole clinic is holding on by virtue of a temporary court order.

Even when not flatly stated, the true purpose of these laws is evident. Abortion is one of the safest medical procedures, yet it is being singled out for burdensome restrictions not placed on comparable medical procedures. For example, obstetricians who perform miscarriage completions in their office practices are not subject to these onerous requirements, despite the fact that they are performing virtually the same medical procedure as abortion providers, who are subject to these requirements.

The American Medical Association and the American College of Obstetricians and Gynecologists have gone on record against many of these laws. And, indeed, you have their testimony before you today for the ACOG. Courts have found some so at odds with medical standards that they can serve no purpose but to prevent women from ending a pregnancy.

But the road blocks keep coming. A year ago, Texas passed a sweeping set of restrictions to devastating effect. At least one-third of that State's clinics have been forced to stop providing abortion care. There is no clinic left in the Rio Grande Valley, an impoverished area with over 1.3 million residents. If the final requirement of Texas' restrictions is allowed to go into effect in September, the number of clinics will plummet to less than ten to serve a sprawling State of over 260,000 square miles and 13 million women.

Even before this new law, a 2012 study in Texas found that 7 percent of women reported attempts to self-abort before seeking medical care. Now women are crossing the border into Mexico to buy miscarriage-inducing drugs at flea markets or off the shelves at pharmacies—and then seeking needed emergency care back in Texas.

Like all of us here, I come to the issue of abortion rights with my own set of life experiences, personal commitments, and religious beliefs. As the Supreme Court wisely noted over 20 years ago in *Planned Parenthood v. Casey*, men and women of good conscience can disagree, and probably always will, about the moral and spiritual implications of ending a pregnancy. In reaffirming the basic tents of *Roe v. Wade*, the Court reminded us that "it is a promise of the Constitution that there is a realm of personal liberty which the government may not enter." The most fundamental decisions about our reproductive health and lives are for each of us to make, and not for the government.

One in three women in the United States makes the decision at some point in her life that ending a pregnancy is the right choice for her. That decision is based on her individual circumstances, her health, and her life. None of us walk in her shoes. None of us know the factors that lead to her decision.

And when a woman makes that decision, she needs good, safe, reliable care from a health care provider she trusts, in or near the community that she calls home.

But today a woman's ability to do so increasingly depends on the State in which she happens to live. Like 20 years ago, Congress needs to take action to ensure that women's constitutional rights and their ability to make the most personal of decisions is not taken from them.

Thank you.

[The prepared statement of Nancy Northup appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Ms. Northup.

Dr. Monique Chireau.

STATEMENT OF MONIQUE V. CHIREAU, M.D., DURHAM, NORTH CAROLINA

Dr. CHIREAU. Yes, thank you. It is an honor to be here today, Senator Blumenthal, Senator Grassley. My name is Dr. Monique Chireau. I am on the faculty of the Duke University Medical School. I am also a practicing obstetrician/gynecologist and a clinical researcher.

S. 1696 could reasonably be interpreted to invalidate virtually any type of current State laws which place restrictions or regulations on abortion. It would also endanger health care providers' freedom of conscience and would prohibit the future enactment of such protective laws.

The stated purpose of the bill, as we have understood it, is to protect women's health by ensuring that abortion services will continue to be available. Implicit in this stated purpose of the bill are the four following assumptions: number one is that abortion is good and safe for women; number two, that State abortion restrictions and regulations are medically unwarranted; number three, that access to abortion is important to women's health; and, number four, that the State has no interest in protecting unborn children. I will address each of these in turn.

The Centers for Disease Control define an induced abortion as "an intervention performed by a licensed clinician that is intended to terminate a suspected or known intrauterine pregnancy and produce a nonviable fetus at any gestational age." The U.S. 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, and that the abortion decision has implications far broader than those associated with other medical treatment.

Assumption number one is that abortion is good for women. However, a substantial body of literature indicates that induced abortion is associated with significant risks and potential harms to women. It is stated to be very safe at early gestational ages; however, in a very large study from Finland of 42,619 women, the maternal mortality rate from abortion was 14.1 per 100,000. Approximately 20 percent of the women in this study experienced severe adverse events, such as hemorrhage and infection.

This study included both surgical and medical abortions. These statistics represent a significant burden of disease, and if they were extrapolated to the United States, that would translate into 260,000 adverse events per year.

Further research has also demonstrated that the risk for abortion performed at greater than 21 weeks is greater—is greater when performed at 21 weeks than at lower gestational ages. The risks for death ranged from about 0.1 to 0.4 per 100,000 to 8.9 per 100,000. However, because of problems with the denominator of this study, the results cannot easily be extrapolated. The point is that late abortion carries a 77 times increased risk for mortality

compared with early abortion, and that is a significant issue. This is mortality. This is not morbidity. This is death.

Other complications can occur following abortion. Induced abortion of a first pregnancy, as we have heard earlier, increases the risk of subsequent preterm birth. There is also a robust literature on mental health problems following abortion. These mental health problems include anxiety, depression, and so on.

Assumption number two is that State abortion restriction regulations are medically unwarranted. States have a compelling interest in protecting the health of their citizens, and they have the authority to do so within regulatory frameworks, including State medical boards and departments of health. Historically, States have regulated medical procedures and clinics by establishing standards for training and credentialing. These standards protect patients from injury and death.

This is important because the fact of the matter is that patient-physician interactions do not occur within a vacuum. The issue of whether patients have access is a two-sided issue, a two-edged issue. This is because access can be—you can have access to care which is inadequate, being performed by incompetent practitioners, or you can have access to good care.

And zip codes do matter. In many zip codes in the United States, patients have access to care which is inadequate, which endangers their health. This bill would not protect the rights of patients because it would remove the ability of States to regulate the practice of medicine.

In addition, the scope of practice for different types of clinicians is carefully defined. Recently, there have been attempts by mid-level practitioners in several States to assume the role of providing abortions. Again, this particular bill would remove the ability of States to monitor and supervise the practice of medicine through abortion.

One of the questions that comes up in any of these discussions regarding the need for improved regulation, including monitoring of the access to clinics, widths of hallways so that emergency personnel can enter buildings, is, what is there to fear from complying with the law? If laws are enacted in order to protect the health of patients and—the health of patients and to protect really practitioners as well by providing them with the appropriate conditions to practice in, what is there to fear in this circumstance?

The question really is, To what extent are we willing to surrender States' ability to regulate laws regarding the provision of medical care?

Finally, the fact that the State does have an interest in protecting unborn life is not acknowledged in this particular bill. There is no mention of unborn children at all, in spite of the fact that the purpose of the bill is to eliminate most regulations or restrictions on abortion. The Supreme Court has recognized since *Roe v. Wade* that States have a compelling interest in the potentiality of unborn life throughout the pregnancy. This is because unborn children and their mothers are vulnerable to injury, exploitation, and social disadvantage. We care about whether a nurse who is mixing chemotherapy is exposing her fetus to potentially carcinogenic or teratogenic drugs, and this relates to the interest around

when pregnancy begins. If we do believe that pregnancy begins at conception rather than at implantation, which is our standard medical definition, we need to begin to consider how to best protect the fetus at early gestational ages. Similarly, neonatologists are pushing back the boundaries of neonatal viability. This bill does not take into account these scientific advances because it removes restrictions on abortions at various gestational ages.

So in conclusion, I would like to say that S. 1696 is a measure that seeks to overturn longstanding State restrictions on abortion that have been supported in the courts. It ignores not only widely supported policies and scientific evidence, but also prior Supreme Court rulings, and clearly targets State regulations which protect the health of our most vulnerable citizens—pregnant women and their unborn children. All access is not equal. Zip codes do matter, because we want patients' zip codes to provide—practitioners within zip codes to provide care that is sensitive, affordable, comprehensive, and competent.

Thank you.

[The prepared statement of Dr. Monique Chireau appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Dr. Chireau.

Dr. Parker.

STATEMENT OF WILLIE PARKER, M.D., BIRMINGHAM, ALABAMA

Dr. PARKER. Good morning, Senators. I consider it a real privilege to speak before this body this morning. My name is Dr. Willie Parker, and I am here to today to offer testimony in support of the Women's Health Protection Act.

I have devoted my whole career to helping women have the families that they want by providing them with prenatal care and delivering their babies, as well as providing them with medically accurate sex education, contraception, and, when they need it, safe abortion care.

If there is a war to defend the right to safe and legal abortion, then Mississippi, where I practice, is on the front line. The State recently passed laws restricting the provision of abortion to obstetrician/gynecologists and those with hospital admitting privileges. Now, this law, which is completely medically unnecessary, would shut down the one remaining clinic in that State, and thereby would effectively deny women in that State access to abortion. On top of this, the State also has mandated delays that are both costly and burdensome to the women seeking this care. A woman's access should not be denied to her simply because she lives in the State of Mississippi, or anywhere else, for that matter. The thing that should determine the care that a woman receives, it should be determined by medical evidence and not by her zip code.

Now, the proponents of these laws would say that they are protecting the health of women, and they are within their right to believe that, but the truth would suggest otherwise. Here are the facts in Mississippi: there are far too many teen and unintended pregnancies; the infant mortality and maternal mortality rates are extremely high; and there are far, far too many Mississippians living in abject poverty. These realities confront every woman wheth-

er she has an undesired pregnancy or a wanted but fatally flawed one. What women in Mississippi need is safe, compassionate medical care, and that need is urgent, and that care should include abortion. Because of these facts, I made what I consider to be the moral decision to provide abortion care in this State.

Now, invariably, given the climate around abortion in this country, I field questions from people regarding that decision, and the most frequently asked question is: Why? Why do you do this? Well, the short answer is because if I do not, who is going to do it?

If women in Mississippi and States surrounding can find a way to travel from rural areas under hostile circumstances to access the abortion care that they are entitled to, then I made a personal decision that I wanted there to be someone at that clinic to meet them when they came.

One patient that I often think of as I think about the work that I do is one of the first patients I took care of in Mississippi, who was a 35-year-old pregnant woman with five children, the youngest of whom had recently died the year before from cancer. This woman found herself with an unplanned pregnancy, and she confided in me that at this particular point in her life she could not care for another child, either economically or emotionally.

Now, she had already traveled an extensive distance to come to the mandated counseling that she was required to receive. And while she was completely resolute when she walked in the door and knew what was best for her and her family, she was still required to be delayed in her decision for political reasons that had nothing to do with her or her medical care.

Other women that I saw on that same day were returning for their procedure after having made the mandated wait, and they had recently completed a second trip from hours away to receive their care. These women made it to the clinic despite distance, work considerations, child care obligations, and travel costs. These women typify the hardships that Mississippi women and many other women around this country face as they endure the barriers created by the present laws.

In the 24 years that I have practiced medicine, I have learned a few things, and this is what I can tell you. Every patient is unique. Every woman is different. And when it comes to abortion, every one of them is grappling with a dilemma. I define a dilemma as a situation in which one has to make a decision between two undesirable outcomes, and yet one does not have the luxury of not making that decision.

While the stories of the women that I see might differ, what they all have in common is that for them it is increasingly difficult for them to access abortion. So as I said earlier, people ask me, "Why do you do it?" Well, I think the answer is very simple. I want for women what I want for myself. I want a life of dignity, good health, self-determination, and I want the opportunity to excel and to contribute in the manner that I best can.

We know that when women have access to abortion, contraception, and medically accurate sex education, they thrive in just the matters that I mentioned. It should be the same for all women, no matter where they live, because the ability to live the life that you imagine should not be limited by your zip code.

Thank you.

[The prepared statement of Dr. Willie Parker appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Dr. Parker.

Ms. Tobias.

STATEMENT OF CAROL TOBIAS, PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE, WASHINGTON, DC

Ms. TOBIAS. Mr. Chairman, Senator Grassley, and members of the Committee, thank you for giving me this opportunity to testify. I am Carol Tobias, president of the National Right to Life Committee. NRLC is a nationwide federation of 50 State-affiliated right-to-life organizations. We are the Nation's oldest and largest pro-life organization.

We find the formal title or marketing label, "Women's Health Protection Act," to be highly misleading. The bill is really about just one thing: stripping away from elected lawmakers the ability to provide even the most minimal protections for unborn children, at any stage of their development. The proposal is so sweeping and extreme that it would be difficult to capture its full scope in any short title. Calling it the "Abortion Without Limits Until Birth Act" would be more in line with truth-in-advertising standards.

In its 1980 ruling in *Harris v. McRae*, upholding the Hyde amendment, the U.S. Supreme Court said: "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life."

Even many Americans who identify as "pro-choice" struggle with the abortion issue because they see it as a conflict involving life itself. Many, while not fully sharing our view that the unborn child should be directly protected in law, nevertheless support the kinds of laws this bill would strike down, laws that take into account what most Americans recognize as a life-or-death decision.

In contrast, the drafters of S. 1696 apparently believe that any woman considering abortion must be shielded from any information that may cause her to change her mind.

Under S. 1696, elective abortion would become the procedure that must always be facilitated, never delayed, never impeded to the slightest degree.

What types of laws would the bill invalidate? The list includes limits on abortions after 20 weeks, past the point at which unborn children can experience pain, which are supported by sizable majorities nationwide; laws limiting abortion after viability; laws protecting individuals or private medical institutions from being forced to participate in abortion, which about three-fourths of the people support, and which the great majority of States have enacted; laws requiring that information be provided regarding alternatives to abortion, which 88 percent of the public supported in a Gallup poll; laws providing periods for reflection; laws prohibiting abortion because of the child's sex, which over 85 percent support. All these would be invalid.

Having failed in many cases to persuade the Federal courts to strike down the laws they dislike, the extreme abortion advocates now come to Congress and demand that this Federal pro-abortion statutory bulldozer be unleashed to scrape everything flat.

The bill would subject any law or Government policy that affects the practice of abortion, even indirectly, to an array of sweeping legal tests, designed to guarantee that almost none will survive. The general rule would be that any law that specifically regulates abortion would be presumptively invalid. The same would be true of any law that is not abortion-specific but has the effect or claimed effect of reducing access to abortion.

It is apparent that those who crafted this bill believe that where abortion is involved, immediate access to abortion at any stage of pregnancy is the only thing that matters.

Mr. Chairman, in a November interview with the newspaper Roll Call, you said, "As the election approaches, I think the voters are going to want to know where legislators stand on these issues." But to know where every Senator stands on S. 1696 would require a vote by the full Senate. By all means, let us see where they stand.

But in the spirit of "pro-choice," how about giving the Senate a choice as well? On May 13, Senator Graham proposed an agreement under which S. 1695, which has 35 cosponsors, would receive a vote of the full Senate, along with a separate vote on his Pain-Capable Unborn Child Protection Act, S. 1670, which has 41 cosponsors. The Pain-Capable Unborn Child Protection Act would protect unborn children in the sixth month and later, with narrow exceptions. By this stage in their development, if not sooner, there is abundant evidence that unborn babies will experience great pain as their arms and legs are wrenched off by brute force in the common second-trimester dismemberment procedure known as D&E.

Mr. Chairman, in your response to Senator Graham's proposal, you made clear your opposition to his bill. But you went on to say, and I quote, "I am more than happy to cast a vote on it along with the Women's Health Protection Act, and I hope they will be considered. This issue deserves to be before this body."

We agree. We challenge you and the leadership of the majority party to allow the American people to see where every Senator stands on both of these major abortion-related bills. Let the American people see which bill reflects the values of each member of the U.S. Senate: life or death for unborn children. Thank you.

[The prepared statement of Carol Tobias appears as a submission for the record.]

Senator BLUMENTHAL. Thank you, Ms. Tobias.

Ms. Taylor.

STATEMENT OF HON. CHRIS TAYLOR, STATE REPRESENTATIVE, WISCONSIN STATE LEGISLATURE, 76TH DISTRICT, MADISON, WISCONSIN

Ms. TAYLOR. Thank you so much. Good morning. My name is Chris Taylor, and I am a State representative from the great State of Wisconsin, representing the 76th Assembly District. I so appreciate the opportunity, Chairman Blumenthal, to testify in strong support of the Women's Health Protection Act, and I thank Ranking Member Grassley and Committee members for this opportunity today.

I also want to thank my Senator, Tammy Baldwim, whom we are very proud of in Wisconsin, for leading the way in cosponsoring this important bill.

I am also the former public policy director for Planned Parenthood of Wisconsin. I have been for over a decade monitoring, advocating for, and attempting to get passed good public policy on reproductive health care.

There is a consensus in Wisconsin about what Wisconsinites want the State legislature to focus on, and it is not abortion restrictions. It is on the critical economic issues that face our State. We have a stagnant economy in Wisconsin. We have stagnant wages. Working families are struggling. Those are the issues that Wisconsinites want the State legislature to focus on. But, unfortunately, that has not been the focus over the last 3 years, and Wisconsin has become one of the many battleground States where fights over a woman's ability to access abortion care are being waged.

We have only a few health centers in Wisconsin that provide abortions, and we have over a dozen abortion restrictions which have nothing to do with the health and safety of women and everything to do with politics.

Wisconsin is on the verge of becoming a State like Mississippi where abortion is simply not accessible. A woman's ability to access safe, legal abortion should not be dependent on where she lives or subject to the political whims of her State legislature, and that is why I am urging you to pass the Women's Health Protection Act.

Since 2011, we have seen a proliferation of abortion restrictions in Wisconsin, including restrictions on medication abortion, banning telemedicine, and requiring physicians who perform abortions to have hospital admitting privileges within 30 miles of their practices. We also have a forced ultrasound law. The hospital admitting privileges mandate is only imposed on physicians who provide abortions.

I am very fortunate to serve on the Health Committee in the State Assembly. There was no medical evidence or testimony presented that the admitting privileges status of a woman's abortion provider in any way enhances the health and safety of women who have abortions. In fact, there was no health care provider or health care organization who advocated for this law at all.

In contrast, the medical community vocally opposed this mandate, including the Wisconsin Academy of Family Physicians, the Wisconsin Hospital Association, the Wisconsin Public Health Association, and the Wisconsin Medical Society that stated, "This requirement interferes with the patient-physician relationship and places an unneeded and unprecedented burden on Wisconsin physicians and women."

The effect of the hospital admitting privileges law is going to be to shut down one of four health centers that provides abortions because the two physicians at this center are ineligible for these admitting privilege requirements. That means that over one-third of the women who seek abortions in Wisconsin are going to have to go elsewhere. The effect of that is to increase waiting times at the three remaining health centers. Currently, there are delays of 3 to 4 weeks to obtain an abortion in Wisconsin. With the closure of this clinic, those delays would be extended to 8 to 10 weeks.

Finally, we would have no health care provider providing abortions post 18 weeks, and so women who have complications or tragedies in pregnancy past 18 weeks are going to have to go else-

where. A delay of this magnitude clearly impacts all Wisconsin women seeking abortion care, but it has particular devastating effects on low-income women who rely on public transportation and cannot afford uncompensated work time and travel costs. So for poor women, these additional barriers may be insurmountable.

The same law that requires admitting privileges also forces a woman seeking abortion to undergo an ultrasound 24 hours before the procedure. The provider must also describe and display the image to the woman. This is the most humiliating and degrading law that I have seen in Wisconsin. It is certainly the Government at its biggest and most intrusive. Women are not able to refuse in most cases what is an invasive vaginal ultrasound. Physicians have no ability to tailor their medical care to the unique situation of each individual woman or adopt the best standard of care.

The medical community in Wisconsin also vocally opposed this restriction. They said that the mandatory performance of an ultrasound before an abortion is not an accepted medical practice or standard of care. This practice does not add to the quality or safety of the medical care being provided. Simply put, ultrasounds are being used in Wisconsin as political bludgeons.

Unfortunately, my Republican colleagues did not listen to the Wisconsin medical community. They did not listen to their own Democratic colleagues. We have 18 women in my caucus, in my Democratic caucus. As we talked about these issues prior to the debate, we realized we all had our own experiences that caused us to make very personal decisions about reproductive health care. We had members who had experienced pregnancy loss, miscarriage, stillbirths, high-risk pregnancies, and sexual assault. And we are just a microcosm of all the women in Wisconsin who we represent.

We decided that though we might be ignored by our colleagues on the other side of the aisle, that we would never be silent, and we decided to tell our own personal stories about why these laws are so harmful to women and have nothing to do with the reality of women's lives and experiences.

It is not my role as a legislator to dictate the most personal private decisions of my constituents. I have no business as a legislator dictating insupportable medical practices to a physician who is ethically obligated to provide the best care for women, and patients. But I am in the business of ensuring that the people in my district, the people I represent, are able to exercise their most fundamental, personal decisions about their lives. As it stands, with States legislating away those rights, we need the Women's Health Protection Act more than ever. Wisconsin women and women throughout this country simply cannot wait.

Thank you.

[The prepared statement of Hon. Chris Taylor appears as a submission for the record.]

Senator BLUMENTHAL. Thank you very much to all of our witnesses. I am going to ask, without objection, that all of your full statements be entered in the record, along with a statement from our colleague, Senator Feinstein.

[The prepared statement of Senator Dianne Feinstein appears as a submission for the record.]

Senator BLUMENTHAL. And to begin the questions. A number of our colleagues have votes at noon, so we will try to move along as quickly as we can.

Ms. Northup, there have been some very dismaying and sweeping claims about the breadth of this proposed legislation. Ms. Tobias referred to it as the "Abortion Without Limits Act." In fact, it is narrowly targeted to certain kinds of, in effect, bogus legislation, legislation that masquerades as health protection but really is designed to prevent access to abortion services that are constitutionally protected.

So I wonder if you could speak a little bit to the limited nature of this legislation, the fact, for example, that it specifically prohibits restrictions—and I am quoting from the Act—that "are more burdensome than those restrictions imposed on medically comparable procedures." In other words, it sets medically comparable procedures as the criteria for preventing certain kinds of bars to access to abortion services. Could you speak to that issue?

Ms. NORTHUP. Yes, Senator Blumenthal. Thank you for that question, because I think we did hear a lot this morning about the alleged sweep of this law. But, in fact, it is very targeted to what is happening right now in the country. It is very targeted to this new tactic of the last several years in which State legislatures have been passing laws that purport to be about health and safety but are not. And that has been shown to be defied in many ways.

I would definitely recommend everyone read the testimony submitted for the record for today's hearing from the executive vice president and CEO of the American College of Obstetricians and Gynecologists, and that, of course, is the well-respected organization to which the vast majority of OB/GYNs belong in this country. And in that testimony, they make quite clear—and I am quoting—"The American College of Obstetricians and Gynecologists strongly support S. 1696, the Women's Health Protection Act." And they do so because from a scientific and medical perspective, these laws are not warranted.

And I think what is really critical about the bill, which you pointed out, Senator, is right from the start, if this is something that is treating medically similar practices and procedures and services the same, there is no objection. Nothing is going to be struck. So that is the starting point.

Second, if there is a substantial safety basis for the regulations, well, then, it is not a law that is unwarranted. That law will stand.

So if it is treating similar medical procedures similarly, if it actually advances a safety basis, then that law is going to stand. And I think that is important, and there are factors that courts would look at in that. But that is what is really critical. If it is a true safety law, if it is not about singling out abortion provision for the motive of shutting down clinics, then that law stands.

Senator BLUMENTHAL. In fact, a number of the regulations that have been claimed to be struck down by this legislation the Act specifically says would not be affected, for example, funding or insurance or parental consent, other kinds of regulations that are now on the books.

Let me ask you, in terms of these regulations, many have been struck down by the courts. Many have been found to be unconstitu-

tional. Why a Federal Act that prevents these laws from being passed as a matter of statute as opposed to simply having the jurisprudential route work its way?

Ms. NORTHUP. Well, we are here today because we have just said 200 of these underhanded laws have been passed, and it is not right that women should have to go to court year after year after year to get the medical services that the Constitution guarantees them. So I think it is important that it be made clear what kind of these are already on record. As I said, the American Medical Association is on record against many of these laws, ACOG is on record against many of these laws, and courts are finding many of these laws unconstitutional. It should not be a charade every year where women are under threat of losing access to services. And we need to make sure that we have strong protections because what is happening right now, we talked about Texas, which will go down to ten clinics in September if that law goes into effect. We have talked about Mississippi. We talked of Dr. Parker's practices hanging on by a court order. And the unfairness of these laws—in Mississippi, the hospitals would not consider giving admitting privileges, not based on medical competency but based on their opposition or other reasons that have nothing to do with the competency of the doctors.

So we need to make sure that there are strong protections, that we do not have this happen every year, and that women can be assured that, wherever they live, their personal, private decision is going to be respected.

Senator BLUMENTHAL. While they are on the books, they have a very practical impact on women's lives and a very severely restrictive impact on their legal rights and a very invasive and intrusive consequence for their exercise of personal choice. Is that correct?

Ms. NORTHUP. That is absolutely correct.

Senator BLUMENTHAL. Let me ask you finally on this round of questioning, the issue of admitting privileges, why are admitting privileges unnecessary, irrelevant, and in many instances found to be unconstitutional?

Ms. NORTHUP. Well, thank you. That is a very important question because that is one of the underhanded tactics that has been sweeping the Nation. And, again, I would commend the testimony that has been filed by the American College of Obstetricians and Gynecologists where they oppose those. It is also the case that the American Medical Association and ACOG, in a brief in the Fifth Circuit as one example, went on record to talk about how there is no medically sound basis for that requirement.

And what is really, I think, important for us to keep in mind is—and the AMA and ACOG talk about this in their briefs—abortion is safe, one of the safest procedures. And an example of how this underhanded tactic has closed a clinic in El Paso, Texas—it is not open now because of it—17,000 patients were seen in that clinic in 10 years, and not one of those had to be taken to a hospital or transferred by the clinic.

So these laws are unwarranted, and they are unfair. And I know that many of us here disagree about the constitutional issues around abortion, about the moral issues around it. But I would hope that we could agree that State legislatures should be trans-

parent in their laws; they should not pretend to be about one thing when they are actually about another, because to do so undermines our faith in the rule of law. It is unfair, it is undemocratic, and it is unconstitutional.

Senator BLUMENTHAL. Thank you very much. My time has expired.

All of the documents that you referenced will be made a part of our record, without objection.

[The information referred to appears as a submission for the record.]

Senator BLUMENTHAL. Senator Grassley.

Senator GRASSLEY. Yes, Ms. Tobias, you heard me mention Kermit Gosnell in my opening statement. We have the grand jury report reconstructing how he had been engaged in an enterprise to kill babies, even violate the law, and I think obviously violating the trust of his patients.

State laws were in place in that State, but as the grand jury report says, authorities did not do inspections for fear it would be seen as "putting barriers up to women seeking abortions."

So my question: Wouldn't this particular piece of legislation make it easier for these types of individuals to continue to operate with impunity?

Ms. TOBIAS. This legislation would make it easier for them to operate. The law actually says—this legislation actually says that if a provision would single out abortion, it would be invalid, or if it would impede access to abortion. And one of the factors to help determine whether or not it impedes access to abortion is allowing the abortion provider to determine whether or not the new law, any law, would impede his ability to render services.

So, yes, abortionists like Kermit Gosnell would be able to continue to practice, to set up shops. Actually we did see that many of the State health departments decided, after hearing about Gosnell and realizing that they as well as Pennsylvania had not done any kind of inspection of the clinics, went in and started doing them, and they were finding some horrible situations, and some clinics have been shut down because of that.

But this law would say that if a law is specific to abortion, it is invalid, or if it would impede access to abortion. And then even then, from there it has to go on to whether or not the State can prove that it is going to improve access for women, health benefits for women, and even then, if it would be yes, then is it the narrow means possible? There are so many layers set up in this legislation that practically any law dealing with abortion or impeding access in any way to abortion would be considered invalid.

Senator GRASSLEY. Dr. Chireau, some States have laws on the books that would require providers of abortion to be located near a health facility in the event that medical care is needed, and that would probably involve the life of a woman. Some States also require abortion providers to have admitting privileges to hospitals.

First of all, do you agree with the laws? And then, second, could you elaborate on why they make sense in your expert medical opinion and tradition?

Dr. CHIREAU. Yes, thank you for the question. So all too often—and this has been my experience as a practitioner—when abortion

complications occur, patients are told to present to the emergency room. They are not given any documentation. No one is told what was done and what the complications were. This has happened to me in practice. A patient experienced perforation of her uterus during a late abortion, had a very complicated hospital course, and I called the abortionist and asked, "Why did you do this? You knew that you perforated her at the time." And essentially what he told me was that he knew that he did it, but that he did not want to send her to the emergency room. And I said, "That is really malpractice. It is not appropriate." And, again, his response was, "Well, she started moving." I said, "That is your issue. If a patient is moving during a procedure, that is your issue. You should be performing the procedure in such a way that it is comfortable."

But to get to—more directly to respond to your question, I do believe that physicians should have admitting privileges because that is part of the standard of care. If you perform a procedure on a patient, if you are caring for a patient, you need to be able to followup on the complications of that procedure. That is a surgical maxim. As an OB/GYN or a general surgeon or whatever surgical specialty you happen to be in, you need to take responsibility for that patient, if they have a complication, to either admit them to the hospital and care for them yourselves or arrange for transfer to the hospital so that that patient can be taken care of. Transfer agreements are very important because they provide for continuity of care, and this is why I believe that physicians (a) need to have admitting privileges and (b) need to be located within a hospital so that patients can be managed. So there are a couple of issues here.

Number one, admitting privileges imply a level of competence in clinical practice on the part of physicians. If physicians cannot obtain admitting privileges, there are reasons why, and that is why peer review is generally the rule when patients are applying for privileges. When physicians cannot get privileges, it is most often because there are issues of competence; they have a trail in their background of malpractice events that causes their peers at the hospital to say this person is not someone that we want to be on the medical staff.

Hospital credentialing protects patients. Hospital credentialing requires that a physician has demonstrated competence in doing specific procedures and that they are not running from medical boards or running from adverse actions on behalf of their licenses.

Physician-to-physician communications improve the process of care. One of the major problems with morbidity and mortality in any surgical specialty, medical specialty, is the hand-off. It is like a baton hand-off in a race. If you fumble the hand-off, you lose the race. If you fumble the hand-off in medicine, patients are injured.

Admitting privileges allow for discipline. If physicians are practicing outside the scope of practice, if their skills begin to deteriorate after time, admitting privileges provide for a regulatory framework where physicians who are in trouble or causing problems with patients can be disciplined. And this is one of the reasons why I think many people in the abortion industry oppose credentialing, because it exposes the fact if they are not competent, if they have had excessive numbers of complications, if they have a trail of injured patients and lawsuits, this is going to be exposed. And then,

finally, I think that it establishes the fact that if you cannot get privileges, you cannot meet the standards for medical practice.

Finally, an important issue is that being on a hospital staff or being on a medical—part of a medical society implies that you are part of the medical community. If you are outside of that medical community, then clearly something is wrong; there is some issue going on.

I hope I have answered your question.

Ms. TOBIAS. Senator Grassley, excuse me. I have an article by Melinda Henneberger that talks about what happens when the abortion industry is allowed to regulate itself. I would like to request that this be added into the permanent record.

Senator BLUMENTHAL. Without objection.

[The article referred to appears as a submission for the record.]

Senator BLUMENTHAL. And Senator Grassley has some documents he would like to enter.

Senator GRASSLEY. Yes, I have 15 different—but I would just like to mention five: Concerned Women of America, Legislative Action Committee, a group of 30 female State legislators across the country, the Association of American Physician Surgeons, the American Association of Pro-Life Obstetricians and Gynecologists, and, last, several OB/GYN physicians, including John Thorpe, North Carolina; Steven Calvin, Minnesota; and Byron Calhoun of West Virginia.

Thank you.

Senator BLUMENTHAL. Thank you. All those documents will be made a part of the record, without objection.

[The information referred to appears as a submission for the record.]

Senator BLUMENTHAL. Senator Hirono.

Senator HIRONO. Thank you, Mr. Chairman.

I represent a State, Hawaii, that has been a leader in protecting women's health and safety. And, in fact, in 1970, we were, I believe, the first in the country to decriminalize abortion, a woman's right to choose, and, therefore, protecting a woman's right to choose.

And I also want to mention by background that the State senator who led the charge to provide women in Hawaii the right to choose was a practicing Catholic, and the Governor of the State of Hawaii, who allowed this bill, this very important bill, to become law to protect a woman's right to make that choice, was a practicing Catholic who went to Mass every single day. We in Hawaii understand the separation of church versus state.

Now, I do agree that abortion is a different procedure from other medical procedures because its foundation is a constitutional right. So in my view, there should be a high burden on laws that limit or abridge such a constitutional right.

We have heard a lot of testimony from our panel members, so I wanted to ask Ms. Northup: Because the right to make this kind of a choice is based on a constitutional right, do you think that anti-choice laws should be based on medical necessity?

Ms. NORTHUP. Absolutely, and I want to just say again all that this bill is about is being sure that women's critical access to reproductive health care, including abortion services—and as I said in

my testimony, that is an issue for one in three women in the United States. That is women in every State, every congressional district, every city, and every town, and her health care is important to her.

But this bill is about making sure that because State legislatures cannot just blatantly ban abortion, which is the desire of some people who sit in them, and some States have certainly been pushing that envelope. North Dakota has banned abortion at essentially 6 weeks, and that is now in the courts. Of course, it has been enjoined because it is blatantly unconstitutional. The State in its responsive briefs in the case said they basically thought *Roe v. Wade* should be overturned. So you have that battle going on.

But you also have this, you know, underhanded attempt to do what they cannot do by the front door by the back door. And so it is important that you make sure that regulation of abortion is not just about singling out abortion providers, but is actually based on good medical practice and scientific evidence.

So the response to even Dr. Chireau's statement is, look, if outpatient doctors who are doing, you know, outpatient surgeries need to have admitting privileges, that is fine. You know, let that be the medical standard that is applied across the board. No objection to that. This bill has nothing to say to that——

Senator HIRONO. I do not mean to cut you off, Ms. Northup, but I do have a question for Dr. Parker—my time is limited.

Dr. Parker, you provide abortion services in Mississippi even if you do not even live there. I understand that you were denied hospital privileges in Mississippi. Is that correct?

Dr. PARKER. Great to see you again, Senator.

Senator HIRONO. Aloha.

Dr. PARKER. As you know, I used to live in Hawaii and enjoyed serving under your leadership.

With regard to my decision to travel to Mississippi to provide abortion care, it is in part in response to the fact that well over 85 percent live in a county where there is no abortion provider, and so as I said earlier, my decision to go there was based on the fact that if nobody else will go, who is going to go?

Senator HIRONO. Yes, I understand.

Dr. PARKER. When I made that decision, the regulations changed in the State of Mississippi to require hospital privileges. I made an effort to apply to all of the hospitals in the given area, and many of the hospitals declined to evaluate my application. So why they chose to do that I am not sure, but in order to meet the law, I was about to—I was unable to do so because there were hospitals who simply declined to evaluate my credentials. I am not sure why they did that.

Senator HIRONO. I think your experience just points out how difficult these laws make it for women in certain States to have access to certain kinds of health care services.

Ms. Northup, I would imagine that these kinds of restrictions would disproportionately impact certain populations such as low-income women, women of color, and immigrant women. Would that be the case?

Ms. NORTHUP. That is absolutely the case, and I gave the example in my testimony that in the Rio Grande Valley, which is one

of the poorest areas in the Nation, the clinic in McAllen, Texas, that had been providing good care for a long time to those residents had to close. And, again, it was under those circumstances where the doctors were not allowed to get their privileges.

Senator HIRONO. Thank you. I just have one question for Ms. Tobias. Do you believe that *Roe v. Wade* should be overturned?

Ms. TOBIAS. Yes, I believe——

Senator HIRONO. Thank you.

Thank you, Mr. Chairman.

Ms. TOBIAS. The answer is yes. I believe unborn children should be protected.

Senator BLUMENTHAL. Thank you.

Senator Graham.

Senator GRAHAM. Thank you very much, Mr. Chairman. I want to thank you for having the hearing because I think it is an important topic, and I would like to join with Ms. Tobias' recommendation that we have a hearing on my bill, which is the Pain-Capable Unborn Child Protection Act, S. 1670, and have a joint vote on the Senate floor and see where everybody falls out on it, because it is a subject worthy of debate.

Let us see if we can find some common ground here about how these laws work. Ms. Tobias, is it your understanding that S. 1670 would prevent a ban on third trimester abortions that protect—with exceptions for the life of the mother and rape and incest?

Ms. TOBIAS. S. 1670?

Senator GRAHAM. Excuse me. The other one, S. 1696.

Ms. TOBIAS. The one today?

Senator GRAHAM. Yes, ma'am. I am sorry.

Ms. TOBIAS. Yes, this bill would limit—would prevent a ban on abortion in the last trimester. It would prevent——

Senator GRAHAM. Could you—Ms. Northup, do you agree with that?

Ms. NORTHUP. The bill has provisions that track the constitutional standard that do say that post-viability there needs to be an exception for a woman's life and health, as the Supreme Court has said.

Senator GRAHAM. So could a State pass a law that banned abortion in the last trimester except for life of the mother and rape and incest? Your answer would be no?

Ms. NORTHUP. The standard would have to be the one the Supreme Court has recognized.

Senator GRAHAM. What do you say, Ms. Tobias?

Ms. TOBIAS. Well, I think probably one of the best examples would be when the sponsor of the bill, Chairman Blumenthal, was asked if this bill would ban abortions. It talks about life or health, and he said that the health exception makes no distinction between physical or psychological health. So it would be very difficult—it would be impossible under this bill to ban abortions for health if psychology and psychological health is going to be comparable.

Senator GRAHAM. Thank you. There are 13 States that ban elective abortions after 20 weeks except in the case of rape, incest, and the life of the mother. Would this bill strike those laws down?

Ms. TOBIAS. Yes, it would.

Senator GRAHAM. Do you agree with that, Ms. Northup?

Ms. NORTHUP. Like the Ninth Circuit did with Arizona's 20-week ban, yes, it would be unconstitutional, and this bill tracks the U.S. Constitution standards.

Senator GRAHAM. Thank you. States that have waiting periods, requiring a waiting period before the abortion is performed, would this bill strike that down?

Ms. TOBIAS. Yes, this bill would say that if you impede access to abortion in any way, it would be struck down.

Senator GRASSLEY. Do you agree with that?

Ms. NORTHUP. I do not. It depends on what the court would look at. So, again, as we were talking about before——

Senator GRAHAM. So you do not know how the bill works?

Ms. NORTHUP. Oh, yes, I do. It is that the first question would be, is this type of waiting period something that is also imposed on similar——

Senator GRAHAM. Well, the ones that are on the books, the ones that you are familiar with, can you name one State law with a waiting period that you think would survive?

Ms. NORTHUP. Well, I would say that I think it is important that we look at the factors in the bill. Does it apply to similar services?

Senator GRAHAM. Can you name one State with a waiting period requirement that you think would survive scrutiny under this bill?

Ms. NORTHUP. Well, if it were able to say that it did not significantly impede access to services, if it was a waiting period that is not a particularly long one——

Senator GRAHAM. So you cannot give an example.

Ms. Tobias, does this bill ban States' requirements that a person can exercise their conscience about not performing an abortion? There are laws on the books that say that, right?

Ms. TOBIAS. Yes. If someone says that, according to their conscience, they cannot take the life of an unborn child, that would be impeding or reducing access to abortion, which would be invalid——

Senator GRAHAM. Would this legislation invalidate those laws?

Ms. TOBIAS. Yes, it would.

Senator GRAHAM. Do you agree with that, Ms. Northup?

Ms. NORTHUP. I do not agree. This legislation does not address the issue of conscience objection.

Senator GRAHAM. Should it? Would you accept an amendment offered by me to make sure people of conscience do not have to do something like this?

Ms. NORTHUP. Well, I think we have important laws that are on the books that respect people's rights of conscience, and so——

Senator GRAHAM. Well, do you—as to this issue, would you accept an amendment by me to this bill to exempt conscience?

Ms. NORTHUP. Well, I am not elected to make those decisions.

Senator GRAHAM. I got you. Fair enough.

Ms. NORTHUP. I think this bill clearly does not cover that.

Senator GRAHAM. Fair enough. I think the answer would be no.

So, Dr. Parker, is it standard medical practice for physicians operating on a child at 20 weeks to provide anesthesia to that child?

Dr. PARKER. Well, Senator, I am not well versed in fetal surgery because most surgeries at 20 weeks would have to occur in utero.

Senator GRAHAM. Right, it would. Ms. Chireau, are you familiar with what would be the standard of care there?

Dr. CHIREAU. Yes, it is, and that is because when fetal surgery is done—and I am very well aware of the fetal surgery landscape. Initially, when fetal surgery was being done, fetuses reacted very strongly to incisions, to placement of catheters, so——

Senator GRAHAM. Is it standard medical practice to provide anesthesia when you operate——

Dr. CHIREAU. Yes.

Senator GRAHAM [continuing]. On a baby at 20 weeks?

Dr. CHIREAU. Yes.

Senator GRAHAM. Medical encyclopedias—and I am sorry I am running over; I will wrap it up here—encourage parents to talk to the baby at 20 weeks. They can hear sounds. They react to your voice. They can hear your heartbeat as a mother. They can hear your stomach growling, and they can react to loud noises. Does that make sense to you, Ms. Chireau?

Dr. CHIREAU. Yes, it does.

Senator GRAHAM. Okay. Has anyone ever been born at 20 weeks that survived?

Dr. CHIREAU. As far as I am aware, no.

Dr. PARKER. Not to my knowledge.

Senator GRAHAM. I can show you twins. Thanks.

Senator BLUMENTHAL. Senator Hatch.

Senator HATCH. Well, thank you, Mr. Chairman.

You know, Congress has a few times told the States that they had to pass certain legislation, but only as a condition of receiving Federal funds of some kind. Now, I am in my 38th year here in the U.S. Senate, and on this Committee, and I do not recall Congress ever passing a law that prohibited States from enacting entire categories of laws simply because Congress says so. I do not recall that.

Can anyone on this panel give me an example of that? And if not, why is abortion so unique that Congress has this authority in this area but not in any other? Anybody care to take a crack at that? I do not see it, personally.

Well, let me ask a question to you, Ms. Tobias. States have been passing laws regarding abortion for almost 200 years. The Supreme Court took over in its *Roe v. Wade* decision, and since 1973 the United States has had the most permissive abortion laws in the world today. But most Americans have always opposed most abortions, and the vast majority of Americans support reasonable and commonsense abortion regulations. At least that has been my experience, and I do not think it is a false experience.

This bill attempts to wipe it all out to eliminate even minimal regulations that most Americans support and that the Supreme Court has already said are constitutional.

Now, I opposed this kind of legislation more than 20 years ago when I was Ranking Member of what is considered today the HELP Committee. This bill would not regulate abortions. It would regulate the States telling them what laws they may or may not pass.

How does Congress have the authority to do that?

Ms. TOBIAS. Currently the law—other than what the Supreme Court will or will not allow—has the State legislatures elected by the people setting the laws for their States. I think that is actually a very good way to handle this. The States have been dealing with the conscience clauses, setting up the waiting periods, informed consent provisions, and the courts have been allowing these to stand. So it is difficult to say that a law that the Court has upheld is unconstitutional. So we certainly think that Congress would be overstepping in passing a law that would completely override a procedure that the Supreme Court has said is different.

Senator HATCH. This bill would prohibit restricting abortions based on the reasons for the abortion. The way I read the bill, neither States nor the Federal Government could prohibit abortions performed because, for example, a child is a girl or because the child has a disability. Is that the way you understand it?

Ms. TOBIAS. Yes.

Senator HATCH. Dr. Chireau, this bill sounds like it is very deferential to medical judgment and that abortion should be treated like any other medical procedure. But under this bill, politicians, lawyers, and judges would make final decisions on such things such as which medical procedures are "comparable," which tasks doctors may delegate to other personnel, which drugs may be dispensed, which medical services may be provided through telemedicine, how many visits to a medical facility are necessary, the relative safety of abortion services, which methods advance the safety of abortion or the health of women more or less than others.

Now, from your perspective as a doctor, doesn't this bill actually compromise the practice of medicine?

Dr. CHIREAU. I think it does compromise the practice of medicine, and I believe that is on two levels: number one, for the reasons that you have enumerated; number two, because I do believe that current legislation in the States to set clinic—specify access to clinics and so on and so forth is protective to patients. So I think that it is doubly a problem, number one, for those reasons that you have listed and also because the regulations that have been enacted were enacted in an attempt to prevent abortion providers from being exempted from the same sorts of regulatory frameworks that other medical practitioners have to operate within.

Senator HATCH. This bill would prohibit restrictions on abortions that are not also imposed on what it calls "medically comparable procedures." Now, that is just one of the key terms in this bill that are brand new and completely undefined. But this bill makes a pretty clear statement that there is nothing unique about abortion, nothing that makes it different from any other medical procedure. And that, of course, is not true.

Dr. CHIREAU. That is correct.

Senator HATCH. Whether you are pro-abortion or anti-abortion. Even in *Roe v. Wade*, the Supreme Court said that the State has unique reasons for restricting abortion because it involves what the Court called "potential human life." And in *Harris v. McRae*, the Supreme Court in 1980 held that the abortion "is inherently different from other medical procedures because no other procedure involves the purposeful termination of a potential life."

I do not think that we need the Supreme Court to tell us that, but there it is. Doesn't that settle this question and completely undercut the entire theory behind this bill?

Dr. CHIREAU. Yes, I believe that it does, and I think that the issue of comparable procedures is really false. I believe that abortion is a unique procedure. As you have said, it is the only procedure that terminates a human life.

In addition, from the technical perspective, an abortion is a very different procedure from, say, completing a miscarriage or doing a dilation and curettage on an non-pregnant woman.

Senator HATCH. Mr. Chairman, could I ask just a couple more questions?

Senator BLUMENTHAL. Sure.

Senator HATCH. I know that there are just two of us here.

Senator BLUMENTHAL. We are approaching a vote, and Senator Cruz is here, so——

Senator HATCH. Oh, I did not see Senator——

Senator CRUZ. Take all the time you——

Senator HATCH. Well, let me just ask one more.

The Supreme Court created one set of rules in 1973 for evaluating the constitutionality of abortion regulations. Then the Court changed the rules in 1992. Now, this bill creates yet another standard: prohibiting regulations that a State cannot show by clear and convincing evidence significantly advanced the safety of abortions.

Now, it is bad enough that the Supreme Court sometimes does Congress' job, but here is Congress attempting to turn around and do the Court's job.

But it gets worse. This bill applies its rules and regulations to all State and Federal statutes, to all State and Federal regulations in the past, in the present, and in the future. Does this mean, for example, that States would be required to repeal any laws or regulations already on the books that do meet these new rules?

Dr. CHIREAU. Yes, sir, I think that that is a very important point. I think that essentially this law guts States' rights with respect to abortion. It creates abortion as a special protected class of procedure and abortion providers as a special protected class of providers.

Senator HATCH. Well, I cannot imagine why any State legislature would support this, no matter their position on abortion. Now, I am having real trouble here with this approach, but at least I wanted to raise these issues because I think they are important issues.

Thank you, Mr. Chairman.

Senator BLUMENTHAL. Thank you.

Senator HATCH. Sorry to impose on Senator Lee and Senator Cruz.

Senator BLUMENTHAL. Senator Cruz, Senator Lee was here earlier, so I am going to call on him at this point. Thank you. Thanks, Senator Hatch.

Senator LEE. Thank you, Mr. Chairman. Thanks to all of you for joining us today.

There was a time when the humanity of an unborn child could plausibly be dismissed as philosophical conjecture. Today we know it is a biologic fact. For every excited announcement, every baby shower, every ultrasound image posted on Facebook, all of this at-

tests to this scientifically confirmed, very deep human truth. The only difference is that unborn boys and girls are small and they are helpless and they are mute. They cannot speak for themselves. They rely on strangers. They rely on us to speak for them.

I believe in the innate dignity of every human life, and I believe every human society is rightly judged by how it treats its most vulnerable members—the aged, the poor, the sick, the disabled, the abused, the homeless, the widowed, and the orphaned, the pregnant mother in crisis, and, of course, the unborn child in the womb.

Neither our society at large nor our laws have to pit the vulnerable one against another. We can choose instead, we have the power to choose instead to welcome and to love and to protect all, even and especially the weakest among us. Making that choice presents an enormous challenge to all of us as policymakers, as citizens, as neighbors and friends, as parents and children ourselves.

But the challenge of life is, after all, why we are here: to use our strength in defense of the weak. We should choose to embrace that challenge and to do so with love and with open arms. We can choose life, and when this debate finally 1 day ends, I think we will. I think we will choose life.

So let me start with a couple of questions for Ms. Tobias, if I might. At a rudimentary level, does S. 1696 even consider the possibility that there might be more than one life involved and at stake when a woman seeks an abortion?

Ms. TOBIAS. No, it does not.

Senator LEE. And yet this proposed legislation would have far-reaching effects, potentially not just for one life but for two, in any given instance. Isn't that right?

Ms. TOBIAS. For every abortion that is performed, there is a human life that is destroyed. This bill does not mention it, treating the child as a tumor instead.

Senator LEE. So in that respect, it is very different than other legislation that might just affect one person, might just affect the health of one person. This one involves the potential in each instance for the destruction of one person's life, its complete termination.

Ms. TOBIAS. Yes.

Senator LEE. Many medical experts and health providers have strong moral and ethical concerns, as they have every right to have, with providing abortions. And yet this bill, as I understand it, would have the Federal Government telling the States that they, the States, may not protect the rights of conscience for medical providers. My own State, for example, guarantees the right of a medical provider to refuse to participate, admit, or treat for an abortion based on moral or based on religious grounds. These laws matter. I can point to several instances in which, absent such laws, university or hospital policies would have forced medical personnel to perform abortions, notwithstanding and against serious moral or religious objections.

So, Ms. Tobias, let me just ask, what role do freedom-of-conscience laws currently play? And what effect would this bill have on those laws? And what concerns should we have and would you have with such an outcome?

Ms. TOBIAS. A lot of people go into the medical field because they want to take care of people. They go into obstetrics and gynecology, they become delivery room nurses because they want to take care of pregnant women and babies, and they do not want to kill unborn children. If they are told that they have no choice, that they will have to perform or participate in the performance of an abortion procedure, they will either be doing something that is very strongly, deeply offensive to them, or they will leave the field, which means we would have a lot of wonderful doctors and nurses who could be helping pregnant women and their children, finding something else completely to do. I think that would actually be a huge detriment to the medical community. This bill would strike down conscience laws because those laws would impede or reduce access to abortion.

Senator LEE. Thank you. Thank you for your answers.

I see my time has expired. Thank you, Mr. Chairman.

Senator BLUMENTHAL. Thank you.

Senator Cruz.

Senator CRUZ. Thank you, Mr. Chairman. I want to thank each of the witnesses for coming and joining us today.

The legislation this Committee is considering is extreme legislation. It is legislation designed to eliminate reasonable restrictions on abortion that States across this country have put in place. It is legislation designed to force a radical view from Democrats in the Senate that abortion should be universally available, common, without limit, and paid for by the taxpayer.

That is an extreme and radical view. It is a view shared by a tiny percentage of Americans, although a very high percentage of activists in the Democratic Party, who fund and provide manpower politically. And it is also a very real manifestation of a war on women given the enormous health consequences that unlimited abortion has had, damaging the health and sometimes even the lives of women.

I have with me 317 statements from Texas women who have been hurt by abortion, along with letters from Texans opposing this bill, along with letters from pro-life doctors, nurses, lawmakers across the United States that, with the Chairman's permission, I would like to have entered into the record.

Senator BLUMENTHAL. Without objection.

[The information referred to appears as a submission for the record.]

Senator CRUZ. A number of the restrictions that this legislation would invalidate are restrictions, commonsense restrictions, that the vast majority of Americans support, for example, restrictions on late-term abortions. The overwhelming majority of Texans do not want to see late-term abortions performed except in circumstances when necessary to save the life of the mother. And yet the United States' laws and the law that would be reflected in this bill is extreme by any measure.

Today the United States is one of seven countries in the world that permits abortion after 20 weeks. We are in such distinguished company as China, North Korea, and Vietnam—those known paragons of human rights.

If you look at some other countries across the world, in France abortion is prohibited after 12 weeks. In Italy abortion is prohibited after 12½ weeks. In Spain abortion is prohibited after the first trimester. In Portugal abortion is prohibited after 10 weeks. This is the norm across the world, and yet this legislation would say that the 23 States who have enacted limits on late-term abortion, their laws would be set aside.

A question I would ask Dr. Parker: Is it your view that these nations—France, Italy, Spain, Portugal—that they are somehow extreme or manifest a hostility to the rights of women?

Dr. PARKER. Senator Cruz, thank you for your question. I am not an international human relations expert. I can tell you that when abortion is legal and safe that the known mortality related to women taking desperate measures when abortion is illegal is greatly minimized, as demonstrated by what happened in this country after 1973.

I do know that internationally in a country like Ghana, where I have traveled, whereas they have made great strides toward reducing their maternal death rate by having better access to maternal care, despite the fact that abortion is legal, because it is so heavily stigmatized when women do not access that care, that—the major cause of maternal mortality in Ghana is related to unsafe abortion.

So if access to legal and safe service being a reality for women with an unplanned or wanted pregnancy or a lethally flawed pregnancy reflects human rights values, then countries that restrict that, we would have to question their commitment to the humanity and safety of the women in their populations.

Senator CRUZ. Well, thank you for your views, Dr. Parker. I would note that the suggestion that somehow France or Italy or Spain or Portugal or much of the civilized world is somehow insensitive to the rights of women is rather extraordinary. And the idea that America would rush out to embrace China and North Korea for the standard on human rights is chilling.

I would note that this law would also set aside State laws prohibiting taxpayer-funded abortion. Thirty-two States have laws to do that. This law would also imperil State laws providing for parental notification if your child needs an abortion that at a minimum before that serious medical treatment that a parent has a right to be notified. Thirty-eight States have that law, and yet this extreme bill in Congress would imperil every one of those laws.

And, finally, if I may have another 30 seconds to just share some of the stories from women in Texas:

Nona submitted this story. She said, "I was told I just had a blob of tissue by Planned Parenthood after they did my pregnancy test and then referred me to a nearby abortion clinic. I was not given the option of having a sonogram. I was not given the option of hearing my baby's heartbeat. Had I been given the opportunity of seeing my baby and hearing the heartbeat, I can assure you that I would not have chosen abortion. I would have chosen life instead of death. How can anyone believe that abortion should be legal after seeing a baby living in the womb of its mother on a sonogram and hearing the heartbeat of that baby? I felt I was pressured by Planned Parenthood because they told me that the best thing I could do was have an abortion since I was so young. I was 15 years

old and still in high school. That abortion ruined any chance of me giving birth. As a result, I have had five miscarriages, three of them have been tubal pregnancies requiring emergency surgery and were very near death experiences. I have suffered from bouts of depression and attempted suicide, self-mutilation. My experience of emotional trauma after abortion is the same as millions of other women and their families."

I have 317 statements, each as powerful as that in terms of the human consequences of what this legislation would produce.

Thank you, Mr. Chairman.

Senator BLUMENTHAL. Thank you.

Ms. Northup, would this legislation prohibit the use of ultrasounds when a patient requests them?

Ms. NORTHUP. Oh, no, not at all. This law again is just very focused on those underhanded type of restrictions that are treating abortion not like similarly situated medical practices that do not advance health and safety and are harming access to services.

Senator BLUMENTHAL. In essence, it would be irrelevant to the instance that Senator Cruz has just described.

Ms. NORTHUP. Yes, absolutely. It also very explicitly does not cover the question of insurance funding. It is not addressing that. It would not invalidate those laws. It has nothing to do with minors. It specifically says it does not address issues about parental consent and notification laws.

Senator BLUMENTHAL. Dr. Chireau, have you ever performed an abortion?

Dr. CHIREAU. No, I have not.

Senator BLUMENTHAL. Dr. Parker, how many abortions have you performed?

Dr. PARKER. I do not have the numbers right off, but I can tell you that over 20 years of patient care, I have seen thousands of women, and some of those women have needed abortion care.

Senator BLUMENTHAL. And in your experience—over how many years?

Dr. PARKER. Twenty.

Senator BLUMENTHAL. Twenty years—has the width of a hallway in those clinics where you have performed your medical services affected the quality or expertness of those medical services?

Dr. PARKER. No, Senator.

Senator BLUMENTHAL. Has the admitting privileges within that State affected the quality or effectiveness of your medical services?

Dr. PARKER. Only to the extent that they prevented me from providing care to women.

Senator BLUMENTHAL. They have barred you entirely, but admitting privileges are irrelevant to the quality and excellence of your medical services because anyone in need of a hospital will be admitted to that hospital.

Dr. PARKER. Correct, Senator.

Senator BLUMENTHAL. And the waiting period, is that relevant to the quality or effectiveness of your medical services?

Dr. PARKER. The reality, Senator, is that women are extremely thoughtful, and most women that I meet, when they present to me to be counseled about their options, they have been thinking about what they are going to do about their pregnancy from the minute

that they found they were pregnant. So I know women to be extremely thoughtful, and I have not seen any woman's ability to make this complex decision enhanced by being forced to wait longer than she has already thought about it.

Senator BLUMENTHAL. Thank you.

Ms. Northup, in response to a number of Senator Graham's questions, you essentially said that the limits embodied and incorporated in this bill were the constitutional standards. Is that correct?

Ms. NORTHUP. That is correct. For example, most States under the Supreme Court's constitutional rulings can ban abortion later in pregnancy, and do. And as long as they have an exception for women's health and life, those laws are on the books now, and they would still be on the books.

Senator BLUMENTHAL. In effect, this law basically enforces the Constitution.

Ms. NORTHUP. Absolutely enforces every woman's constitutional right to make the important decisions for herself.

Senator BLUMENTHAL. And, finally, in those countries—and a reference was made to a number of them—where abortion is made illegal, is it made safer?

Ms. NORTHUP. No. Around the world many of the places where abortions happen, women are terminating pregnancies where it is illegal and it is unsafe. And whether you see this country before *Roe v. Wade* or you look at places in Latin America and Sub-Saharan Africa today, when women do not have access to safe and legal abortion, they are harmed.

Senator BLUMENTHAL. You made reference, speaking about the State of Texas, to women in Texas going across the border to Mexico so that they could buy at a flea market drugs necessary, they thought, for abortions because they could not get that service in the United States?

Ms. NORTHUP. Yes. As the clinics have been shrinking in Texas because of laws that—again, I commend the American Medical Association's brief in the Fifth Circuit talking about the medically unnecessary laws that have been passed in Texas. That is the AMA, a very mainstream medical opinion. Because it is taking clinics from three dozen, cut by a third, and it will be down to less than ten if it is allowed to go into effect, women have been going over the border in Mexico. They have been buying medication on the black market. They have been trying to self-abort. And the situation is going to be worse. Women are hurt when they cannot get the medical care that they need.

Senator BLUMENTHAL. Ms. Taylor, in your experience in Wisconsin, have the restrictions on women's access to reproductive rights made abortions safer?

Ms. TAYLOR. No, Mr. Chairman, they have not.

Senator BLUMENTHAL. Have they created confusion, in fact, discouraged women from seeking to exercise their right?

Ms. TAYLOR. Absolutely, and they have sent women out of State.

Senator BLUMENTHAL. Thank you.

We are voting, so I apologize. I am going to have to close the hearing. My colleagues are on their way there. I want to enter into the record, without objection, various statements, including

Planned Parenthood in Southern New England, a statement that has been submitted for the record.

As is our custom, our record will remain open for 1 week in case my colleagues have additional questions, and I again really want to thank every one of our witnesses for participating in this very, very important hearing. Thank you all for attending.

[Whereupon, at 12:08 p.m., the Committee was adjourned.]

[Additional material submitted for the record follows.]

APPENDIX

Additional Material Submitted for the Record

Witness List

Hearing before the
Senate Committee on the Judiciary

On

"S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"

Tuesday, July 15, 2014
Dirksen Senate Office Building, Room 226
10:00 a.m.

Panel I

The Honorable Tammy Baldwin
United States Senator
State of Wisconsin

The Honorable Diane Black
United States Representative
State of Tennessee, 6th District

The Honorable Judy Chu
United States Representative
State of California, 27th District

The Honorable Marsha Blackburn
United States Representative
State of Tennessee, 7th District

Panel II

Nancy Northup
President
Center for Reproductive Rights
New York, NY

Dr. Monique Chireau
Durham, NC

Dr. Willie Parker
Birmingham, AL

Carol Tobias
President
National Right to Life Committee
Washington, DC

The Honorable Chris Taylor
State Representative
Wisconsin State Legislature, 76th District
Madison, WI

PREPARED STATEMENT OF SENATOR TAMMY BALDWIN

Senator Baldwin
Testimony for Senate Judiciary Hearing: S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights
July 15, 2014

Thank you, Chairman Leahy, Ranking Member Grassley, and Senator Blumenthal for holding this important hearing on women's health equity. I am encouraged that the Committee is pursuing a constructive conversation on this issue, and I am grateful for the opportunity to share my work on the Women's Health Protection Act.

And, I would also like to recognize the tireless advocacy of my Wisconsin State Representative Chris Taylor, who is here today to share her experience working to defend women's access to care in Wisconsin. I thank her for her testimony today.

Americans across the country expect to have access to high quality, dependable health care when they and their families need it. Indeed, my colleagues and I have worked to reform and improve our health care system to expand access to quality, affordable health care options so that all patients have care that meets their needs.

Unfortunately, for women across this country, this access has come under attack. Over the last 40 years, politicians across the country have been increasingly chipping away at the Constitutional rights guaranteed under Roe v. Wade, which affirmed that women have the right to make their own, personal health care decisions and to have access to safe and legal reproductive care.

Since that landmark decision by our nation's highest court, too many states have been trying to turn back the clock on women's access to quality care.

In just the past three years, states across the country have enacted a total of 205 provisions that restrict women's access to safe abortion services. This year, 13 states have been busy working to erode women's freedoms and have already adopted 21 new restrictions designed to limit access to abortion.

In my home state of Wisconsin, we are now ranked as one of the worst states when it comes to women's reproductive rights thanks to the restrictive measures enacted by our Governor and legislature.

To name just one, last year our Governor signed a measure forcing women – who are already required by law to make two separate trips to the clinic – to also undergo an invasive ultrasound 24 hours before receiving abortion care.

This same law also forces health care professionals to have unnecessary admitting privileges at a local hospital. If it was not for a federal judge temporarily blocking this provision, two of Wisconsin's four abortion clinics would have been forced to shut their doors and others would have been forced to reduce services, leaving many Wisconsin women out in the cold.

But, women and their families should not have to rely on last minute court decisions to be able to make the best health decisions for themselves and their families.

I recently heard from a mother in Middleton, Wisconsin, who wasn't so lucky. When she found out her baby had a severe fetal anomaly and would not survive delivery, she had to endure the consequences of the Governor's new law before the judge blocked the provision.

She had to undergo an emergency termination and a clinic in Milwaukee was the only place that would do the procedure. But because the Governor was set to sign this law imposing unreasonable requirements on providers, the clinic was preparing to close its doors and would not schedule her procedure. She and her husband were forced to find childcare for their two sons, and travel out of state so she could access the medical care she needed.

The threat in Wisconsin and in states across the country is clear.

Some politicians are doing this because they think they know better than women and their doctors. The fact is, they don't.

Women are more than capable of making their own personal, medical decisions without consulting their legislator.

It is not the job of politicians to play doctor and to dictate how professionals practice medicine. Nor is it our job to intrude in the private lives and important health decisions of American families

This is why I was proud to introduce the Women's Health Protection Act with my colleagues Senator Blumenthal and Congresswoman Chu to put a stop to these relentless attacks on women's freedoms.

The Women's Health Protection Act would prohibit these laws that undermine and infringe on a woman's Constitutional rights guaranteed under Roe v. Wade. Specifically, our bill would outlaw any mandate or regulation that does not significantly advance women's health or the safety of abortion services. Our legislation also protects women by invalidating measures that make abortion services more difficult to access and restrictions on the provision of abortion services that are not imposed on any other medical procedures.

Congress is responsible for enforcing every American's fundamental rights guaranteed by our Constitution. Throughout history, when states have passed laws that make it harder – or even impossible – to exercise those rights, we have necessarily stepped in with federal protections. The Women's Health Protection Act would ensure that every woman – no matter where she lives—has access to safe, quality reproductive care without interference from politicians.

We need to act now to guarantee that American women will continue to have the freedom to make their own health care decisions and to have access to essential, quality women's health care services.

I stand with 35 of my Senate colleagues and over 120 members of the House of Representatives to move our country forward with the Women's Health Protection Act, and I urge the Committee to help us advance this important measure to safeguard women's access to care and her constitutional rights no matter where she lives. Thank you.

PREPARED STATEMENT OF REPRESENTATIVE DIANE BLACK

Testimony of Representative Diane Black (R-TN 6th District)

Chairman Blumenthal, Ranking Member Grassley, and Members of the Committee, thank you for the opportunity to testify before you today. My name is Diane Black and I am privileged to have the honor of serving in the House of Representatives on behalf of Tennessee's 6th Congressional District.

Prior to entering public service, I built my career in the health care sector as a registered nurse. My career began as an emergency room nurse, where I most enjoyed my time, but I have also worked as a long-term care nurse and as part of an outpatient surgery team. I decided to run for office after I witnessed first-hand how poor policy was directly impacting my ability to deliver health care, and more importantly, the unfortunate outcomes on the lives of my patients.

Today, I am here to share with you, as a colleague in the House, and also as a mother, a grandmother, and a nurse, my grave concerns with the Chairman's legislation. Although called "The Women's Health Protection Act," this bill would nullify and declare unlawful any law at any level of government – whether federal, state or local – that presents what the bill deems to be an undue burden on a woman seeking an abortion. This legislation would effectively overturn the majority of state laws regulating abortions.

As a nurse, I can tell you that abortion is unlike any other medical procedure. This is an act that does not just involve the mother, but the child. It takes the life of an unborn child and in the process, imposes many serious medical risks to the mother.

To be clear and transparent, I am unapologetically pro life. While I believe the life of the unborn must be protected, I also believe we must do everything in our power to protect any woman who decides to have an abortion, even though I disagree with the choice.

During my time as an ER nurse, a young woman came in after having complications with her abortion, which was done at a clinic that was not regulated appropriately. When the complications occurred, there was no answer at the afterhour's number she called. By the time she reached me in the hospital, she was dying and there was nothing I could do to save her.

As a result of an abortion, this young woman lost her precious life. Her life could have been saved if proper regulations been in place that protected her health and well-being, and that held the abortionist accountable.

Infections occur in 1 to 5 percent of abortions. Cervical lacerations, incompetent cervix and other injuries can occur to the cervix and other organs during abortion procedures. Worse, minors are up to twice as likely to experience cervical lacerations during abortion and, overall, are even more susceptible to short-term risks than are older women.

Women who have had abortions are at a 37% increased risk of pre-term birth in subsequent pregnancies, a 30% to 50% increased risk of placenta previa in subsequent pregnancies, and 18% more likely to develop breast cancer as opposed to the average of just 12%. In the case of women with a family history of breast cancer, this figure jumps to 80%.

Abortions not only pose serious physical health risks, but endanger a woman's mental health as well. After having an abortion, a woman is 81% more likely to develop a mental health issue, is at a 37% increased risk of depression, a 110% increased risk of alcohol abuse, and sadly, a 155% increased risk of suicide.

After the horrific case of abortionist Kermit Gosnell, Americans know that even though abortion is legal, these procedures are not safe. Perhaps this is why 39 states require that abortion be performed by a licensed physician and why 26 states require abortion clinics to meet the same clinic standards as ambulatory surgical centers. And just as important, 42 states prohibit abortion after a certain point in pregnancy, and about 9 states that prohibit abortions at 20 weeks, or at the start of the sixth month of pregnancy, when medical research affirms unborn children can feel pain during an abortion. We are, after all, discussing a medical procedure that ends a human life.

Let us also not forget that the Supreme Court indicated in Planned Parenthood v. Casey, that the government has an interest in preserving fetal life. S. 1696 represents a sweeping attempt to undermine dozens of measures enacted by states to protect women, all under the false pretense that abortions are safe and rare.

My hope today is that we can reach across party lines, release our preconceived notions on this topic, and see abortion for what it truly is. Abortion is brutal – to both mothers and their unborn children. It is not healthcare. To reference the Supreme Court, a Dilation and Extraction abortion, which represents the majority of abortion procedures in America, is as equally gruesome as a partial birth abortion. These abortion procedures are the most common for abortions performed in the second trimester of pregnancy, where the unborn child is literally torn apart limb by limb.

In considering this and the many health care risks that can occur as a result of abortions, I strongly urge you reconsider advancing S. 1696 and any other effort that would undermine current laws that exist to protect the health and well-being of women and unborn children at the federal, state, and local level of government.

Thank you again for the opportunity to be here today. I yield back.

PREPARED STATEMENT OF REPRESENTATIVE JUDY CHU

Testimony of Congresswoman Judy Chu (CA-27)
Hearing on "S. 1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"
Senate Committee on the Judiciary
July 15, 2014

Thank you Chairman Leahy, Ranking Member Grassley, and Senator Blumenthal for the opportunity to testify today.

Every woman should have access to affordable and comprehensive health care coverage that protects her right to choose. This should be the case regardless of her income, the type of insurance she has or the state she resides in, so she can make personal health decisions based on what is best for her and her family.

We are witnessing a historic moment. Attacks on reproductive rights are intensifying. Having lost in our court system with *Roe v. Wade*, opponents of reproductive freedom are trying to undercut our Constitutional right and make it increasingly difficult to access a legal abortion.

They're trying to take us back to a time before *Roe*, when 1.2 million women resorted to illegal abortions each year. They're goal is to take us back to a time when unlicensed doctors, in unsanitary conditions, performed abortions that led to infections, hemorrhages, and at times, death. They're taking us back to a time when many women knew the hazards, but they risked all of this because they were desperate – and this was their only option.

The new trend is to shut down abortion services – this time, state-by-state.

This is happening all across the country – individual states have signed into law restrictive regulations that single out abortion services. Between 2011 and 2013, more than two dozen states passed over 200 restrictions that block access to abortion services. This translates to more restrictions placed on women's health care in three years than in the entire preceding decade.

The effect of these laws is that a woman's constitutional right now depends on her zip code. The rights of women residing in my home state of California now vastly differ from the rights of women living in Texas or Mississippi. According to the Guttmacher Institute, 56 percent of women – over half of women in our country -- now live in a state that is hostile to abortion.

These laws range from mandatory waiting periods to biased counseling requirements to the exact size requirements and corridor width for the offices in which the procedure is to take place.

They are laws like the recent one in Texas, which make no sense medically. They require doctors performing abortion procedures to have formal admitting privileges at a hospital within 30 miles of their clinic, among other senseless requirements. We already see the effects. After the law passed, clinics began closing their doors. For women in Texas, this means longer waits,

higher costs, and canceled appointments. Some have to travel over 150 miles to get to the nearest clinic. These obstacles have put many women in desperate circumstances, some of which may very well endanger their lives.

We need laws that put women's health and safety first – not politics.

This is why we introduced the Women's Health Protection Act this Congress. We recognized that without the ability to access it, the *right* to abortion is meaningless. This bill would outlaw the restrictive state laws that target abortion services and shut down clinics across the country…State laws that make abortion harder – *and sometimes impossible* – to obtain. The bill would outlaw state-mandated medical procedures such as forced ultrasounds, restrictions on medication abortions, and other onerous TRAP laws.

Simply put: This bill would end discrimination against abortion access for women based on their zip code.

I am so proud to be the lead sponsor of this bill in the House, and to partner with Senators Blumenthal, Baldwin, and Congressmembers Fudge and Frankel – to push as hard as we can on this bill. We already have 124 cosponsors in the House.

Constitutional rights should never be subject to the personal whims or beliefs of political leaders. Nor should the safety of mothers, daughters, sisters or wives be jeopardized in the process.

Thank you for the opportunity to testify and thank you for holding this important hearing to discuss how we can protect the health, safety and rights of all women.

PREPARED STATEMENT OF REPRESENTATIVE MARSHA BLACKBURN

Representative Blackburn Testimony:

Thank you –

We all share a desire to see what is best for women and children. We differ on what that would be and how to get there, but I appreciate the opportunity to share my views on your Women's Health Protection Act.

The Women's Health Protection Act is an extraordinarily broad, blunt instrument that through its ranging words would substitute the special interests of the abortion industry for both the well-being of women and the value of human life.

This legislation would jeopardize and nullify hundreds of laws that protect both mothers and their unborn children. Among its many faults, it would render impossible efforts by the states to limit abortions based on the sex of the child, putting a double pressure on women, who are often forced by familial and cultural pressures, to exercise son bias in pregnancy and eliminate a female child.

Furthermore, this legislation sets a dangerous precedent because it would place unconstitutional limits on a state's ability to assure the safety of medical facilities. Abortions, despite their grotesque nature, are medical procedures and should be regulated by the state as such.

By considering this legislation, many of your constituents perceive the Senate as out-of-touch with the consensus opinion in this country. Public opinion polls show time and time again that the American people support limits on abortion. 60% of Americans believe abortion should not be permitted in the second trimester and an overwhelming 80% believe it should never happen in the third. Women hold these convictions at a higher percentage than men, and it is no wonder. We bear life – and we bear the burden when public policies fail to support women at a critical hour.

The Committee would be advised to consider how far this bill would go in reversing and uproot both a long existing and rising consensus. S. 1696 would attack conscience exemptions that have existed since the 1973 abortion decisions. It would bar laws that provide for periods of reflection and consideration before an abortion is chosen – it would even prevent a state from assuring that a physician is physically present when abortion drugs are given, or even that only a physician may perform a surgical abortion. It will make abortion less safe.

What the Senate should be considering today is the Pain-Capable Unborn Child Protection Act which passed the House of Representatives on June 17, 2014 on a bipartisan vote, 228-196. The Pain-Capable Act is a piece of legislation that is supported by the American people, based in science, and filled with compassion. The Pain-Capable Unborn Child Protection Act limits abortions after the 20th week of pregnancy except in instances of rape, incest, or to protect the

life of the mother. Our nation is one of only four countries in the world to allow elective abortion to term, and this legislation would take one small, but vital step to move us closer to international norms.

Polls by Quinnipiac University, the Washington Post, and the Huffington Post have all shown that a strong majority of people support limiting abortion after the 20th week of pregnancy. Quinnipiac University's poll shows that women support a 20-week limit in even greater numbers than men - 60% of women versus just 25% in opposition – that's a 35 point margin.

How much longer can we in Washington keep our heads in the sand and claim to be representing the American people, and specifically women, as we seek to expand the abortion industry?

The opinions of the American public regarding abortion have changed and it is time our laws reflect that change.

The American public was horrified by the crimes committed by Kermit Gosnell, the Philadelphia-based abortionist who ran a dangerous, illegal, and ghastly "clinic." He was tried, and rightly convicted, for the crimes he committed and the deaths he caused in that terrible place. Yet, the legislation before you could be used to validate the acts that placed him behind bars and to invalidate the bipartisan legislation put in place to prevent future Gosnells from preying on the poor and the young.

I find it so curious that this legislation is termed "The Women's Health Protection Act." In my opinion it would more accurately be titled the "Removal of Existing Protections and Safety Measures for Women Undergoing Abortion Act." I would encourage the Committee to hit the pause button and consider the consequences, intended or not, of the legislation before passage.

The Women's Health Protection Act is grossly misnamed legislation that seeks to destroy common ground and defy the will of the American people. Reasonable legislation, like the Pain-Capable Unborn Child Protection Act, would protect the lives of unborn children and safeguard women from exploitation by limit abortions after 20 weeks. We must listen to the wisdom of the American people and indeed people everywhere. I urge the Senate to consider positive and mainstream legislation, like the Pain-Capable Unborn-Child Protection Act and to reject categorically the sweeping and radical proposal that is before this committee today.

PREPARED STATEMENT OF NANCY NORTHUP

United States Senate
Committee on the Judiciary

Hearing
"S.1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights"

Prepared Statement of Nancy Northup
July 15, 2014
Washington, DC

Chairman Leahy, Ranking Member Grassley, Senator Blumenthal and Members of the Committee:

I am Nancy Northup, president and CEO of the Center for Reproductive Rights, a global human rights organization that works to ensure that access to reproductive health care and the ability to make reproductive decisions are guaranteed in law as fundamental human rights that all governments are legally obligated to protect, respect, and fulfill. I bring to this issue my perspectives as the leader of an organization that has been, for more than 20 years, on the front lines of the legal battles over reproductive rights in the United States. I am also a former federal prosecutor and constitutional litigator with an abiding belief in the rule of law and in equal legal rights and protections for all.

Just over 20 years ago, Justices of the United States Supreme Court wrote, in *Planned Parenthood v. Casey*, that "the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives."[1] In that decision, the "central premise" of *Roe v. Wade*—decided 20 years prior—was reaffirmed: that a "woman has a right to choose to

[1] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 835 (1992).

terminate her pregnancy" before viability.[2] As the Court held in *Roe*, "'the right of the individual . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child' . . . necessarily includes the right of a woman to decide whether or not to terminate her pregnancy."[3]

These essential principles remain as vitally important today as they were when the Court handed down these historic rulings. This is an issue for women in every state, every congressional district, every county, and every city and town in America. Indeed, approximately one in three women in the U.S. will decide over the course of her life that ending a pregnancy is the right decision for her.[4] Her decision is based on her individual circumstances, her health and her life. And when a woman makes that decision, she needs access to good, safe, reliable care, from a health care provider she trusts, in or near the community she calls home.

But today, a woman's ability to access that care increasingly depends on the state in which she happens to live. There were over 200 state laws passed from 2011-2013 designed to make it harder or impossible for women to access abortion services in their communities.[5] And where not blocked by court orders, this new wave of restrictions is shutting down clinics, closing off essential services, and harming women.

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[2] 505 U.S. at 870.
[3] *Roe v. Wade*, 410 U.S. 113, 169-70 (1973) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)).
[4] At 2008 rates, 3 in 10 women will have an abortion by age 45. *Induced Abortion in the United States* GUTTMACHER INSTITUTE (July 2014), *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.html#1 (citing Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 OBSTETRICS & GYNECOLOGY 1358 (2011), *available at* http://journals.lww.com/greenjournal/Fulltext/2011/06000/Changes_in_Abortion_Rates_Betweeen_2000_and_2008.14.aspx).
[5] From 2011-2013, 205 abortion restrictions were enacted: 92 in 2011, 43 in 2012, and 70 in 2013. Elizabeth Nash et al, *State Trends for 2013 on Abortion, Family Planning, Sex Education, STIs and Pregnancy*, GUTTMACHER INSTITUTE (2013), *available at* http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html.

These restrictions take many forms. Some blatantly defy the U.S. Constitution and decades of settled law. In 2013, North Dakota enacted a ban on abortion as early as six weeks of pregnancy—before many women will even know they are pregnant.[6] That same year, Arkansas passed a ban at 12 weeks.[7]

Other restrictive laws single out reproductive health care providers for excessively burdensome requirements designed to regulate them out of practice under the false pretext of health and safety.[8]

This is the newest strategy in the four-decade campaign to deprive women of the promise of *Roe v. Wade*. During that history, there have been terrorizing physical attacks—clinics blockaded, bombed, vandalized and torched, doctors and clinic workers murdered.[9] Twenty-five years ago, I locked arms with members of my church and other concerned citizens in Baton Rouge, Louisiana to form a human chain of protection around a reproductive health clinic as hundreds of Operation Rescue protesters descended, intent on obstructing patients from entering. That scene was played out over and over across the nation. Federal action was needed—

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[6] H.B. 1456, 63d Leg. Assemb., Reg. Sess. (N.D.2013); *see also MKB Mgmt. Corp. v. Burdick*, 1:13-CV-071, 2014 WL 1653201, at *1, (D.N.D. Apr. 16, 2014) (finding H.B. 1456 unconstitutional, stating "[t]he North Dakota strict ban on abortions at the time when a 'heartbeat' has been detected – essentially banning all abortions as early as six weeks of pregnancy – cannot withstand a constitutional challenge."), *appeal filed*, No. 14-2128 (8th Cir. May 14, 2014).
[7] Ark. Code Ann. §§ 20-16-1301 through 1307; *Edwards v. Beck*, No. 4:13CV00224 SWW, 2014 WL 1245267, — F. Supp. 2d — (E.D. Ark. Mar. 14, 2014) (finding law unconstitutional and granting motion for partial summary judgment), *appeal filed*, No. 14-1891 (8th Cir. Apr. 16, 2014).
[8] *See, e.g.*, Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—And the Women They Serve—Pay the Price*. GUTTMACHER INSTITUTE (2013), *available at*, http://www.guttmacher.org/pubs/gpr/16/2/gpr160207.pdf ("having mostly exhausted legal means of discouraging women from choosing abortion, opponents recently have stepped up their efforts to block clinics from providing them. More than half the states now have laws instituting onerous and irrelevant licensing requirements, known as Targeted Regulation of Abortion Provider (TRAP) laws, which have nothing to do with protecting women and everything to do with shutting down clinics").
[9] *See, e.g.*, CENTER FOR REPRODUCTIVE RIGHTS, DEFENDING HUMAN RIGHTS: ABORTION PROVIDERS FACING THREATS, RESTRICTIONS, AND HARASSMENT 40 (2009), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/DefendingHumanRights.pdf.

and taken in 1994, with Congress' passage of the Freedom of Access to Clinic Entrances Act.[10]

The parallels to the present day are striking. The Senate Committee Report, in describing the problem FACE was designed to remedy, stated that blockades were "interfering with the exercise of the constitutional right of a woman to choose to terminate her pregnancy" and that "such conduct. . . threatens to exacerbate an already severe shortage of qualified providers available to perform safe and legal abortions in this country." [11]

Today, women's access to abortion services is being blocked through an avalanche of pretextual laws designed to accomplish by the pen what could not be accomplished through brute force—the closure of facilities providing essential reproductive health care to the women of this country.

Year after year poll after poll shows that a strong majority of Americans favor retaining the protections of *Roe v. Wade*.[12] So opponents of women's reproductive rights, seeking to make an end run around public opinion and the Constitution itself, have shifted their strategy. They have resorted to obfuscating their true agenda by pushing laws that pretend to be about one thing but are actually about another. They claim these laws are about defending women's health and well-being, and improving the safety of abortion care—but they most assuredly are not. They are wolves in sheep's clothing. They are advanced by politicians, not by doctors, often based on model legislation written by explicitly anti-abortion groups.

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[10] 18 U.S.C. § 248.

[11] FREEDOM OF ACCESS TO CLINIC ENTRANCES ACT OF 1993, REPORT FROM THE COMMITTEE ON LABOR AND HUMAN RESOURCES, S. REP. NO. 103-117 (1993), at 2.

[12] Louise Radnofsky & Ashby Jones, *Support Grows for Roe v. Wade*, WALL ST. J., Jan. 22, 2013, at A2, *available at*: http://online.wsj.com/news/articles/SB10001424127887323301104578255831504582200; *see also* Michael Lipka, *5 Facts About Abortion*, PEW RESEARCH CENTER (Jan. 22, 2014), http://www.pewresearch.org/fact-tank/2014/01/22/5-facts-about-abortion/ ("More than six-in-ten (63%) U.S. adults say they would not like to see the Supreme Court completely overturn *Roe v. Wade*, while about three-in-ten (29%) want to see the ruling overturned. These figures have remained relatively stable for more than 20 years.").

When Mississippi enacted such a law in 2012, a state senator put it quite plainly: "There's only one abortion clinic in Mississippi. I hope this measure shuts that down."[13] Others showed their hands as well. Lt. Governor Tate Reeves stated that the measure "should effectively close the only abortion clinic in Mississippi" and "end abortion in Mississippi" when the bill passed the state Senate.[14] Governor Phil Bryant, in vowing to sign the bill, said that he would "continue to work to make Mississippi abortion-free."[15] When he actually signed it, he said, "If it closes that clinic, then so be it."[16] Right now, Mississippi's sole clinic is holding on by virtue of a temporary court order.[17]

In Texas, Governor Rick Perry, who called a second special session of his state's legislature in 2013 specifically to pass that state's most recent set of abortion restrictions, not only declared his intention to "make abortion, at any stage, a thing of the past" at a Texas Right to Life press conference[18]—but also wrote the preface to this year's legislative playbook by the anti-abortion organization that wrote the language on which parts of the Texas law are based.[19]

More recently, the state legislative director of one of the nation's leading anti-choice organizations openly criticized the movement's cynical focus on women's health

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[13] Phil West, *Mississippi Senate Passes Abortion Regulation Bill*, COMMERCIAL APPEAL (Apr. 4, 2012), http://www.commercialappeal.com/news/2012/apr/04/mississippi-senate-passes-abortion-regulation-bill (quoting Sen. Merle Flowers).
[14] Joe Sutton & Tom Watkins, *Mississippi Legislature Tightens Restrictions on Abortion Providers*, CNN (Apr. 5, 2012, 5:25 AM), http:// www.cnn.com/2012/04/04/politics/mississippi-abortion/.
[15] James Eng, *Mississippi on Way to Becoming 'Abortion-Free' State?*, MSNBC.COM (Apr. 5, 2012, 3:26 PM), http:// usnews.msnbc.msn.com/_news/2012/04/05/11039503-mississippi-on-way-to-becoming-abortion-free-state.
[16] Jeffrey Hess, *Governor Bryant Signs New Regulations For Mississippi's Only Abortion Clinic*, MISSISSIPPI PUBLIC BROADCASTING ONLINE (Apr. 16, 2012, 6:56pm), http://mpbonline.org/News/article/governor_bryant_signs_new_regulations_for_mississippis_only_abortion_clinic ("If it closes that clinic then so be it. We are going to continue to try to work to end abortion in Mississippi and this is an historic day to begin that process.").
[17] *Jackson Women's Health Org. v. Currier*, 940 F. Supp. 2d 416 (S.D. Miss. 2013).
[18] Laura Basset, *Rick Perry: Banning Abortion Is 'My Goal'*, HUFFINGTON POST (Dec. 11, 2012, 5:27 pm), http://www.huffingtonpost.com/2012/12/11/rick-perry-abortion_n_2279734.html (last visited July 13, 2014).
[19] AMERICANS UNITED FOR LIFE, DEFENDING LIFE 2014: THE WOMEN'S PROTECTION PROJECT, A STATE-BY-STATE GUIDE TO ABORTION, BIOETHICS, AND END OF LIFE, *available at* http://aul.org/downloads/defending_life_2014.pdf.

because it is so clearly unconnected to the reality of how safe abortion really is. Mary Spaulding Balch of the National Right to Life Committee, at a 2014 conference, conceded that data show that abortion, even after the first trimester, carries a lower risk of serious complications than vaginal births, cesarean sections, and even plastic surgery procedures such as facelifts and liposuction.[20] And she recognized the absurdity of asserting women's health as a rationale for some of the stringent laws legislators have been leveling at abortion care: "Who," she asked, "would ever say that we should ban liposuction?"[21]

Abortion is one of the safest medical procedures,[22] yet is being singled out for burdensome restrictions not placed on comparable medical procedures. For example, ob-gyns who perform miscarriage completions in their office practices are not subject to these onerous requirements, despite the fact that they are performing the same medical procedure as abortion providers, who are subject to the requirements.[23]

The American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) have gone on record against many of these laws. For example, in 2012, the executive staff leadership of ACOG and the four other professional societies which together "represent the majority of U.S. physicians providing clinical care" published an editorial in the New England Journal of Medicine noting the "alarming" trend of political interference in medicine. They

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[20] Sofia Resnick, *National Right to Life Director Admits Pregnancy Is Riskier Than Abortion*, RH REALITY CHECK (July 2, 2014, 2:16 pm), http://rhrealitycheck.org/article/2014/07/02/national-right-life-director-admits-pregnancy-risky-abortion/.
[21] *Id.*
[22] *Planned Parenthood of Greater Tex. Surgical Health Svcs. v. Abbott*, Brief of Amici Curiae Am. Coll. Obstetricians & Gynecologists & Am. Med. Ass'n in Support of Pls.-Appellees & in Supp. of Affirmance, No. 13-51008, at 2 (5th Cir., filed Dec. 19, 2013) (hereinafter "ACOG/AMA 5th Cir. Brief") ("Abortion is one of the safest medical procedures performed in the United States. The risk associated with childbirth is approximately fourteen times higher.").
[23] *See, e.g.*, Linda W. Prine & Honor MacNaughton, *Office Management of Early Pregnancy Loss*, 84 AM. FAMILY PHYSICIAN 75 (2011), *available at* http://www.aafp.org/afp/2011/0701/p75.html (describing the methods of treating a miscarriage); *see also, e.g.*, Tex. Health & Safety Code Ann. § 245.002 (West) (defining "abortion" for the purposes of facility regulation to include induced but not spontaneous abortion though they entail procedures that are substantially the same).

called out "laws [that] would require physicians to provide — and patients to receive —diagnostic tests or medical interventions whose use is not supported by evidence, including tests or interventions that are invasive and required to be performed even without the patient's consent," including Virginia's law requiring women to undergo ultrasonography before having an abortion. [24]

Recently, these concerns have prompted both ACOG and the AMA to file amicus briefs in the lawsuits challenging Texas' admitting privileges and medication abortion law, Arizona's medication abortion restrictions, and North Carolina's mandatory ultrasound law, making clear that the restrictions at issue were not medically justified. For example, in the Texas case, the organizations filed a joint amicus brief stating that "there is no medically sound reason for Texas to impose a more stringent requirement on facilities in which abortions are performed than it does on facilities that perform other procedures that carry similar, or even greater, risks. Therefore, there is no medically sound basis for H.B. 2's [admitting] privileges requirement. ... H.B. 2 is also inconsistent with prevailing medical practices, which are focused on ensuring prompt medical care and do not require that each individual abortion provider have admitting privileges."[25]

But the roadblocks keep coming. Since Texas passed its sweeping set of restrictions a year ago, at least one third of the state's clinics have been forced to stop providing abortion care.[26] There is no clinic left in the entire Rio Grande Valley, an

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[24] Steven E. Weinberger et al., *Legislative Interference with the Patient–Physician Relationship*, 367 N. ENG. J. MED 1557 (2012), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsb1209858.
[25] ACOG/AMA 5th Cir. Brief, *supra* note 22, at 2-5; *see also Planned Parenthood of Ariz. v. Humble*, No. 14-15624, Brief of Amici Curiae ACOG & AMA in Supp. of Pls.-Appellants & in Supp. of Reversal (9th Cir., filed April 23, 2014), at 3 ("The district court correctly recognized that medical abortion is extremely safe; that the medical abortion regimens employed by [Plaintiffs] constitute sound medical practice in line with medical norms and the best interests of patients; and that there is no evidence [that Arizona's medication abortion restrictions] promote women's health"); *Stuart v. Camnitz*, No. 14-1150, Brief for Amici Curiae ACOG & AMA at 3 (4th Cir., filed July 1, 2014) ("The district court correctly held that the 'Display of Real-Time View' Requirement [...] serves no medical purpose and should be invalidated.").
[26] *See, e.g.*, Chuck Lindell, *Since New Law, One-Third of Texas Abortion Clinics Close*, STATESMAN.COM, (Mar. 6, 2014, 2:11 PM), http://www.statesman.com/news/news/since-new-law-one-third-of-texas-abortion-clinics-/nd69d/.

impoverished area with over 1.3 million residents.[27] If the final requirement is allowed to go into effect in September, the number of clinics will plummet to less than 10 to serve a state of over 260,000 square miles and 13 million women.[28]

Even before this new law, a 2012 study in Texas found that 7% of women reported attempts to self-abort before seeking medical care.[29] Now, women are crossing the border into Mexico to buy miscarriage-inducing drugs at flea markets or off the shelves at pharmacies—and then seeking needed care back in Texas.[30]

Courts have noted the pretextual nature of these abortion restrictions. In preliminarily blocking Wisconsin's admitting privileges requirement, the district court said that "the complete absence of an admitting privileges requirement for clinical [i.e., outpatient] procedures including for those with greater risk is certainly evidence that [the] Wisconsin Legislature's only *purpose* in its enactment was to restrict the availability of safe, legal abortion in this State, particularly given the lack of any demonstrable medical benefit for its requirement either presented to the Legislature or [to] this court."[31] Affirming this decision, Judge Richard Posner of the U.S. Court of Appeals for the Seventh Circuit noted "the apparent absence of any

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[27] Manny Fernandez, *Abortion Law Pushes Clinics to Close Doors*, N.Y. TIMES, Mar., 7, 2014, at A1, *available at* http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html?_r=0. ("Shortly before a candlelight vigil on the sidewalk outside, employees of the last abortion clinic in the Rio Grande Valley in South Texas shut the doors early Thursday evening, making legal abortion unavailable in the poorest part of the state in the wake of tough new restrictions passed last year by the Texas Legislature."); U.S. Census Bureau, Population Div., Annual Estimates of the Resident Population: Apr. 1, 2010 to July 1, 2012 (2010), http://factfinder2.census.gov/bkmk/table/1.0/en/PEP/2012/PEPANNRES/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed July 13, 2014).

[28] *See* Texas Quick Facts from the US Census Bureau, http://quickfacts.census.gov/qfd/states/48000.html (last visited July 13, 2014).

[29] Daniel Grossman et al, *The Public Health Threat of Anti-Abortion Legislation*, 89 CONTRACEPTION 73 (2014), *available at* http://www.utexas.edu/cola/orgs/txpep/_files/pdf/Grossman,White,Hopkins,Potter-PublicHealthThreatofAnti-abortionLegislation-Contraception-2014.pdf.

[30] *See*, Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, ATLANTIC (June 27, 2014, 9:00 AM) http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/; Lindsey Beyerstein, *'Miscarriage Management': The Next Front in the Abortion Wars*, NEW REPUBLIC, Jan. 29, 2014, *available at* http://www.newrepublic.com/article/116399/abortion-texas-survives-miscarriage-management.

[31] *Planned Parenthood of Wis., Inc. v. Van Hollen*, No. 13-CV-465-WMC, 2013 WL 3989238, at *10 n.26 (W.D. Wis. Aug. 2, 2013) (emphasis in original).

medical benefit from requiring doctors who perform abortions to have [admitting] privileges at a nearby or even any hospital [and] the differential treatment of abortion vis-à-vis medical procedures" with comparable risks.[32]

The Oklahoma Supreme Court, in interpreting Oklahoma's restrictions on medication abortion as unconstitutional, agreed with the state district court that the law was "so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do."[33]

In many states, the only thing holding back the further spread of these very real threats to women's health and lives are court orders blocking these laws from taking effect.[34] In many states, the passage of new laws and subsequent litigation goes on year after year after year. For example, Oklahoma passed legislation restricting access to medication abortion in 2008, 2011 and now again in 2014[35]– both earlier laws were enjoined by court order[36] (the most recent would not go into effect until late this year).[37] North Dakota has just one clinic, which remains open because it has repeatedly sued the state over its succession of unconstitutional laws.[38]

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[32] *Planned Parenthood of Wisconsin, Inc. v. Van Hollen,* 738 F.3d 786, 791 (7th Cir. 2013).
[33] *Cline v. Okla. Coal. for Reprod. Justice,* 313 P.3d 253, 262 (2013) (quoting *Okla. Coal. for Reprod. Justice v. Cline,* No. CV–2011–1722, slip op., ¶ 7 (Dist. Ct. Okla. Cnty. May 11, 2012)) (emphasis omitted).
[34] *See, e.g., supra* notes 7, 17, 31-33 & *infra* notes 35-38, and accompanying text.
[35]Senate Bill 1878, 2008 Okla. Sess. Law Serv. Ch. 36 (codified at Okla. Stat. tit. 63, §§ 1-728 *et seq.*) (multiple restrictions, including on medication abortion); House Bill 1970, 2011 Okla. Sess. Law Serv. Ch. 216 (amending Okla. Stat. tit. 63, § 1-729a) (restrictions on medication abortion); House Bill 2684, 2014 Okla. Sess. Law Serv. Ch. 121 (amending Okla. Stat. tit. 63, § 1-729a) (same).
[36] *Nova Health Systems v. Edmondson,* No. CJ-2008-9119, slip op. (Okla. Dist. Ct. Sept. 3, 2009) (finding 2008 Senate Bill 1878 unconstitutional); *Cline v. Okla. Coal. for Reprod. Justice,* 292 P.3d 27 (2012) (ruling that 2011 law imposing restrictions on provision of medication abortion was unconstitutional); *see also id.,* 313 P.3d 253 (2013) (explaining scope and unconstitutionality of 2011 law in response to certified questions from U.S. Supreme Court).
[37] Senate Bill 1878, see n. 35 *supra.*
[38] For example, North Dakota House Bill 1456, which was enacted in 2013 and bans abortion once a heartbeat is detectable, has been permanently enjoined by a federal district court. *MKB Mgmt. Corp. v. Burdick,* 2014 WL 1653201 (D.N.D. April 16, 2014) (finding North Dakota's ban on abortion once a heartbeat is detectable unconstitutional and permanently enjoining its implementation), *appeal filed*

While courts repeatedly strike down these restrictions as unconstitutional, such an outcome is far from assured. When the provision in last year's Texas law requiring admitting privileges was challenged, the district court, in issuing a permanent injunction, held that the law was unconstitutional because "admitting privileges have no rational relationship to improved patient care."[39] But when the state appealed that ruling, the U.S. Court of Appeals for the Fifth Circuit chose to ignore the evidence in front of the trial court and ruled instead that the State did not have to supply any evidence at all in support of its claim that the law was really about protecting women's health, and that speculation was enough to justify restricting women's constitutional rights.[40]

Clearly, stronger legal protections are needed. The Women's Health Protection Act would enforce and protect a woman's right and access to safe, legal abortion care no matter what state she lives in. It would prohibit states from singling out reproductive health care providers with oppressive requirements that grossly exceed what is necessary to ensure high standards of care and that apply to no similar medical practices. True health and safety laws that apply to all similarly situated medical care would be maintained, while dangerous regulations passed under pretext that cut off access to abortion care and endanger women's health and lives would be prohibited. It would require states to regulate abortion care as it does other similarly low-risk practices and procedures.

No. 14-2128 (8th Cir. May 14, 2014). House Bill 1297, which was enacted in 2011 and restricts the provision of medication abortions, has been permanently enjoined by a state district court. *MKB Mgmt. Corp. v. Burdick*, No. 09-2011-CV-02205 (N.D. Dist. Ct. July 15, 2013) (finding medication abortion restrictions unconstitutional under state constitution), *appeal filed* No. 20130259 (N.D. Aug. 26, 2013). Senate Bill 2305, which was enacted in 2013 and imposes an admitting privileges requirement, was blocked from going into effect; after several months, physicians at the state's only abortion clinic were able to obtain admitting privileges and the challenge was dismissed. *Id.*, slip op. (N.D. Dist. Ct. July 31, 2013) (preliminarily enjoining admitting privileges requirement during pendency of court proceedings), *case dismissed on stipulation of parties* (N.D. Dist. Ct. Mar. 14, 2014).

[39] *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 900 (W.D. Tex. 2013) *rev'd by* 748 F.3d 583 (5th Cir. 2014) (petition for rehearing en banc filed Apr. 10, 2014).

[40] *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 594 (5th Cir. 2014), *petition for rehearing en banc filed* (5th Cir. April 10, 2014).

As the Supreme Court reminded us over 20 years ago in *Planned Parenthood v. Casey*, "it is a promise of the Constitution that there is a realm of personal liberty which the government may not enter."[41] The most fundamental decisions about our reproductive health and lives are for each of us – and not the government - to make.

Like it did 20 years ago, Congress needs to take action to ensure that women's constitutional rights, and their ability to make the most personal of decisions, is not taken from them.

Thank you.

[41] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).

PREPARED STATEMENT OF DR. MONIQUE V. CHIREAU

Testimony of Monique V. Chireau, M.D.,M.P.H., F.A.C.O.G.
before the
United States Senate Judiciary Committee
July 15, 2014

Hearing on S. 1696, "The Women's Health Protection Act"

My name is Dr. Monique Chireau, and I am Assistant Professor in the Division of Clinical and Epidemiological Research in the Department of Obstetrics & Gynecology at Duke University Medical Center. I appreciate the opportunity to testify today regarding the impact that S. 1696 would have on the regulation of abortion in the United States.

S.1696 could be reasonably interpreted to invalidate virtually any type of current state laws which place restrictions or regulations on abortion. It would also endanger healthcare providers' freedom of conscience. It would also prohibit the future enactment of any of these laws. The purpose of the bill is given as "protect[ing] women's health by ensuring that abortion services will continue to be available and that abortion providers are not singled out for *medically unwarranted restrictions* that harm women by preventing them from *accessing* safe abortion services" (emphasis added).

Implicit in this stated purpose are the following four assumptions: abortion is good and safe for women; state abortion restrictions and regulations are "medically unwarranted;" access to abortion is important to women's health; and, that the state has no interest in protecting unborn children. I will address each in turn.

The Centers for Disease Control (CDC) defines an induced abortion as "an intervention performed by a licensed clinician...that is intended to terminate a suspected or known intrauterine pregnancy and produce a nonviable fetus at any gestational age" (*Morbidity and Mortality Weekly Report*, November 29, 2013, volume 16:8). 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). The Court recently held that "[s]evere depression and loss of esteem can follow" the abortion decision. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

I. Assumption A: Abortion is Good for Women.

A substantial body of literature indicates that induced abortion is associated with significant risks and potential harms to women. While abortion is stated to be very safe at early gestational ages, it carries specific risks. These include infection, bleeding, uterine perforation with damage to bowel or bladder, and the significance of these risks is underlined by the need to document them when obtaining informed consent from patients prior to performing this procedure. This is especially noteworthy given that induced abortion is an elective procedure.

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. 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. Therefore, any assertions that there are no significant risks to abortion, either medical or surgical, are contradicted by data.

I believe the lack of oversight, reporting, data collection and monitoring of the abortion industry in the United States has caused the true extent of harm to women caused by this procedure to be understated. No other commonly performed procedure, which is potentially associated with injury or death to a patient, receives

so little scrutiny. This lack of accountability in abortion service provision has contributed to other social ills such as enabling the cover-up of the sexual abuse of minors, human trafficking, rape and the exploitation of women.

If abortion is "good" for women and essential to women's health and central to women's ability to participate equally in the economic and social life of the United States as stated in the first finding of Senate bill 1696, one would naturally be led to ask why abortion should not be subject to the same oversight, monitoring and accountability as procedures considered to be "medically comparable."

S. 1696 provides that someone challenging a law need only show that the law "impedes women's access to abortion services" based on one or more of an extensive list of factors. In other words, even a state law, for example, that includes abortion clinics in a list of medical facilities required to meet ambulatory surgical standards would likely be in violation of this act if abortion clinics closed as a result of failing to meet these standards.

II. Assumption B: State abortion restrictions and regulations are "medically unwarranted".

With this backdrop, it is important to note that States have a compelling interest in protecting the health of their citizens when it comes to abortion, and they have the authority to do so within regulatory frameworks including state medical boards and departments of health. States traditionally regulate the practice of medicine, provide health surveillance and enforce public health standards. These principles are well established in law and should apply to abortion; but unfortunately, in some states they do not.

S. 1696 would undermine State efforts to protect the health of women by exempting abortion from the most basic common-sense regulations that could be interpreted as making abortion "more difficult to access" and it would preclude states from giving abortion the breadth of oversight which the United States Supreme Court has recognized is allowed for this unique procedure.

It should go without saying that the promulgation of regulations requiring clinics to meet certain basic health and safety standards is essential for the health and safety

of citizens. Historically, states have regulated medical procedures by establishing standards for the proper training and credentialing of medical care providers, both physician and non-physician. In addition, states have established health and safety standards of facilities in order to ensure safe conditions not only for the procedures being performed in the facilities but to accommodate any emergent response which may be required.

These standards protect patients from injury and death. Even simple procedures such as laser hair removal are regulated. A recent article in the Widener Law Review noted that liposuction, a procedure performed in physician offices, which does not enter any body cavities and which is routinely performed for outpatients, is associated with mortality. The point is that all medical procedures involve varying levels of risk and it is no less true for abortion. It is important to note that induced abortion differs significantly from dilation and curettage in a non-pregnant patient for a variety of reasons, including differences between the pregnant and non-pregnant uterus, the presence of the fetus, increased risk for perforation, bleeding and infection, and the consequences of incomplete evacuation of the uterus.

In addition, states have the responsibility for oversight of the collection of vital statistics on individuals undergoing procedures so that complications and trends can be analyzed and systems improved. Abortion should be subject to the same regulation and oversight, and Congress should not preempt the ability of the states to discharge their traditional regulatory functions. This is especially important since, as noted above, abortion surveillance is deeply flawed and inadequate.

Abortion regulations protect women's health by preventing serious consequences including death, which are potential complications of abortion. Abortion is not necessarily a routine or safe procedure; it has known risks and consequences as noted above. These risks have not been defined on a large scale due to the fact that large-scale accurate statistics on abortion complications are not collected.

Recent publicized deaths due to abortion include Lakisha Wilson who died in March 2014 at a Cleveland, Ohio clinic; Tonya Reaves, who died following a late term abortion in a Chicago Planned Parenthood Clinic in 2012; Jennifer Morbelli who died following a late term abortion in 2013; and an unknown patient, died

after abortion at Nova Women's Healthcare, Fairfax, VA, 2013. These cases are only the more notorious examples of the risks – including mortality – associated with legal abortion.

To the extent some studies on abortion safety cite low morbidity and mortality, it is because these procedures are carried out in clinical settings where health and safety policies and procedures are in place. The fact that morbidity and mortality rates are lower in these settings is clear evidence that regulation is needed and protects women.

At a minimum, health and safety standards allow for proper oversight, facilities and procedures. For example, parking lot, hallway and door width regulations facilitate access by emergency personnel in case of a complication requiring transport to a hospital. It is difficult to overstate the importance of these most basic facility regulations.

A prime example of their importance can be found in the Report of the Grand Jury investigating the Kermit Gosnell case, in which he was found guilty of manslaughter in the death of Karnamaya Mongar. Among other things, at page 129 of its Report, the Grand Jury cited doorways and narrow, substandard hallways as factors contributing to the inability of emergency personnel to save her: "Mrs. Mongar's slim chances of survival were seriously hampered because it was exceedingly difficult for responders to get her to the waiting ambulance. The emergency exit was locked. Gosnell sent Ashley to the front desk to look for the key, but she could not find it. Ashley told us that a firefighter needed to cut the lock, but "It took him awhile… because the locks is old." She testified that it took "twenty minutes, probably trying to get the locks unlocked." After cutting the locks, responders had to waste precious more minutes trying to maneuver through the narrow cramped hallways that could not accommodate a stretcher.

Also significant for patient health and safety standards are regulations regarding instrument cleaning and processing to prevent disease transmission and requirements for resuscitation equipment to allow emergency personnel the opportunity to provide timely and appropriate care.

Because complications from abortion (especially at later gestational ages) can and do occur, policies and procedures must be in place to provide emergency follow up care for women. It is a maxim within medicine that a provider has an obligation to provide follow up care and to manage the complications caused by any procedures they have performed, or to arrange for follow up care. Hence if a provider is performing abortions, they should either be able to admit a patient who is experiencing complications to the hospital, or have an arrangement in place to provide these services.

It is also worth noting that within states, the scope of practice for different types of clinicians is carefully defined. As noted above, physicians are responsible for managing complications for their patients, and are held accountable to standards of care for their specialties. States' scope of practice laws prevent these responsibilities from being casually delegated to another practitioner (such as a nurse practitioner or physician assistant) and prevent the practice of medicine by unqualified individuals.

This situation is already occurring in various states; in an effort to circumvent medical board regulations, non-physicians are being trained to perform medical and surgical abortions outside their scope of practice in violation of State law. "...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..."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." (see apctoolkit.org).

This is willful violation of state regulations designed to protect patients. Under this illegal scenario, since the provider is essentially practicing outside of the law, patients with complications are told to "go the emergency room, but don't tell them you had an abortion, just that you're miscarrying". Emergency department physicians in this predicament not only lack critical clinical information from the provider who performed the abortion (since management of miscarriage is quite different from that of complicated abortion) but are also unable to elicit an accurate history from patients, who are often too fearful or ashamed to tell what really

happened. These women are victimized twice – first through abortion, and again through emotional blackmail. This shows disregard for patient welfare through patient abandonment as well as refusal to take responsibility for women's care. It is ironic that the current generation of abortionists, who decry the "back-alley butchers" of the past, have adopted the same tactics, performing clandestine abortions and forcing women to lie about their real reason for coming to the hospital with complications.

Nightmare situations such as Kermit Gosnell's filthy, dangerous and ultimately homicidal "women's health clinic", where untrained staff gave anesthesia and performed procedures, provide irrefutable evidence that health and safety standards for abortion clinics are mandatory.

III. Assumption C: Access to abortion is important to women's health.

Abortion is an elective procedure which is not medically indicated, since pregnancy is not a disease. In point of fact, abortion does not prevent, treat or palliate any disease. It is not a procedure which contributes to a woman's health or to women's health *per se*.[1]

Abortion alone, and in and of itself, does not provide "care" for the health of a pregnant woman. While in rare circumstances the termination of pregnancy as part of medical care for the mother can be lifesaving, this occurs in the context of a *program* of treatment for the woman, not as an isolated procedure where the sole intent is the death of the fetus.[2]

[1] Examples of interventions which improve women's health include cancer prevention; smoking cessation; treatment of hypertension, diabetes and other diseases; and pain control in terminal stages of cancer.

[2] This is an example of the ethical principle of double effect—When a physician terminates a pregnancy because continuing pregnancy poses a risk to the life of a pregnant women, the physician expects the death of, but does not intend to kill, the fetus. This motivation can be tested by the question, "if the fetus does not die as a result of my intervention, will I have failed to accomplish what I intended to do?"

Abortion is also not necessarily a panacea when a woman is carrying a baby with a significantly life-limiting condition. Studies show that aborting a child with a fetal anomaly can cause great psychological harm for some parents.[3] Researchers have stressed the importance of adequate psychological support and guidance from the woman's caregiver during the decision-making process.[4]

A more compassionate option for women in these circumstances is perinatal hospice, a multidisciplinary approach that helps parents experience the life of their child to the fullest extent possible before and after birth. When presented with this option, more than 80 percent of parents choose perinatal hospice.[5] Physicians in one study reported that 87 percent of their patients diagnosed to be carrying a child with a lethal congenital disorder choose to continue pregnancy in this environment of care.[6]

Yet, S. 1696 would invalidate any laws that require abortion providers to educate their patients about the availability of perinatal hospice.

Ultimately, the overwhelming majority of abortions (78%) are done because "having a baby would change my life drastically." An unwanted pregnancy is for many women a very difficult and life-changing circumstance, but not a life-threatening health problem.

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[3] In 2004, one study revealed that maternal grieving after such abortions continued for over six months and included pathological anxiety and depression. A. Kersting et al., *Grief after termination of pregnancy due to fetal malformation*, J. PSYCHOSOM. OBSTET. GYNAECOL.25:163 (2004). In 2005, a study by Korenromp et al. revealed that a substantial number of the participants (17.3 percent) showed pathological scores for posttraumatic stress. Korenromp et al., *supra.* A follow-up study in 2009 revealed that at 14 months post-abortion, 16.7 percent of women were diagnosed with a psychiatric disorder. A. Kersting et al., *Psychological impact on women after second and third trimester termination of pregnancy due to fetal anomalies versus women after preterm birth: A 14-month follow up study*, ARCH. WOMEN'S MENTAL HEALTH 12:193 (2009).

[4] Korenromp, *supra.*

[5] M. D'Almeida et al., *Perinatal Hospice: Family-Centered Care of the Fetus with a Lethal Condition*, J. AMER. PHYSICIANS & SURGEONS 11:52 (2006);

[6] B.C. Calhoun et al., *Perinatal Hospice: Comprehensive Care for the Family of the Fetus with a Lethal Condition* (2005).

IV. Assumption D: The State has no interest in protecting unborn life.

S. 1696 utterly fails to acknowledge the state's compelling interest in protecting unborn life. In fact, there is no mention of unborn children at all, in spite of the fact that the purpose of the bill is to eliminate most regulations or restrictions on abortion.

The Supreme Court has recognized since *Roe v. Wade* that the state has an interest in the "potentiality" of unborn life that increases through the pregnancy. Further, the vast majority of Americans support many regulations of abortion because they understand that abortion ends a human life—71% of Americans believe abortion should never be legal or be legal only in certain circumstances (Gallup, May 2014). 64% believe that it should be illegal in the second trimester; 80% in the third (Pew, Jan. 2014.

Unborn children and their mothers are vulnerable to injury, exploitation and social and economic disadvantage. This interest underlies state programs to provide health insurance and food assistance to pregnant women. Other examples are efforts to prevent women from taking medications that might harm a fetus; protecting women from occupational exposures such as radiation (e.g. radiology technicians, power plant workers) and chemotherapy (e.g. nurses). It is noteworthy that substance abuse, intimate partner violence, sexual exploitation and mental health problems are risk factors for abortion, suggesting that abortion may be a marker for these social comorbidities. Thus, women seeking abortion are likely a vulnerable population, who need special protections. It is therefore clear that for practical, medical and legal reasons states have an interest in pregnant women and unborn life because of their need for these protections.

Undergirding this interest is the need to define when pregnancy begins. Traditionally, OB/GYN physicians were tasked with this definition. For generations pregnancy was assumed to begin at conception. The decision as to when pregnancy began later became a pragmatic one based upon basic science research and clinical diagnostics – upon implantation the embryo sends out a detectable hormonal signal, human chorionic gonadotropin (hCG), which is the basis for current pregnancy testing. This is an arbitrary way to define the onset of pregnancy since it is based on detecting an event – implantation – rather than when

the embryo came into existence at fertilization, 8-10 days earlier. The distinction is important because embryonic and fetal vulnerability to certain environmental exposures is high at early gestational ages. However, because laboratory studies could only detect implanted embryos, the pragmatic definition prevailed. Recent research has focused on diagnostic markers which may identify very early pregnancies.

Similarly, neonatologists are pushing back the boundaries of neonatal viability (currently at approximately 23-24 weeks). Scientific advances such as surfactant and antenatal steroid therapy have markedly increased survival rates for even the most premature infants, increasing a fetus' likelihood of surviving a late abortion and the need for resuscitation Much recent research has focused on prenatal treatment of Down Syndrome (61-93% of Down Syndrome fetuses are aborted in the US). We are moving closer to being able to treat Down Syndrome and prevent its complications. If this becomes possible, couples may likely choose to carry these pregnancies to term rather than aborting them. S. 1696 ignores these scientific advances by removing restrictions on abortion at various gestational ages.

Conclusion

S. 1696 is a measure that seeks to overturn longstanding state restrictions on abortion that have been supported in the courts. It ignores not only widely supported policies and scientific evidence, but also prior Supreme Court rulings, and clearly targets state regulations which protect the health of our most vulnerable citizens – pregnant women and their unborn children -- and undermines states' compelling interest in the health of the unborn. It does not merit support based on these findings. Thank you.

PREPARED STATEMENT OF DR. WILLIE PARKER

Statement of Dr. Willie Parker
Senate Judiciary Committee
Hearing on S. 1696, The Women's Health Protection Act
Removing Barriers to Constitutionally Protected Reproductive Rights
July 15, 2014

Good morning. My name is Dr. Willie Parker and I am here to today to offer testimony in support of the Women's Health Protection Act.

I have devoted my career to helping women have the families they want by supporting early and comprehensive prenatal care, preventing unintended pregnancy with medically accurate sex education and evidence-based contraception, delivering babies, and providing safe abortion care.

I support the Women's Health Protection Act because women across the country are losing the ability to make their own very personal, private health care decisions. In recent years, states have passed numerous measures that restrict abortion that are not based on medical evidence and do nothing to benefit patients.

In the war to defend the right to safe and legal abortion care, Mississippi, where I provide, is at the frontline. The state passed a law restricting the provision of abortion to obstetrician/gynecologists with hospital admitting privileges. This law, which is completely unsupported by evidence-based medicine, would shut down the one remaining abortion clinic in the state, effectively denying women access to abortion. On top of this, the state mandates delays that are costly and burdensome. A woman's access shouldn't be denied simply because she lives in Mississippi. The care she receives should be determined by medical evidence, not by her zip code.

Proponents of these laws can argue that they are "protecting" the health of women, but the truth would suggest otherwise. Here are the facts in Mississippi: there are high teen and unintended pregnancy rates, high infant mortality rates, high maternal mortality rates, and too many Mississippians living in astronomical poverty. These realities confront every woman in the state who has an undesired pregnancy, or a wanted but fatally flawed one. Their need for safe, compassionate, medical care is urgent. Because of that, I made the moral decision to provide care in this state.

Now, invariably, I field questions regarding that decision, with the most often asked being: Why? The short answer is: Because if I don't, who will? If women can find a way travel from all over the state of Mississippi and beyond under hostile circumstances to access abortion care at the clinic, I want to ensure there will be someone there for them.

Some people ask if I am concerned about my own safety. Of course I am. But I am less concerned for my safety than for what will happen to women if I am not there to provide the care they need and deserve.

One patient I think of often was a pregnant woman with five children, the youngest who had died just the year before from cancer. She found herself pregnant and knew that she could not care for another child financially or emotionally. She had traveled some distance for her first state-mandated counseling visit. Even though she was resolute, and knew what was best for her

family, her procedure was required to be delayed for political reasons that had nothing to do with her medical care.

Other women I saw that day were returning for their procedure following a second trip from hours away. These women come to the clinic despite distance, work considerations, childcare obligations, and increased travel costs. They typify the hardships that Mississippi women, and in fact many women across the country, endure due to present laws.

Every patient is unique. Every woman is different. Each one of them is grappling with a personal dilemma. I define a dilemma as a situation in which one has to decide between nondesirable options without the luxury of forgoing the decision. While their stories might differ, what all women I see have in common is the increasing difficulty in abortion access.

So, as I said, people will ask, "Why do you do it?"

The answer is, I want for women what I want for myself: a life of dignity, health, self-determination, and the opportunity to excel and contribute. We know that when women have access to abortion, contraception, and medically accurate sex education, they thrive. It should be the same for all women, no matter where they live. The ability to live the life you imagine should not be limited by your zip code.

We who provide abortions do so because our patients need us, and that's what we are supposed to do: respond to the needs of our patients. It has become a conviction of compassion in a

spiritual sense for me to provide abortion care. It is the deepest level of love that you can have for another person, that you can have compassion for their suffering and you can act to relieve it. Thank you.

PREPARED STATEMENT OF CAROL TOBIAS

Testimony of Carol Tobias

President

National Right to Life Committee

Before the Committee on the Judiciary,

United States Senate

on S. 1696, the "Women's Health Protection Act"

July 15, 2014

Mr. Chairman[1], distinguished members of the Committee on the Judiciary, I am Carol Tobias. I am the president of the National Right to Life Committee (NRLC). NRLC is a nationwide federation of 50 affiliated state-level right-to-life organizations. We are the nation's oldest and largest pro-life organization.

I welcome this opportunity to testify today in opposition to S. 1696.[2] I would note at the outset that we find the formal title or marketing label, "Women's Health Protection Act," to be highly misleading. The bill is really about just one thing: It seeks to strip away from elected lawmakers the ability to provide even the most minimal protections for unborn children, at any stage of their pre-natal development. While the proposal is so sweeping and extreme that it would be difficult to capture its full scope in any short title, calling the bill the "Abortion Without Limits Until Birth Act" would be more in line with truth-in-advertising standards.

We have heard a great deal of rhetoric from certain advocates of this legislation who claim to speak for the women of America. Yet if we look at objective polling data on various facets of abortion policy, these advocates do not speak for *most* women in America. Indeed, on some important issues that are

directly impacted by this legislation, advocates for this legislation speak for a fairly small minority of women.

We have even heard claims that this legislation is necessary to counter a "war on women." To millions of American women, such demagoguery is profoundly offensive, and I count myself among them. Our concepts of female autonomy and equality do not require us to deny the human dignity or the intrinsic right to life of our unborn children.

Even the doctrine of the original *Roe v. Wade* ruling never showed such an utter disregard or disrespect for pre-born members of the human family, as we find reflected in this bill. In its 1980 ruling in *Harris v. McRae*, upholding the Hyde Amendment, the U.S. Supreme Court said this:

> ***Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.***[3]

The great majority of Americans do not believe that abortion is just another "medical procedure," or that removing an unborn child is equivalent to removal of a malignant tumor. The elected representatives of the people have chosen, in many jurisdictions, to enact laws that are based in whole or in part on recognition

that abortion is *different*, precisely because every abortion stops a beating heart.

Throughout the text of S. 1696, the unborn child is a non-entity, a completely invisible being – yet only a small minority of Americans embrace the ideology that an unborn human is merely a blob of tissue. Even many Americans who self-identify as "pro-choice" struggle with the abortion issue, because they see it as a conflict of rights. There are many people who, while not fully sharing our view that the unborn child should be directly protected in law, nevertheless favor laws to ensure that the pregnant woman has the opportunity to view state-of-the-art imagery of her child, that she has a period for reflection before an abortion, that she receives full information about the resources available to her if she chooses to carry the baby to term, and other laws that take into account the gravity of what most Americans recognize as a life-and-death decision.

In contrast, the drafters of S. 1696 apparently believe that any woman who is considering abortion must be shielded from any imagery or information that may cause her to change her mind.

Under S. 1696, abortion would indeed be "inherently different" from other "medical procedures," but now in a new, inverted, and perverse sense. Under S. 1696, elective abortion would become the procedure that must always be facilitated, never delayed, never impeded to the slightest degree. The practices of

the abortion industry, or any segment of that industry, or even of an individual practitioner, would be granted extraordinary immunity from constraints or accountability. Each abortionist would become, in effect, a legislature onto himself or herself.

S. 1696 would greatly impede the ability of states to curb the activities of those abortion providers who most frequently injure or kill women, or exploit them in various ways – an area in which many jurisdictions have been unduly lax for decades. Dr. Kermit Gosnell of Philadelphia is only the most notorious recent example of a certain type of abortion provider who flourishes under the aura of political immunity generated by pro-abortion advocacy groups in some jurisdictions. There are many others who have demonstrated repeatedly that they should not be allowed anywhere near pregnant women or their unborn children, some of whom have been operating in multiple states for many years, shielded from real accountability by the timidity of state officials who are wary of offending the abortion industry and the political activist groups that fly cover for that industry. S. 1696 would make matters worse by saddling state and local officials with well-founded fears of federal lawsuits based on the sweeping provisions of the proposed statute.

It is noteworthy that S. 1696 would invalidate at least one of the

Pennsylvania laws under which Gosnell was convicted – a law that limits the circumstances under which abortions can be performed after 24 weeks of gestation – and would also invalidate the requirements for tighter oversight of abortion providers that were enacted in the wake of the Gosnell scandal, which reflected the detailed, damning findings of the grand jury that investigated the history of Gosnell's activities.[4]

Supporters of S. 1696 say that it is necessary to "remove barriers to constitutionally protected reproductive rights." But this is not a bill to vindicate constitutional rights. New laws pertaining to abortion are generally quickly blocked by the federal courts, if they actually transgress the constitutional doctrines enunciated by the U.S. Supreme Court. In reality, the central purpose of this bill is precisely to invalidate many state laws, and a significant number of federal laws, that have been upheld by the federal courts, or that are likely to survive federal judicial scrutiny if they are ever challenged.

It is in large part because they have failed to persuade federal courts to invalidate certain types of reasonable laws that they dislike – laws that have broad popular support, and that were enacted through the normal processes of democracy -- that groups such as Planned Parenthood (the nation's largest abortion provider) and the Center for Reproductive Rights are now demanding that Congress drive

this federal pro-abortion bulldozer from coast to coast, scraping everything flat.

What would the bill knock flat? Limits on abortions after 20 weeks – past the point at which unborn children can experience pain – which are supported by sizeable majorities nationwide, and in multiple polls by 60 percent of women. Laws limiting abortion even after viability, unless they allow each abortionist to abort based on his assertion that an abortion will preserve emotional "health." Laws protecting individuals or private medical institutions from being forced to participate in abortion, which about three-fourths of the American people support, and which the great majority of states have enacted – including Connecticut, Mr. Chairman. Laws prohibiting the aborting of an unborn child because of the child's sex, which over 85 percent of the American people support. Laws requiring the providing of information on alternatives to abortion, which 88 percent of the public supported the last time Gallup asked the question[5] (this would include, for example, a requirement that a woman seeking an abortion be given printed information describing the legal responsibilities of biological fathers to provide economic support if she decides to carry her child to term). Laws providing periods for reflection. All these would be among the types of laws that would fall under the prohibitions contained in S. 1696.

The bill would subject any law or government policy that affects the

practice of abortion, even indirectly, to an array of sweeping and often overlapping legal tests, designed to guarantee that almost none will survive.[6 7] Under S. 1696, the general rule would be that any law that specifically regulates abortion would be presumptively invalid, *and the same would be true of any law that is not abortion-specific but has the effect or claimed effect of diminishing access to abortion.*

In theory there is a tiny keyhole to permit a few laws that mention or affect abortion to survive, if a state can convince a judge "by clear and convincing evidence" that the law serves the sole purpose of protecting "the safety of abortion services or the health of women," and that it is the narrowest means to achieve those ends. S. 1696 is crafted to weigh the judicial scales heavily against abortion regulations – for example, by establishing a *prima facie* premise that laws regulating abortion are invalid, and instructing the courts to "liberally construe" the pages of prohibitions contained in the bill, in order to "effectuate the purposes of the Act."

In several provisions S. 1696 prohibits distinctions between abortion and "medically comparable" procedures. The bill fails to define what "medically comparable" means. Asked about this by a reporter, Mr. Chairman, you responded that the meaning is "for doctors to decide."[8] Presumably the doctors who would

decide are the abortionists themselves.[9] In our view, there are no procedures that are "medically comparable" to abortion, because there are no other procedures in which medical professionals deliberately kill a member of the human family (except, in a few jurisdictions, physician-assisted suicide). But that is clearly not the construction of "medically comparable" that would be adopted by the courts in interpreting S. 1696, in view of the explicit statements regarding the purposes of the act, and the admonition that "a court shall liberally construe such provisions to effectuate the purposes of the Act."

In addition, the bill requires each state legislature, and Congress, to defer to the personal judgment of each abortionist. It instructs the courts that a law "impedes access to abortion services" – and is, therefore, presumptively invalid – if it "interferes with an abortion provider's ability to provide care and render services in accordance with her or his good-faith medical judgment." One could hardly draft a more sweeping federal grant-of-immunity to the abortion industry as a whole, and to each individual abortionist – including the Gosnells.

Allow me to underscore that it is quite clear that, under this bill, it will avail a state nothing to prove that a given abortion-related or abortion-impacting law has *no harmful impact* on women's health, and that the law in question serves other important public interests. It is apparent that those who crafted this bill

believe that, where abortion is involved, *there are no other interests* – untrammeled, immediate access to abortion, at any stage of pregnancy, is the only thing that matters.

So, for example: Federal law, and the laws of most states, protect (to varying degrees) the right of individual medical practitioners, and of private medical institutions, to decline to participate in the performance or providing of abortions.[10] We generally refer to such laws by the term "conscience protection laws." The pro-abortion advocacy groups call them "refusal clauses," and have escalated their rhetorical, legal, and legislative attacks on such laws in recent years. It is crystal clear that the existing state and federal conscience laws would be nullified by S. 1696. These laws do not jeopardize women's health, but they would be nullified, both because they specifically mention abortion and because they may reduce access to abortion by allowing medical providers to refuse to collaborate in the killing of innocent members of the human family.

As a result, many dedicated medical professionals would be driven from their chosen fields of medicine, because they will not participate in the killing of their unborn patients; the net effect of these professionals leaving the field will be to the detriment of women's health. Medical institutions that are animated by religious convictions that do not allow them to participate in the deliberate

destruction of human life could be forced to close or to narrow their services, often to the detriment of the urban poor most often served by such institutions.[11]

The ideology of those who crafted S. 1696 drives them to demand that all medical service providers collaborate in the killing of innocent unborn humans, or face professional destruction. They have compared the existing conscience-protection laws to "Jim Crow" laws, saying that they provide government protection for "discrimination." In S. 1696, you would give their ruthless ideology the force of federal law.

Some may claim that when I use terms like "killing" I am using rhetoric that is harsh or inflammatory. But no, I am simply clinically describing the reality that this legislation seeks to ignore. As feminist author Naomi Wolf wrote, "[T]he pro-life slogan, 'Abortion stops a beating heart,' is incontrovertibly true."[12] Faye Wattleton, the former president of the Planned Parenthood Federation of America said, "So any pretense that abortion is not killing is a signal of our ambivalence, a signal that we cannot say yes, it kills a fetus but it is the woman's body, and therefore ultimately her choice."[13]

The bill contains a cosmetic provision that is intended to fool the uninitiated or inattentive into believing that it allows substantial limitations after "viability," but this is entirely illusory. Even after "viability," which would be defined and

determined solely by the abortion practitioner, the bill prohibits any limitation on abortion that the abortionist believes is required to enhance "health," a term that the bill leaves entirely unconstrained, and that the states would therefore be powerless to narrow. We note that when a reporter pressed you, Mr. Chairman, to say whether the bill is in fact intended to allow abortions *after viability* based on "psychological" as well as physical health factors, your response was, "It doesn't distinguish."[14]

Besides the general prohibitions that by themselves would result in invalidation of nearly all laws that directly or indirectly touch on the practice of abortion, already discussed, S. 1696 also contains a list of specifically prohibited types of laws. These would guarantee elimination, among other things, of the laws that ensure that women who are considering abortion will have access to information that the abortion industry will not voluntarily provide, and time to absorb it before making a final decision. Of course, abortion providers hate such laws, in part because they result in some substantial loss of business – because many women, given concrete information on alternatives to abortion and time to consider that information, decide to carry their children to term.

These laws are, obviously, abortion-specific, and therefore they would be invalid under the tests imposed by S. 1696 -- yet I've never seen a poll on such a

requirement that showed less than 80 percent public support.

Or, consider the laws that require that the woman be informed of the right to view the ultrasound images of her unborn child. Abortion providers routinely perform ultrasounds in preparation for any abortion, including first-trimester abortions, but few abortionists can be expected to voluntarily display or offer to display the ultrasound images to the woman. Why do those who term themselves "pro-choice" fear laws that require the abortionist to offer or display the image? Is it because the ultrasound images provide graphic evidence that the ideological construct on which S. 1696 is based – that abortion is "just another medical procedure" – is a lie?

A 2011 Gallup poll found that 50 percent of respondents nationwide favored ultrasound display laws, and 69 percent favored a 24-hour waiting period, both of which would be impermissible under S. 1696.[15]

S. 1696 explicitly prohibits any limitation on reasons for which abortion may be performed. This would invalidate, for example, any state law that prohibits advertising or performing abortions purely for the purpose of eliminating unborn children who are not of the sex desired by a parent or parents. A 2012 report by the Committee on the Judiciary of the U.S. House of Representatives observed, "[T]he United States is one of very few industrialized nations that do not

restrict the various methods of sex-selection – despite our continuous condemnation of other countries that permit the practice."[16] A national poll in 2006 found that 86 percent of Americans agreed that abortion to select the sex of a child should not be legal.[17]

In nations in which sex-selection abortion is widespread, and in certain communities in the United States in which it is also practiced, the targets are usually unborn females. It is curious that some of those who readily mouth polemic about a "war on women" also oppose both national and state legislation to curb this practice, as we saw in 2012 when the House of Representatives debated and gave strong majority support to the Prenatal Nondiscrimination Act.

Numerous polls have shown strong public support for legislation such as the Pain-Capable Unborn Child Protection Act (S. 1670), introduced last year by Senator Lindsey Graham -- upwards of two-to-one in some polls, with women more supportive than men.[18] [19] The Pain-Capable Unborn Child Protection Act would extend protection to unborn children in the sixth month and later, by which point they are capable of experiencing great pain during the process of abortion[20], with certain exceptions. Ten states have already enacted laws very similar to Senator Graham's bill,[21] [22] and several other states have passed other measures intended to curb abortion after the fifth month. Because the pro-abortion extremist

groups have not been able to defeat these measures in the legislatures, and because they are afraid to take them to the U.S. Supreme Court, they now come to you to seek this legislation, which would invalidate both the 20-week laws and any meaningful post-viability abortion limitations, such as Pennsylvania's limitation on the circumstances in which abortions may be performed after 24 weeks, which was the one of the statutes that Kermit Gosnell was convicted of violating.

The so-called "Women's Health Protection Act" is not a new idea. It is an expanded version of the so-called "Freedom of Choice Act" or "FOCA," originally proposed in 1989. While we recognize the FOCA as an antecedent to S. 1696, there are some important distinctions between the two, and the current bill is even more extreme. For example, the FOCA of 1993 applied only to state laws, while S. 1696 would apply also to previous acts of Congress limiting abortion, with the exception of the Partial-Birth Abortion Ban Act of 2003.[23] The Hyde Amendment, the Helms Amendment to the Foreign Assistance Act, federal conscience protection laws, and many other previous congressional enactments would be invalidated by S. 1696.[24]

In 1992, committees in both the House and Senate approved the FOCA. Presidential candidate Bill Clinton endorsed the measure, and after his election in 1992, Planned Parenthood predicted that the FOCA would be law within six

months of Clinton's inauguration. In early 1993, committees in both the Senate and the House again approved the FOCA, albeit in slightly differing versions,[25] and pro-abortion activist groups made an all-out effort to enact it.

But the wheels came off when, encouraged by a national educational campaign directed by National Right to Life, many lawmakers belatedly looked beyond the title of that bill, and beyond the marketing slogan – which was that the bill was simply a "codification of *Roe v. Wade*." These lawmakers came to realize that they would be accountable for the *actual sweeping effects* of the operative language of the legislation, which would have invalidated a great number of state laws that enjoyed (then and now) broad popular support.

Because the actual language of the bill would have imposed a national policy far out of step with mainstream public opinion, the FOCA was eventually shelved.[26]

This history is instructive with respect to S. 1696. Pro-abortion advocates seek to advance this legislation behind a smokescreen of highly generalized and demagogic rhetoric about "women's health" – and perhaps initially, the mainstream news media will be uninterested in engaging in detailed exploration of the sweep of the bill, and disinclined to get specific about the types of state laws that are targeted by this proposal. Nevertheless, the radical sweep of the so-called

"Women's Health Protection Act" will be more and more widely understood as time goes on. Those lawmakers who embrace this measure ultimately will have a great deal of explaining to do.

Endnotes

1. The chairman of the Committee on the Judiciary is Senator Patrick Leahy (D-Vt.), but by his designation, this hearing is chaired by Senator Richard Blumenthal (D-Ct.), who is the chief sponsor of S. 1696. Therefore, all references in this testimony to "Mr. Chairman" are addressed to Senator Blumenthal, including quotations of past public statements by Senator Blumenthal.

2. My testimony is applicable as well to the companion bill introduced in the U.S. House of Representatives, H.R. 3471.

3. In quoting the statement of the Supreme Court on this point, I do not fully embrace the Court's terminology. We recognize that an abortion ends not "a potential life," but the life of an actual unique human individual, with all of his or her inherent potential. Nevertheless, the Court's recognition that abortion is "inherently different" is noteworthy, especially since three of the justices who endorsed this statement had been in the majority in *Roe v. Wade* (Justices Stewart, Burger, and Powell).

4. The 281-page report on the Gosnell affair issued in 2011 by a grand jury in Philadelphia catalogs, in unsparing detail, the politically motivated "hands off" mindset adopted by state agencies, and the tolerance and active collaboration of others in the abortion-provider "community," that allowed Gosnell to operate his carnal house without impediment and at great profit for decades. Although the entire report should be required reading for any lawmaker considering support for S. 1696 or H.R. 3471, a few brief excerpts must suffice here:

> Pennsylvania is not a third-world country. There were several oversight agencies that stumbled upon and should have shut down Kermit Gosnell long ago. But none of them did, not even after Karnamaya Mongar's death.

In the end, Gosnell was only caught by accident, when police raided his offices to seize evidence of his illegal prescription selling. Once law enforcement agents went in, they couldn't help noticing the disgusting conditions, the dazed patients, the discarded fetuses. . . . After 1993, even that pro forma [inspection] effort came to an end. Not because of administrative ennui, although there had been plenty. Instead, the Pennsylvania Department of Health abruptly decided, for political reasons, to stop inspecting abortion clinics at all. The politics in question were not anti-abortion, but pro. With the change of administration from Governor Casey to Governor Ridge, officials concluded that inspections would be "putting a barrier up to women" seeking abortions. Better to leave clinics to do as they pleased, even though, as Gosnell proved, that meant both women and babies would pay. (pp. 8-9)

Gosnell, bizarrely, applied for admission [to the National Abortion Federation] shortly after Karnamaya Mongar's death. Despite his various efforts to fool her, the evaluator from NAF readily noted that records were not properly kept, that risks were not explained, that patients were not monitored, that equipment was not available, that anesthesia was misused. It was the worst abortion clinic she had ever inspected. Of course, she rejected Gosnell's application. She just never told anyone in authority about all the horrible, dangerous things she had seen. Bureaucratic inertia is not exactly news. We understand that. But we think this was something more. We think the reason no one acted is because the women in question were poor and of color, because the victims were infants without identities, and because the subject was the political football of abortion. (p. 13)

. . . Gosnell began to rely much more on referrals from other areas where abortions as late as 24 weeks are unavailable. More and more of his patients came from out of state and were late second-trimester patients. Many of them were well beyond 24 weeks. Gosnell was known as a doctor who would perform abortions at any stage, without regard for legal limits. His patients came from several states, including Delaware, Maryland, Virginia, and North Carolina, as well as from Pennsylvania cities outside the Philadelphia area, such as Allentown. He also had many late-term Philadelphia patients because most other local clinics would not perform procedures past 20 weeks. (p. 27)

Report of the Grand Jury, in the Court of Common Pleas, First Judicial District of Pennsylvania, Criminal Trial Division, In Re Misc. No. 0009901-2008, R. Seth Williams, district attorney.
http://www.phila.gov/districtattorney/PDFs/GrandJuryWomensMedical.pdf

5. Gallup, January 10-12, 2003, asked respondents if they would vote for "a law requiring doctors to inform patients about alternatives to abortion before performing the procedure." Yes 88%, no 11%.

6. S. 1696 contains a "Limitation" that provides exceptions for four types of abortion-related laws, three of which would otherwise be invalid under the general prohibitions in the bill; it appears that the three exceptions were included for purely tactical reasons. One exception fences off "the procedure described in section 1531(b)(1) of title 18, United States Code," which is the federal Partial-Birth Abortion Ban Act, enacted in 2003 and upheld by the U.S. Supreme Court in the 2007 decision in *Gonzales v. Carhart*. In addition, there are exceptions for "laws regulating physical access to clinic entrances," "requirements for parental consent or notification before a minor may obtain an abortion," and "insurance coverage of abortion." Regarding the last, see the next endnote.

7. The provision dealing with "insurance coverage of abortion" apparently protects the laws, now enacted by more than half the states, to limit coverage of abortion under health insurance plans sold on the Obamacare exchanges. Some defenders of S. 1696 have claimed that this exception also protects the federal Hyde Amendment and the similar laws that are in effect in most states, which prevent funding of elective abortion under entitlement programs such as Medicaid, but it is highly doubtful that such programs would be considered "insurance" as the term is used in the bill. Thus, all limitations on abortion coverage under government entitlement programs, such Medicaid, would be subject to challenge and likely invalidation under S. 1696. In addition, it is beyond dispute that longstanding provisions of federal law that prevent direct funding of abortion under Title X of the Public Health Service Act and under the Foreign Assistance Act (which no one can claim relate to "insurance") would be nullified. Those who crafted S. 1696 could easily have drafted an exception to cover laws of the Hyde Amendment type, if that had been their real intent. Indeed, the version of the "Freedom of Choice Act" that was approved by the Senate Committee on Labor and Human Resources on April 29, 1993, contained such an exception, which

read: "Nothing in this Act shall be construed to . . . prevent a State from declining to pay for the performance of abortions." For further discussion of the application of S. 1696 to laws limiting government funding of abortion, see John McCormack, "Senate Democrats Introduce Bill to Strike Down State Abortion Laws: Far-reaching measure would invalidate law used to convict late-term abortionist Kermit Gosnell," *The Weekly Standard*, November 20, 2013. http://www.weeklystandard.com/blogs/senate-democrats-introduce-bill-strike-down-popular-state-abortion-laws_767931.html

8. McCormack, *ibid.*

9. The great majority of states do limit the performance of legal abortions to licensed physicians, and the U.S. Supreme Court has repeatedly held that such a "restriction" is constitutional. However, pro-abortion activist groups have been campaigning to weaken or repeal these "doctor-only" laws, and recently succeeded in California. It is highly doubtful that such "doctor-only" laws could be sustained in the face of the prohibitions contained in S. 1696.

10. "Quickly following the 1973 Church Amendment [a federal law, 42 U.S.C. § 300a-7], almost every state enacted its own abortion conscience law. Today, 46 states provide protection to individual providers. Almost as many states provide protection to institutions. But sometimes institutional conscience protection is limited only to private or even only to religious hospitals." Thaddeus Mason Pope, "Legal Briefing: Conscience Clauses and Conscientious Refusal," *The Journal of Clinical Ethics* 21, no. 2 (Summer 2010): 163-80.

11. It is noteworthy that the version of the "Freedom of Choice Act" reported by the Senate Committee on Labor and Human Resources on April 29, 1993, contained an explicit exception to preserve conscience protection laws: "Nothing in this Act shall be construed to . . . prevent a State from protecting unwilling individuals or private health care institutions from having to participate in the performance of abortions to which they are conscientiously opposed." Such a provision is conspicuously lacking from the so-called "Women's Health Protection Act," because the drafters of this legislation apparently believe that conscience and religious liberty count for nothing in any case in which they might impede access to abortion.

12. Naomi Wolf, "Our Bodies, Our Souls," *The New Republic*, October 16, 1995, page 29.

13. "Speaking Frankly," *Ms.*, May/June 1997, page 67. Such quotations could be multiplied for pages. See also "Partial-Birth Abortion on Trial," by Cathy Cleaver Ruse, Esq., *Human Life Review*, Spring 2005, http://www.nrlc.org/uploads/pba/RusePBAonTrial.pdf.

14. John McCormack, "Senate Democrats Introduce Bill to Strike Down State Abortion Laws: Far-reaching measure would invalidate law used to convict late-term abortionist Kermit Gosnell," *The Weekly Standard*, November 20, 2013. (TWS: And you can't say whether it's physical or also psychological? BLUMENTHAL: It doesn't distinguish.) http://www.weeklystandard.com/blogs/senate-democrats-introduce-bill-strike-down-popular-state-abortion-laws_767931.html

15. Gallup poll, July 15-17, 2011: "A law requiring women seeking abortions to wait 24 hours before having the procedure." – favor 69%, oppose 28%. "A law requiring women seeking an abortion to be shown an ultrasound image of her fetus at least 24 hours before the procedure." – favor 50%, oppose 46%.

16. Committee on the Judiciary, U.S. House of Representatives, 112th Congress, report on the Prenatal Nondiscrimination Act (PRENDA) (H.R. 3541), May 29, 2012, page 11. The PRENDA, in the form considered by the House on May 31, 2012, would have made it a federal offense to knowingly do any one of the following four things: (1) perform an abortion "knowing that such abortion is sought based on the sex or gender of the child"; (2) use "force or the threat of force . . . for the purpose of coercing a sex-selection abortion"; (3) solicit or accept funds to perform a sex-selection abortion; or (4) transport a woman into the U.S. or across state lines for this purpose. The bill explicitly provided, "A woman upon whom a sex-selection abortion is performed may not be prosecuted or held civilly liable for any violation of this section, or for a conspiracy to violate this section." A solid majority of the House (246-168) voted to pass the bill, but it fell short of the two-thirds majority required for passage under Suspension of the Rules. President Obama opposed the PRENDA.

17. Zogby poll, March 10-14, 2006: "Do you agree or disagree that it should be illegal in the U.S. to have an abortion because of the sex of the fetus?" Agree 86%, disagree 10%, not sure 4%.

18. *Washington Post-ABC News* Poll, July 18-21, 2013: "The U.S. Supreme Court has said abortion is legal without restriction in about the first 24 weeks of

pregnancy. Some states have passed laws reducing this to 20 weeks. If it has to be one or the other, would you rather have abortions legal without restriction up to (20) weeks, or up to (24) weeks?" Up to 20 weeks, 56% (including 60% women); up to 24 week, 27%.
http://www.washingtonpost.com/page/2010-2019/WashingtonPost/2013/07/25/National-Politics/Polling/question_11465.xml?uuid=bN9EXvUZEeKB-o6Ds4ZMNg

19. Quinnipiac University Poll, July 28-31, 2013: "The U.S. Supreme Court has said abortion is legal without restriction in about the first 24 weeks of pregnancy. Some states have passed laws reducing this to 20 weeks. If it has to be one or the other, would you rather have abortions legal without restriction up to 20 weeks, or up to 24 weeks?" Up to 20 weeks, 55% (60% of women); up to 24 weeks, 30%.
http://www.quinnipiac.edu/news-and-events/quinnipiac-university-poll/national/release-detail?ReleaseID=1931

20. While a detailed discussion of this subject is beyond the scope of this hearing, extensive medical documentation is posted on the NRLC website at
http://www.nrlc.org/abortion/fetalpain/
See, for example, "Fetal Pain: The Evidence" and "Report of Dr. Kanwaljeet S. Anand, expert on fetal pain, to U.S. federal court reviewing the Partial-Birth Abortion Ban Act."

21. In order of enactment: Nebraska, Kansas, Idaho, Oklahoma, Alabama, Georgia, Louisiana, Arkansas, North Dakota, and Texas.

22. It should also be noted that on June 18, 2013, the U.S. House of Representatives passed the Pain-Capable Unborn Child Protection Act, H.R. 1797, which is virtually identical to Senator Graham's S. 1670, by a margin of 228 to 196. On May 13, 2014, Senator Blumenthal objected to a unanimous consent request, propounded by Senator Graham, under which the Senate would have voted on both S. 1670 and S. 1696 (one after the other, not one as an amendment to the other). See *Congressional Record*, May 13, 2014, pp. S2935-36. See also
http://www.nationalrighttolifenews.org/news/2014/05/nrlc-and-allies-press-for-senate-action-on-key-pro-life-bill-but-senate-democrats-block-votes/#.U8Ew1iieb4Z

23. The Partial-Birth Abortion Ban Act is 18 U.S.C. §1531. The National Right to Life Committee presented extensive information on the practice of partial-birth abortion to the Senate Judiciary Committee in 1997. See testimony of Douglas Johnson, legislative director, National Right to Life Committee, on the Partial-

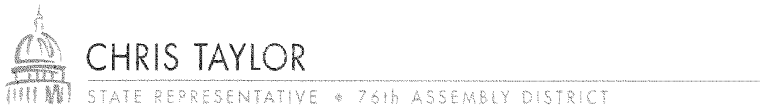
Birth Abortion Ban Act, Joint Hearing Before the U.S. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee, March 11, 1997, http://www.nrlc.org/abortion/pba/test/

24. Regarding the four "exceptions" contained in S. 1696, see endnotes no. 6 and 7.

25. S. 25, approved by the Senate Labor and Human Resources Committee on April 29, 1993, and H.R. 25, approved by the House Judiciary Committee on May 19, 1993.

26. While a detailed discussion of the history of the "Freedom of Choice Act" is beyond the scope of my testimony today, see, for example, "Congress Faces New Abortion Battle," Timothy M. Phelps, *Newsday*, April 12, 1993; and "High Hopes Turn to Uncertainty for Freedom of Choice Act," Alissa J. Rubin, *Congressional Quarterly Weekly Report*, May 8, 1993, 1154.

PREPARED STATEMENT OF HON. CHRIS TAYLOR



WHPA Senate Judiciary Committee Hearing
Testimony of Wisconsin Rep. Chris Taylor

Chairman Leahy, ranking member Grassley and Judiciary Committee members,

My name is Chris Taylor, and I am a state Representative for the 76th Assembly district from the great state of Wisconsin. I am honored to be here this morning to provide testimony in strong support of the Women's Health Protection Act. I would like to especially thank Chairman Leahy, acting Chairman Blumenthal, ranking member Grassley and members of the Committee for this opportunity. I especially want to thank my Senator Tammy Baldwin, whom we are very proud of in Wisconsin, for leading the way and cosponsoring this important bill.

I am also the former Public Policy Director for Planned Parenthood of Wisconsin. For over a decade, I have been monitoring, advocating for and now attempting to pass good policy around reproductive health issues.

My state faces many critical challenges. Job creation in Wisconsin is stagnant--we are at the bottom of the barrel for job creation in the Midwest. Like the country as a whole, Wisconsin is struggling with epic income inequality between the wealthiest and everyone else. And racial disparities in education, incarceration and poverty are some of the greatest in the nation. These are pressing issues that Wisconsinites want state government to address. I ran for office because I wanted to do my part in addressing these challenges to guarantee that Wisconsin continues to be a great place for my young children and for generations to come.

Numerous public polls in Wisconsin clearly indicate that Wisconsinites want their elected officials to address the critical economic issues our state faces. Unfortunately, my Republican colleagues in the state legislature have been more focused on passing restrictions on reproductive health care and information than on the issues my constituents and Wisconsinites throughout the state want us to focus.

From legislation to litigation, over the last three years the state of Wisconsin has become one of the many battlegrounds in the fight over a woman's ability to access abortion care. Abortion restrictions that have recently passed in Wisconsin include forced ultrasounds and hospital admitting privileges. These restrictions do not promote women's health or safety, and run counter to sound medical practice and opinion. In fact, by making abortion services more difficult or impossible to access, these restrictions threaten the health, safety and lives of Wisconsin women and women throughout this country. Global evidence indicates that where abortion services are restricted and unavailable, abortions still occur and are mostly unsafe. Worldwide, unsafe abortion is one of the top causes of maternal death.[1]

[1] World Health Organization, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed. Geneva: World Health Organization. http://apps.who.int/iris/bitstream/10665/75173/1/WHO_RHR_12.01_eng.pdf?ua=1

State Capitol: P.O. Box 8953, Madison, WI 53708
(608) 266-5342 • E-mail: rep.taylor@legis.wi.gov • Web: http://taylor.assembly.wi.gov

This is why we need a federal response and the Women's Health Protection Act. We need you to ensure that in my state and throughout our country, a woman's ability to access safe, legal abortion is not dependent on where she lives, and not subject to the political whims of her state legislators.

Abortion Access limitations in Wisconsin

With over a dozen abortion restrictions and few abortion providers, Wisconsin is on the verge of becoming a state where abortion is inaccessible for many women. Only four health centers provide abortions, and only a few hospitals provide them only in very limited circumstances. As a result, Wisconsin women have less access to abortion services than the average American woman. As of 2011, 89% of U.S. counties had no health center providing abortion, and 38% of American women lived in these counties. The same data shows that 96% of Wisconsin counties had no health center providing abortions, and more than two-thirds of Wisconsin women lived in these counties.[2]

Abortion is a common healthcare experience in Wisconsin, just as it is across the United States. But at three of the four health centers providing abortions, women must wait three to four weeks to obtain an abortion because of physician shortages. This type of delay pushes women further into their pregnancy. In some cases, women must undergo a more complicated, expensive procedure because of this long wait. Increased costs may further delay the procedure.

There is only one health center that provides abortions post 18 weeks, and the two physician owners of that clinic want to retire. As a result, patients who need an abortion post 18 weeks, including those with medical issues and pregnancy complications, often travel out of state.

Wisconsin has over a dozen abortion restrictions, including funding restrictions, a twenty-four hour waiting period, mandated lectures and a pre-*Roe* criminal abortion ban that would go into effect should *Roe v. Wade* be overturned. We are currently categorized by the Guttmacher Institute as a state hostile to abortion rights because of the number of restrictive abortion laws.[3]

Recent Abortion Restrictions & the Impact on Wisconsin Women

While the rates of unintended pregnancy[4] and abortion in Wisconsin are lower than that of the United States as a whole,[5] the Wisconsin state legislature has spent an inordinate amount of time and resources in restricting women's reproductive health care access and rights. Since 2011, a plethora of laws have been passed including repealing comprehensive, medically accurate sex education instruction, banning some insurance coverage for abortion, creating new criminal penalties for abortion providers, placing new restrictions on medication abortion and eliminating state funding for Planned Parenthood of Wisconsin for cervical and breast cancer screening, birth control, and testing and treatment for Sexually Transmitted Diseases. These restrictions do not promote the health and safety of Wisconsin women.

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[2] http://www.guttmacher.org/pubs/sfaa/wisconsin.html
[3] http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html
[4] http://www.guttmacher.org/statecenter/title-X/WI.html
[5] http://www.guttmacher.org/pubs/sfaa/wisconsin.html

Admitting privileges and forced ultrasound requirements were signed into law by Governor Scott Walker in 2013. Physicians who perform abortions are required to have admitting privileges at a hospital within 30 miles. This requirement is not extended to physicians who provide any other outpatient procedures in Wisconsin, including those who perform surgeries under general anesthesia in ambulatory surgery centers.

Admitting privilege requirements, at first glance, might seem benign. In fact, the only thing such requirements achieve is to prevent qualified, experienced physicians from providing care to their patients. Some abortion providers are categorically ineligible because they have no or very low rates of patient hospital admissions. This is due to the safety of abortion and low complication rates.[6] I sit on the State Assembly Health committee, and during the hearing on this bill, there was no medical evidence or testimony presented that the admitting privileges status of a woman's abortion provider in any way enhances the health and safety of women obtaining abortions.

When I questioned the bills two main sponsors whether they would reconsider this requirement if physicians could not comply and health centers providing abortions were forced to shut down, they refused.

The point of this requirement, clear and simple, is to impede access to abortion care by shutting down health centers that provide abortions.

During the legislative process, the Wisconsin medical community vocally opposed requiring hospital admitting privileges for physicians providing abortions, including the Wisconsin Academy of Family Physicians, the Wisconsin Hospital Association, the Wisconsin Public Health Association, the Wisconsin Association of Local Health Departments and Boards and the Wisconsin Medical Society (WMS). In fact, there was no health care provider or health care organization who advocated for this bill. WMS urged lawmakers to oppose it, noting that this requirement "interferes with the patient-physician relationship and places an unneeded and unprecedented burden on Wisconsin physicians and women"[7].

The federal judge now hearing the case, in entering a preliminary injunction, noted a complete lack of a record in establishing any relationship between admitting privileges and protecting and improving a women's health. He specifically stated that "On the record, the admitting privileges requirement is a solution in search of a problem." The 7th Circuit Court of Appeals also noted a complete lack of justification for the law and that it would have a substantial impact on the availability of abortions in Wisconsin.

And unfortunately, that potential could indeed become a reality should this law, still on review in federal court, go into effect.

One of the four health centers providing abortions would be shut down, as its two physicians are ineligible for admitting privileges at area hospitals. This is the only health center providing

[6] https://www.prochoice.org/about_abortion/facts/safety_of_abortion.html

[7] https://www.wisconsinmedicalsociety.org/_WMS/advocacy/at_the_capitol/find_your_issue/society_testimony/2013/pdf/SB206_memo_06052013_a.pdf

abortions post 18 weeks. This means that most women experiencing serious health complications or tragedies in pregnancy will have no option but to leave Wisconsin to obtain the abortions they need. This health center also serves one-third of the women seeking abortions in Wisconsin. The three remaining health centers could not absorb the additional patients without significant new delays of 8-10 weeks in providing abortions.

A delay of this magnitude clearly impacts all Wisconsin women seeking abortions. But the closing of a health center providing one-third of the abortions in the state will have particularly devastating effects on low-income women, who rely on public transportation and cannot afford uncompensated work absences or additional child care costs.[8] For poor women, these additional barriers may be insurmountable, and a significant number will not be able to legally obtain the abortion they seek.

The same law that requires admitting privileges also forces a woman seeking an abortion to undergo an ultrasound 24 hours before obtaining an abortion. The provider must also describe and display the image to the woman. Only a woman who has been sexually assaulted and files a police report or whose continued pregnancy threatens her life or the loss of one or more bodily functions can escape this requirement.[9] Physicians have no ability to tailor their medical care to the unique situation of each individual woman, or to adopt the best standard of care they ethically must provide women.

Forcing women to undergo ultrasounds is government at its biggest and most intrusive. This law places politicians in the examining room, dictating medical care to patients they do not know. In most cases, women will be subjected to an invasive vaginal ultrasound. Women are unable to refuse, including women whose wanted pregnancies go wrong and the majority of sexual assault and incest victims who do not file police reports. This simply is a cruel and inhumane requirement for a woman and family experiencing a crisis. Providers have reported that a patient's inability to refuse is creating divisions between the health care provider and patient, creating more tension and stress for the patient. At a minimum, it humiliates and degrades women, treating them like second class citizens who are denied the patient autonomy and personal decision making afforded most other patients.

Wisconsin's medical community also vocally opposed forced ultrasounds. In its written testimony the Wisconsin Medical Society (WMS) stated that the "mandatory performance of an ultrasound before an abortion is not an accepted medical practice or standard of care. . .this practice does not add to the quality or safety of the medical care being provided." Upon the signing of the bill by Governor Scott Walker, WMS stated that ". . . legislating what occurs in the exam room is unequivocally unacceptable."[10]

My Republican colleagues in our state legislature did not listen to our state's medical community. They did not listen to their democratic female colleagues as we shared our own stories about pregnancy loss, miscarriage, stillbirths, high risk pregnancies and sexual assault on

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[8] Testimony of Jane Collins, a Professor at the University of Wisconsin and an expert on issues faced by women in poverty in Wisconsin, in the federal trial on the Wisconsin admitting privileges requirement, *Planned Parenthood of Wisconsin v. JB Van Hollen*, 13-cv-465-wmc.

[9] Wis. Stat. § 253.10(3g).

[10] https://www.wisconsinmedicalsociety.org/news/society-extremely-disappointed-by-enactment-of-2013-wis-act-37/

the floor of the Assembly, to underscore the complexities of child bearing and pregnancy decisions and the potential harmful and dangerous effect of this bill. What we knew as we went through this debate was that these abortion restrictions are not only medically insupportable and dangerous to women, but they are out of touch with our experiences and our lives. These are the most personal, complex decisions women and families make in their lives, and politicians should not make them.

It is not my role as a legislator to dictate the most personal, private decisions of my constituents. I have no business as a legislator dictating insupportable medical practices to a physician who is ethically obligated to operate in the best interest of patients. But I am in the business of ensuring that the people in my district, the people I represent, are able to exercise their most fundamental , personal decisions about their lives. As it now stands, with states legislating away those rights, we need the Women's Health Protection Act more than ever. Wisconsin women and women throughout this nation simply cannot wait.

Thank you.

PREPARED STATEMENT OF SENATOR DIANNE FEINSTEIN

Statement of Senator Dianne Feinstein

Hearing on the Women's Health Protection Act

Senate Judiciary Committee

July 15, 2014

Thank you very much, Mr. Chairman. I am pleased to be a cosponsor of the *Women's Health Protection Act*, and I regret that I cannot attend today's hearing.

As the first woman to serve on this committee, protecting women's access to health care has always been deeply important to me. It is a fundamental issue at every confirmation hearing for a Supreme Court Justice. It is an issue that impacts women across the country.

The last several years have seen the adoption of many laws at the state level that harm women's health by subjecting abortion services to onerous restrictions that have no basis in medical science. Some of these laws, like requirements that women obtain medically unnecessary tests, interfere in the doctor-patient relationship and make it more difficult for women to access care.

Other laws have forced clinics to close. The Rio Grande Valley in Texas – a region with over 1.3 million people – is now without a single medical clinic that

provides a range of health care services that includes abortion care. I fear that the reality for millions of women in some parts of this country will be no different than it was before *Roe v. Wade.*

That is a frightening prospect. I remember how unsafe, and even deadly, it was for women in the 1950s and 1960s to seek abortions. I remember a young woman who committed suicide because she was pregnant and abortion was illegal. I remember passing a plate in a college dormitory so that another friend could go to Mexico for an abortion. Simply put, women were forced into great danger.

Some states are also forcing physicians to prescribe a drug in a way that they know is inconsistent with the best available medical evidence.

As the American Medical Association and the American College of Obstetricians and Gynecologists said last year, "a number of evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved over 13 years ago."

From a health perspective, it makes no sense to forbid physicians from using their best medical judgment in prescribing these drugs. Yet some states are doing just that.

In fact, when an Oklahoma law was struck down by the Oklahoma Supreme Court, the court agreed with a trial court's finding that the law was "so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do."

In striking down an Arizona law, the Ninth Circuit similarly found that the State had "presented no evidence whatsoever" that this sort of restriction "furthers any interest in women's health."

When our health is on the line, women – like most Americans – care about the medical evidence and want physicians and their patients making these choices together.

As Justice John Paul Stevens explained in a concurring opinion in *Stenberg v. Carhart* (2000), "a woman's right to make this difficult and extremely personal decision" is protected by the Constitution, a holding that "makes it impossible . . . to understand how a State has any legitimate interest in requiring a doctor to follow any procedure other than the one that he or she reasonably believes will best protect the woman in her exercise of this constitutional liberty."

For me, that is what this bill is about, and I am pleased to cosponsor it.

QUESTIONS SUBMITTED TO NANCY NORTHUP BY SENATOR COONS

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR COONS

Questions for Ms. Northup

1. Large areas of the country, such as Texas's Rio Grande Valley region have no abortion providers. In states where women have limited access to safe and legal abortions they resort to traveling to other countries like Mexico to get services or turn to unregulated providers. What do we know about the safety of these providers and the impact on women's health?

2. Do state laws restricting access to abortion disproportionately affect low income and minority women?

QUESTIONS SUBMITTED TO DR. WILLIE PARKER BY SENATOR COONS

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR COONS

Questions for Dr. Parker

1. Physicians in other parts of the country have reported an increase in the number of women who arrive at doctors' offices having previously tried to self-abort—which we know can lead to death—have you seen a similar increase in your practice?

2. You are the sole abortion provider for Mississippi but live in Alabama, two states with some of the highest poverty rates in the country. None of the doctors who live in Mississippi are willing to provide abortion services and 94% of Alabama's counties do not have abortion providers. Looking around the country, I am struck that the most restrictive statutory regimes exist in those states with the highest rates of poverty. How have these abortion restriction impacted the level of access women have to reproductive care and family planning service, and in particular poor and minority women?

3. Both Alabama and Mississippi, like many other states, have enacted laws that require doctors to force women to have ultrasounds. Some laws prevent doctors from using telemedicine to provide care to women. Others have required doctors to use outdated and medically unsafe medical protocols which are all designed to target abortion. How have these restrictions interfered in the doctor-patient relationship?

QUESTIONS SUBMITTED TO HON. CHRIS TAYLOR BY SENATOR COONS

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR COONS

Question for Ms. Taylor

1. We currently have a situation in this country where a woman's constitutionally protected right to access abortion services depends on the state she lives in, the politics of the legislators in her state, and the amount of money she has. Is this fair, and what impact would passage of the Women's Health Protection Act have on ensuring that a woman's right to choose is respected equally, wherever she may happen to live?

QUESTIONS SUBMITTED TO NANCY NORTHUP BY SENATOR BLUMENTHAL

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR NANCY NORTHUP:

Ms. Northup, you are the President and CEO of the Center for Reproductive Rights, an organization that frequently works in countries where abortion is illegal or heavily restricted. A 1990 study found that in the United States 62 percent of deaths from illegal abortion and 51 percent of deaths from spontaneous abortion were due to infection. In contrast, only 21 percent of deaths from legal abortions in the United States were caused by infection. Can you comment on the patient safety risks that result from making abortion illegal or from unduly limiting access? Specifically, can you provide a general comparison of the reproductive health outcomes in countries with restrictive abortion laws with the outcomes in countries where abortion is legal, accessible, and safe?

During the hearing, some Senate Judiciary Committee Members expressed doubt regarding Congress' authority to enact laws that prevent states from legislating in certain areas or in certain ways. Based on your extensive experience as a litigator and state policy advocate, please provide some examples of federal statutes that limit states' ability to legislate.

If the Women's Health Protection Act had been federal law at the time that Pennsylvania authorities tried and convicted Kermit Gosnell of multiple crimes, would Gosnell still have been convicted and imprisoned? Would the Women's Health Protection Act have affected the outcome of Gosnell's case in any manner whatsoever?

Would the Women's Health Protection Act force clinicians to provide abortion care if they do not wish to for personal or religious reasons?

Some Members of the Senate Judiciary Committee as well as some of the witnesses who testified stated that the Women's Health Protection Act would invalidate laws requiring parental involvement in the abortion decision of a minor, laws restricting public insurance coverage of

abortion, and all limitations on abortion later in pregnancy. Do you agree that such laws would run afoul of the Women's Health Protection Act?

QUESTIONS SUBMITTED TO DR. WILLIE PARKER BY SENATOR BLUMENTHAL

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR DR. WILLIE PARKER:

Dr. Parker, your perspective as a practicing physician, as a doctor who provides reproductive health care for underserved populations, and as an abortion provider in particular, is very valuable to the ongoing debate about abortion rights in this country. Many legislators who enact abortion laws, and sometimes very harmful laws, have never seen the inside of a clinic. Indeed, many of them will never personally face the question of whether or not to have an abortion, since most are men. Real world experiences like your work providing care to thousands of individual women should carry great weight in today's abortion debates.

1. In your experience as a medical provider, are there cases that demonstrate the problems with the pretextual restrictions the Women's Health Protection Act guards against? If so, can you please describe a few of them?

2. How would the Women's Health Protection Act affect your patients?

The recent hearing on the Women's Health Protection Act devoted significant attention to state requirements that abortion providers have hospital admitting privileges. As mentioned in some testimony provided during the hearing, admitting privileges *can* serve important purposes. Hospitals often review a doctor's educational background, licenses, and experience before granting membership. Such review processes can help ensure that only appropriately qualified doctors provide care. Yet even physicians without admitting privileges, including some abortion providers, must adhere to regulations regarding medical licensing and ensuring patient health and safety. In addition, federal law requires hospital emergency rooms to treat any patient with an emergency condition until the condition is stabilized. In other words, all patients are entitled to equal access to emergency hospital care, irrespective of whether their treating clinician has admitting privileges. Dr. Parker, can you share your perspective as a reproductive health care

physician and explain the challenges you have faced with obtaining admitting privileges in Mississippi?

QUESTIONS SUBMITTED TO HON. CHRIS TAYLOR BY SENATOR BLUMENTHAL

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR CHRIS TAYLOR:

During the Senate Judiciary Committee hearing on the Women's Health Protection Act, Senator Hatch said "I can't imagine why any state legislature would support this no matter their position on abortion." Representative Taylor, as a duly elected representative of the 76th Assembly District of the State of Wisconsin, how do you respond to that statement?

As a state legislator what is your view on the appropriateness of a federal law that would prevent states from enacting laws that undermine access to abortion services?

Oklahoma State Representative Doug Cox, a former Emergency Room physician, recently wrote an op-ed on the Republican party's current view of women's health care. Representative Cox lamented his party's view of abortion, stating "What happened to the Republican Party that I joined? The party where conservative presidential candidate Barry Goldwater felt women should have the right to control their own destiny?...What happened to the Republican Party that felt government should not overregulate people until (as we say in Oklahoma) 'you have walked a mile in their moccasins'?" Today, State Representative Cox is an anomaly in his party. Representative Taylor, in your opinion, why should a woman's right to make her own health care decisions not be a partisan issue?

QUESTIONS SUBMITTED TO CAROL TOBIAS BY SENATOR GRASSLEY

Questions for the Record
By Senator Chuck Grassley
Senate Judiciary Committee Hearing
S. 1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights

To Carol Tobias:
Nancy Northup, president and CEO of the Center for Reproductive Rights, repeatedly indicated that a law would be permissible under S. 1696 if regulated abortion is done in the same manner as other "similar" procedures. She said, "I think what's really critical about the bill . . . is right from the start, if this is something that is treating medically similar practices and procedures and services the same, there's no objection, nothing's going to be struck." The bill itself uses the term "medically comparable procedures," and in your written testimony, you discuss the ambiguity of the term "medically comparable," and difficulties in applying that term to abortion. Taking this into consideration, consider this possibility: Law X is a state law that regulates all centers in which surgical procedures are performed, and although Law X does not mention abortion, surgical abortion centers are obviously within the scope of the law. Let's even go a step further and stipulate, purely for purposes of my question, that a federal court finds that for purposes of reviewing this Law X under the terms of the federal law, S. 1696, abortion is indeed a "medically comparable procedure." Is Ms. Northup correct in suggesting that, once a court has concluded that Law X treats abortion the same as other "medically comparable procedures," Law X is therefore permissible under S. 1696?

During the hearing, Senator Blumenthal suggested that S. 1696 contains an exception to protect current laws against government funding of abortion. Do you agree with Senator Blumenthal on this point? If not, please explain why.

Nancy Northup, president and CEO of the Center for Reproductive Rights, in her written testimony to the Committee, on pages 5-6, stated that Mary Spaulding Balch, state legislative director for National Right to Life, recently "openly criticized the [pro-life] movement's cynical focus on women's health because it is so clearly unconnected to the reality of how safe abortion is." Ms. Northup asserted that Ms. Balch "conceded that data show that abortion, even after the first trimester, carries a lower risk of serious complications than vaginal births, cesarean sections, and even plastic surgery procedures such as facelifts and liposuction. And she recognized the absurdity of asserting women's health as a rationale for some of the stringent laws legislators have been leveling at abortion care . . ." These statements by Ms. Northup were all based, according to a footnote, on a single article by Sofia Resnick that appeared on the "pro-choice" advocacy website ***RH Reality Check*** on July 2, 2014. Did Ms. Northrup's testimony accurately reflect the position of your organization? Please offer any additional observations that would clarify, give context to, or otherwise illuminate the statements made by Ms. Northup or the thrust of the underlying article by Ms. Resnick.

Relating also to the conscience issue, some groups that advocate for abortion have asserted that federal law already requires that hospitals, including private religious hospitals, must perform abortions in circumstances that someone considers to be "emergencies," however that term might be defined under the laws of a given state or under federal regulatory guidance, now or in the future. The federal law that they cite as support for this assertion is the Emergency Medical Treatment and

Active Labor Act (EMTALA), Section 1867 of the Social Security Act. Do you agree with this characterization of current federal law?

QUESTIONS SUBMITTED TO DR. MONIQUE V. CHIREAU BY SENATOR GRASSLEY

Questions for the Record
By Senator Chuck Grassley
Senate Judiciary Committee Hearing
S. 1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights

To Dr. Chireau:
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?

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

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

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?

QUESTIONS SUBMITTED TO CAROL TOBIAS BY SENATOR GRAHAM

SENATOR LINDSEY O. GRAHAM
22 JULY 2014
U.S. SENATE COMMITTEE ON THE JUDICIARY
HEARING TITLE: "S.1696, THE WOMEN'S HEALTH PROTECTION ACT: REMOVING BARRIERS TO CONSTITUTIONALLY PROTECTED REPRODUCTIVE RIGHTS"

QUESTIONS FOR THE RECORD FOR MS. CAROL TOBIAS:

1. Regarding the impact of S. 1696 on the ability of states to limit late abortions: In her testimony, Nancy Northup, president and CEO of the Center for Reproductive Rights, suggested that S. 1696 simply reiterates the current "constitutional standard," which, she suggested in her written testimony, draws a sharp demarcation at "viability." Do you agree with Ms. Northup's reading on what the current "constitutional standards" are, regarding limits on late abortions, and do you agree with those who suggest that S. 1696 does nothing more than codify the current "constitutional standard" with respect to regulation of abortion?

2. In your testimony to the Committee, both verbal and written, you asserted that S. 1696 would result in invalidation of federal and state laws that protect individual doctors, nurses, and other health-care providers, and usually private institutions as well, from being penalized for declining to participate in the providing of abortions. These are often referred to as "conscience protection laws," although some of the critics of such laws call them "refusal clauses." During the question period at the hearing, when I suggested to Nancy Northup, president and CEO of the Center for Reproductive Rights, that the bill would result in invalidation of the conscience laws, she said, "I don't agree. This legislation doesn't address the issue of conscience objection." However, she did not explain how these laws could survive scrutiny under the tests imposed by the bill, and she was evasive when I asked her if she would endorse an amendment to S. 1696 exempting these laws from the scope of the bill. Do you have any comment on Ms. Northup's claim that the bill "does not address" the issue of conscience protection laws, and could you please explain the process of judicial analysis that you believe would result in invalidation of these laws under S. 1696?

3. At the hearing I asked Ms. Northup whether a waiting period for elective abortion would be permissible under S. 1696. She said it would depend on various factors, yet she evaded my repeated requests that she name a single state waiting-period law that might survive under the bill. Do you believe that a state law requiring a waiting period prior to an elective abortion could survive under the prohibitions that S. 1696 would impose, and if not, why not?

RESPONSES OF NANCY NORTHUP TO QUESTIONS SUBMITTED
BY SENATORS COONS AND BLUMENTHAL

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR RICHARD BLUMENTHAL

QUESTIONS FOR NANCY NORTHUP:

1. *Ms. Northup, you are the President and CEO of the Center for Reproductive Rights, an organization that frequently works in countries where abortion is illegal or heavily restricted. A 1990 study found that in the United States 62 percent of deaths from illegal abortion and 51 percent of deaths from spontaneous abortion were due to infection. In contrast, only 21 percent of deaths from legal abortions in the United States were caused by infection. Can you comment on the patient safety risks that result from making abortion illegal or from unduly limiting access? Specifically, can you provide a general comparison of the reproductive health outcomes in countries with restrictive abortion laws with the outcomes in countries where abortion is legal, accessible, and safe?*

Response:

The World Health Organization ("WHO") has recognized that "women all over the world are highly likely to have an induced abortion when faced with an unplanned pregnancy – irrespective of legal conditions."[1] Women who live in countries that permit abortion under broad indications are more likely to have access to safe abortion services, whereas in countries with restrictive abortion laws that make abortion illegal in most circumstances, women will often be forced to resort to self-induced abortions or to untrained providers in hazardous environments. The WHO recognizes that in countries with restrictive abortion laws, induced abortion rates are high, most abortions are unsafe, and women's health and lives are frequently jeopardized.[2] For example, according to a study by the WHO and the

[1] WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008 6 (6th ed., 2011).
[2] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 23 (2012).

Guttmacher Institute, the Latin American and African regions had the highest rates of unsafe abortion in 2008.[3] The vast majority of countries in these regions have restrictive abortion laws.[4]

Conversely, in Western Europe, where abortion is generally treated as a covered medical service under nationalized health care systems and compulsory health insurance schemes and is available without restriction as to reason in the early months, abortion rates and maternal mortality due to unsafe abortion are the lowest. For example, according to the same study, the rate of unsafe abortion was less than 0.5% in this region.[5] In countries where abortion is legal, maternal mortality and morbidity are generally lower because abortions are performed by trained professionals in hygienic conditions and are safer, more available, and more affordable.

Evidence from around the world clearly demonstrates the negative reproductive health outcomes that result from restrictive abortion laws. For example, in 1996, South Africa changed its law to permit abortion services without restriction as to reason during the first 12 weeks of pregnancy and thereafter on specific grounds.[6] The former law only permitted abortion to save a woman's life, preserve her physical or mental health, or in cases of rape, incest, or fetal impairment.[7] According to South Africa's National Committee of Confidential Inquiries into Maternal Deaths, the liberalization of the abortion law led to a 91% decline in abortion-related maternal mortality between 1994 and 1998-2001.[8]

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[3] *See* Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008,* 379 THE LANCET 625, Table 1 (2012).
[4] *See* WHO, *supra* note 2 at 25.
[5] Sedgh et al., *supra* note 3, at Table 1.
[6] Choice on Termination of Pregnancy Act 92 of 1996, § 2 (S. Afr.).
[7] Abortion and Sterilization Act 2 of 1975 (S. Afr.), *reprinted in* INT'L ADVISORY COMMITTEE ON POPULATION AND L., ANNUAL REVIEW OF POPULATION LAW 48 (1975).
[8] Before 1996, abortion was legal only to protect life and health or in the cases of rape, incest, other unlawful intercourse, and some fetal impairments. In 1996, the law was liberalized to permit the service without restrictions pertaining to the woman's reason during the first trimester and thereafter on numerous grounds. Choice on Termination of Pregnancy Act 92 of 1996 (S. Afr.); Rachel Jewkes et al., *The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa After the Legislative Change*, 112 BRIT. J. OBSTETRICS AND GYNAECOLOGY 355 (2005).

In Romania, in 1966, the government restricted the availability of abortion to limited circumstances.[9] During the time these restrictions were in effect, maternal mortality rates skyrocketed.[10] Between 1980 and 1989, 80% of maternal deaths were due to unsafe abortions.[11] After the repeal of the restrictive abortion legislation in 1989, maternal mortality rates dramatically decreased, falling 50% in the first year after the law was repealed.[12] This decline continued and by 1996, the registered number of maternal deaths caused by abortion dropped 76%.[13]

Similarly, in Nepal, where revisions to the country's legal code in 2002 granted women the right to terminate a pregnancy up to 12 weeks without restriction as to reason and later on specific grounds, the removal of restrictions contributed to a decline in complications from unsafe abortion.[14] Specifically, "abortion–related complications fell from 54% to 28% of all maternal morbidities treated at relevant facilities between 1998 and 2009."[15]

2. *During the hearing, some Senate Judiciary Committee Members expressed doubt regarding Congress' authority to enact laws that prevent states from legislating in certain areas or in certain ways. Based on your extensive experience as a litigator and state policy advocate, please provide some examples of federal statutes that limit states' ability to legislate.*

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[9] *See* DEP'T OF ECON. AND SOC. AFFAIRS, UNITED NATIONS POPULATION DIV., ROMANIA, ABORTION POLICIES: A GLOBAL REVIEW 53-54 (2002) ("Council of State Decree No. 770 of 29 September 1966 restricted abortion to the following situations: the continuance of the pregnancy posed a serious danger to the life of the pregnant woman …; one parent suffered from a serious hereditary disease or a disease likely to cause serious congenital malformations; the pregnant woman suffered from a serious physical, mental, or sensory disorder; the pregnancy resulted from rape or incest; the pregnant woman was over age 45 …; or the pregnant woman had given birth to at least four children that were under her care.").

[10] ROMANIA: A COUNTRY STUDY, GPO FOR THE LIBRARY OF CONGRESS (Ronald D. Bachman, ed., 1989), *available at* http://countrystudies.us/romania/.

[11] *See id.*

[12] *See id.*; WHO, Unsafe Abortion: Global and Regional Estimates of Incidence of a Mortality Due to Unsafe Abortion with a Listing of Available Country Data, Introduction (3rd ed. 1997).

[13] *See* UNICEF, INTERNATIONAL CHILD DEVELOPMENT CENTRE, WOMEN IN TRANSITION: A SUMMARY 117, Table 2.8 (1999); ASTRA NETWORK, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE: REPORT TO THE EUROPEAN Union 20 (Jan. 2006).

[14] GUTTMACHER INSTITUTE, MAKING ABORTION SERVICES ACCESSIBLE IN THE WAKE OF LEGAL REFORMS: A FRAMEWORK AND SIX CASE STUDIES 27-28 (Apr. 2012), *available at* http://www.guttmacher.org/pubs/abortion-services-laws.pdf.

[15] Sedgh et al., *supra* note 3, at 631.

Response:

The Supreme Court has consistently held that Congress has the power to ensure equal access to health services in interstate commerce and to ensure equal protection of constitutional rights. The Women's Health Protection Act thus correctly cites two bases of constitutional authority: Article I, Section 8 ("Commerce Clause"), and the Fourteenth Amendment, Section 5. While Congress will sometimes use both powers, particularly when effectuating important rights, e.g., the Freedom of Access to Clinic Entrances Act of 1994 ("FACE") (18 U.S.C.A. § 248), the Civil Rights Act of 1964 (42 U.S.C.A. §§ 2000a-2000h-6), the Age Discrimination in Employment Act of 1976 ("ADEA") (29 U.S.C.A. §§ 621-634), and the Americans with Disabilities Act of 1990 ("ADA") (42 U.S.C. § 12101 *et. seq.*), either power would provide sufficient authority for this legislation.

Commerce Clause

Both health care services generally, and abortion services specifically, have been found to fall within interstate commerce. Two major federal laws addressing access to abortion services are grounded in Commerce Clause authority: FACE and the Partial Birth Abortion Ban Act of 2003 ("PBABA") (18 U.S.C.A. § 1531). In every case in which the constitutionality of FACE has been challenged, it has been upheld as a valid exercise of Congress's commerce powers. *See, e.g.*, *Norton v. Ashcroft*, 298 F.3d 547, 559 (6th Cir. 2002); *Hoffman v. Hunt*, 126 F.3d 575, 588 (4th Cir. 1997); *U.S. v. Dinwiddie*, 76 F.3d 913, 919 (8th Cir. 1996); *U.S. v. Soderna*, 82 F.3d 1370, 1373-74 (7th Cir. 1996). In *Gonzales v. Carhart*, the Supreme Court did not rule on Congress' authority to enact the PBABA, but did reference Congress's authority under the Commerce Clause "to regulate the medical profession." 550 U.S. 124, 166 (2007).

The power of Congress to regulate interstate commerce also includes the converse power to restrict states in their regulation of interstate commerce. *See Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001) (Federal Cigarette Labeling and Advertising Act precludes states from enacting more restrictive regulations regarding the location of cigarette advertising when

Congress has already addressed the content of such advertising); *Cipollone v. Liggett Grp.*, 505 U.S. 504 (1992) (Public Health Cigarette Smoking Act of 1969 preempted state requirements regarding labeling of cigarettes that were specifically addressed in the Act's language); *Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978) (federal Ports and Waterways Safety Act of 1972 foreclosed the imposition of certain more stringent requirements by the state regarding tanker construction and operation). Thus Congress has the power under the Commerce Clause to prohibit the type of burdensome and medically unjustifiable state regulations addressed in the Women's Health Protection Act that are preventing women from getting access in their communities to essential reproductive health services.

A prominent example of Congress restricting the ability of states to legislate is the Employee Retirement Income Security Act of 1974 ("ERISA") (29 U.S.C. § 1144), a federal law (based on Commerce Clause authority) that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. Section 514(a) of ERISA provides that it supersedes any and all state laws insofar as they relate to any employee benefit plan. The breadth of this provision is clear – the definition of "state laws" includes "all laws, decisions, rules, regulations, or other state actions having the effect of law, of any state." 29 U.S.C. § 1144(c)(1). The only exception to this broad preemption is a "savings clause" which provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A).

Another example of Congress abrogating state lawmaking authority is the Federal Aviation Administration Authorization Act ("FAAAA"), which blocks state regulations relating to specific motor transportation questions. Congress enacted the law to *de*regulate this area, and wanted to ensure that states would not pick up where Congress had left off and regulate what had just been deregulated. 49 USCS § 1450(a)(1). A third example is the Airline Deregulation Act of 1978. Like the FAAAA, it blocks any state regulation in an area of transportation that Congress was intentionally deregulating; the whole purpose of the law was to prohibit state laws in an area Congress was choosing *not* to regulate. That federal law provides that "a State, political subdivision of a State, or political authority of at least 2 States

may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." 49 U.S.C.A. § 41713.

Congress used its Commerce Power to enact The Civil Rights Act of 1964, which bans state and local governments, as well as private actors, from discriminating in a number of areas on the basis of "race, color, religion, sex, or national origin." For example, private actors may not discriminate in any "public accommodations engaged in interstate commerce," and state and local governments cannot deny access to public facilities. The Supreme Court has found that Congress had the authority to regulate a business with discriminatory practices that served mostly interstate travelers in *Heart of Atlanta Motel v. United States*. 379 U.S. 241 (1964). It also ruled that federal civil rights legislation could be used to regulate a restaurant because, although most of its customers were local, the restaurant served food that had previously crossed state lines. *Katzenbach v. McClung*, 379 U.S. 274 (1964); *Willis v. Pickrick*, 231 F. Supp. 396 (N.D.Ga.1964). Additionally, the Fourth Circuit has ruled that if an establishment "serves, or offers to serve" interstate travelers, it must comply with the Act pursuant to Congress' commerce powers. *Wooten v. Moore*, 400 F.2d 239 (4th Cir.), *cert. denied*, 393 U.S. 1083, 21 L. Ed. 2d. 776, 89 S. Ct. 866 (1968).

Other civil rights laws also have been grounded in Congress' power to regulate interstate commerce. Congress enacted the ADEA to prohibit age discrimination in employment, based on both the Fourteenth Amendment and the Commerce Clause. In *EEOC v. Wyoming* the Supreme Court affirmed Congress' use of its Commerce Power to extend the ADEA to cover state and local governments. 460 U.S. 226, 243 (1983). Congress again used its Commerce Power in enacting the ADA, which prohibits certain discrimination by state and local governments, as well as private actors, based on disability. While the Supreme Court has not decided the issue, the Fifth Circuit has held that Congress has the power to apply the ADA to the states.[16]

[16] *See United States v. Mississippi Dep't of Public Safety*, 321 F.3d 495 (5th Cir. 2003) (Congress rationally concluded, in light of Congressional findings, that regulation of employment discrimination was necessary to regulate national market of employment.).

Fourteenth Amendment

Congress has the affirmative power under Section 5 of the Fourteenth Amendment to enforce the provisions of the Fourteenth Amendment, including by enacting legislation to prevent states from "depriv[ing] any person of ... liberty ... without due process of law," as forbidden by Section 1 of that Amendment. In *Roe v. Wade*, 410 U.S. 113 (1973), the Court ruled that the right to privacy protected by the U.S. Constitution includes the right to terminate a pregnancy, and that the right is "founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action." 410 U.S. 113 at 153. Almost twenty years later, in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State" was reaffirmed and grounded in the Due Process Clause of the Fourteenth Amendment. *Id.* at 846 (plurality opinion). Congress therefore may use its enforcement powers under Section 5 of the Fourteenth Amendment to effectuate the right to abortion.

In enacting FACE, Congress used not only its power to regulate commerce, but also its power under Section 5 of the Fourteenth Amendment. Two federal district courts have upheld Congress' authority under Section 5.[17]

Courts have also upheld Congress' authority under Section 5 to apply the ADEA to state governments. Constitutionality was presumed in *Hodgson v. University of Texas Medical Branch at Galveston*, in which the ADEA was held to abrogate states' Eleventh Amendment sovereign immunity. 953 F. Supp. 168, 169 (S.D. Tex. 1997). Additionally, the U.S. Court of Appeals for the First Circuit held that Congress, under the Fourteenth Amendment, may provide for private suits against states or state officials. *Ramirez v. Puerto Rico Fire Service*, 715 F.2d 694, 700 (1st Cir. 1983).

[17] *United States v. McMillan*, 946 F. Supp. 1254, 1262 (S.D. Miss. 1995); *Riely v. Reno*, 860 F. Supp. 693, 708-09 (D. Ariz. 1994).

Congress also relied on the Fourteenth Amendment, along with the Commerce Clause, to enact the ADA. The U.S. Court of Appeals for the Ninth Circuit has held that in enacting Title II of the ADA, Congress validly abrogated state sovereign immunity pursuant to its Fourteenth Amendment powers. *Dare v. California*, 191 F.3d 1167, 1174 (9th Cir. 1999).

The Voting Rights Act of 1965 (42 U.S.C.A. § 1973) provides a particularly apt parallel to the Women's Health Protection Act, as Congress was responding to state efforts to curtail constitutionally protected rights by limiting states' ability to regulate their voting and election rules, an area of traditional state authority. While the right to vote is guaranteed without regard to race pursuant to the Fourteenth and Fifteenth Amendments, in the years following the Amendment's ratification many states enacted laws and voting rules designed to disenfranchise minority voters by creating an array of structural barriers, including poll taxes and literacy tests. As noted by the 1982 Senate Judiciary Committee Report, "...case-by-case litigation proved wholly inadequate. Justice Department attorneys were spread thinly among numerous lawsuits in many different jurisdictions. ... Finally, after long frustration and in the fact [sic] of tenacious resistance, Congress affirmed our fundamental principles by passing the Voting Rights Act in 1965."[18] Section 2 of the Voting Rights Act prohibits any state or local government from imposing any voting law that results in discrimination against racial or language minorities. Additionally, the Act specifically outlaws literacy tests and similar devices, even though literacy tests had been upheld by the Supreme Court in *Lassiter v. Northampton Cnty. Board of Elections*, 360 U.S. 45, 53-54 (1959), based on a legislative record that such devices were used to disfranchise racial minorities[19]

3. *If the Women's Health Protection Act had been federal law at the time that Pennsylvania authorities tried and convicted Kermit Gosnell of multiple crimes, would Gosnell still have been convicted and imprisoned? Would the Women's Health Protection Act have affected the outcome of Gosnell's case in any manner whatsoever?*

[18] S. REP. NO. 97-417, at 5 (1982), *reprinted in* 1982 U.S.C.C.A.N. 177, 182.
[19] *Id.* at 285.

Response:

Kermit Gosnell was an unscrupulous practitioner operating outside the bounds of law and morality. The Women's Health Protection Act would not have affected Pennsylvania's ability to prosecute Gosnell for his horrific crimes: first- and third-degree murder, involuntary manslaughter, conspiracy, criminal solicitation, and running a corrupt organization. The Act would affect none of those laws. Nor would it have affected his prosecution for abortion-specific crimes. He was convicted of blatantly violating Pennsylvania's ban on abortion past the state's legal limit of 24 weeks. The Women's Health Protection Act tracks what the U.S. Supreme Court has consistently said about bans on later abortion: a state may restrict abortion after viability if the law contains exceptions for pregnancies that endanger the woman's life or health. *Compare* Section 4(c)(2) of the Women's Health Protection Act (prohibiting ban on abortion "after fetal viability when, in the good-faith medical judgment of the treating physician, continuation of the pregnancy would pose a risk to the pregnant woman's life or health") *with, e.g.*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (reaffirming "the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health"). Thus the Act does not alter the existing constitutional standard under which states can, and the vast majority do, ban abortion post-viability. Nor would Pennsylvania's mandatory waiting period and mandatory counseling requirements be affected. Those provisions would not violate Sections 4(a) or 4(c) of the Act, as they do not require in-person provision of the mandated information and thus do not require a woman to make a medically unnecessary visit to a provider of abortion services, nor do they require a visit to an individual or entity that does not provide abortion services. Given the dissimilarities between those provisions of Pennsylvania's law and the measures detailed in Section 4(a) of the bill, it is questionable whether they could be established as violating the "similar measures" provision of Section 4(b). In sum, if Women's Health Protection Act had been law at the time, Kermit Gosnell would still have been convicted for his heinous criminal acts and sentenced to life in prison without the possibility of parole.

The unrelenting efforts by many politicians to reduce access to safe abortion services by interfering with health care professionals' ability to provide such services, making it more difficult and in some cases impossible for them to continue to provide those services, only create more opportunities for unethical and unscrupulous predators like Gosnell to thrive. That is another reason why the Women's Health Protection Act is critically needed, as it would ensure that only laws and regulations that truly advance and protect women's health will stand, and pretextual measures designed to block access to safe, high-quality, legal abortion care will fall.

4. *Would the Women's Health Protection Act force clinicians to provide abortion care if they do not wish to for personal or religious reasons?*

Response:

No. The Women's Health Protection Act addresses the onslaught of underhanded laws and regulations that purport to be about health and safety but in reality are designed to block providers who want to deliver care to women from being able to do so. The Act's stated purpose is "to protect women's health by ensuring that abortion services will continue to be available and that abortion providers are not singled out for medically unwarranted restrictions that harm women by preventing them from accessing safe abortion services." The Act does not compel any person to provide abortion care. Moreover, there are federal statutes that allow healthcare providers to decline to provide abortion services based on their personal religious beliefs. See "Church Amendments," 42 U.S.C.A. §300a-7 *et seq.*; Public Health Service Act, 42 U.S.C.A. § 238n; Affordable Care Act, 42 U.S.C.A. § 18023(b)(4); Weldon Amendment, Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, § 507(d), 128 Stat. 5, 409.[20] The Women's Health Protection Act ensures that those health care providers who

[20] For an overview, *see Overview of Federal Statutory Health Care Provider Conscience Protections*, U.S. Dep't of Health & Human Servs., http://www.hhs.gov/ocr/civilrights/faq/providerconsciencefaq.html (last visited Aug. 6, 2014).

have chosen to provide abortion services are subject to the same health and safety rules as other providers performing medical procedures with comparable risk.

5. *Some Members of the Senate Judiciary Committee as well as some of the witnesses who testified stated that the Women's Health Protection Act would invalidate laws requiring parental involvement in the abortion decision of a minor, laws restricting public insurance coverage of abortion, and all limitations on abortion later in pregnancy. Do you agree that such laws would run afoul of the Women's Health Protection Act?*

Response:

Section 4(d) of the Women's Health Protection Act clearly and unambiguously exempts parental involvement laws, restrictions on insurance programs, and the Partial Birth Abortion Ban Act from its scope of effect. Section 4(d) entitled "Limitation," flatly states that:

> The provisions of this Act shall not apply to laws regulating . . . requirements for parental consent or notification before a minor may obtain an abortion, insurance coverage of abortion, or the procedure described in section 1531(b)(1) of title 18, United States Code.

The Purpose section, Section 2(b), further underscores the limited scope of the law. It explains:

> It is not the purpose of this Act to address all threats to access to abortion (for example, this Act does not apply to . . . restrictions on insurance coverage of abortion, or requirements for parental consent or notification before a minor may obtain an abortion) which Congress should address through separate legislation as appropriate.

Finally, as discussed above, a state prohibition on abortion later in pregnancy after fetal viability would not run afoul of the bill, provided it included the constitutionally required

exception for situations in which continuing the pregnancy would pose a risk to the pregnant woman's life or health.[21]

[21] *See Casey*, 505 U.S. at 846; *Roe*, 410 U.S. at 163-64.

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR CHRIS COONS

QUESTIONS FOR MS. NORTHUP:

1. *Large areas of the country, such as Texas's Rio Grande Valley region have no abortion providers. In states where women have limited access to safe and legal abortions they resort to traveling to other countries like Mexico to get services or turn to unregulated providers. What do we know about the safety of these providers and the impact on women's health?*

Response:

In 2013, the Texas legislature passed House Bill 2 (HB2), a sweeping piece of anti-choice legislation which included several extreme and unnecessary new restrictions on abortion access that have already shuttered clinics across the state. If the final requirement of HB2 is allowed to go into effect, fewer than 10 clinics will remain open to serve the second largest state in the nation, with over 13 million female residents. As you note, there is currently no clinic providing abortion services remaining open in the Rio Grande Valley, which is an extremely poor region of our country with over 1.3 million residents.

Some women will not be able to travel the long distances to find care or overcome the many hurdles that have been enshrined into law in Texas and in other states around the country. Some of these women will take desperate measures to end their pregnancies, including crossing the border into Mexico or finding other ways to purchase miscarriage-inducing drugs on the black market. A 2012 study in Texas found that 7% of women reported attempts to self-abort before seeking medical care, which was **before** the recent closure of approximately one-third of Texas abortion clinics.[22] Since the clinic closures,

[22] Daniel Grossman et al., *The Public Health Threat of Anti-abortion Legislation*, 89 CONTRACEPTION, 73 (2014).

providers have noted the growth in black-market purchases of miscarriage-inducing drugs,[23] and a new report from the Texas Policy Evaluation Project shows a 13% decline in the abortion rate in Texas since the law took effect last November.[24] Although the full impact on women's health from the increase in self-induction and/or utilization of unregulated providers remains unclear, we have no doubt that restrictions that force abortion clinics to close their doors are direct threats to women's health and safety. Ensuring that safe and legal abortion services are available is the best way to prevent women from resorting to desperate measures that could threaten their health and lives.

2. *Do state laws restricting access to abortion disproportionately affect low income and minority women?*

Yes. State laws that restrict access to abortion exacerbate pre-existing health disparities caused by poverty and racial inequality. Restrictions that increase the cost of abortion disproportionately harm lower income women and women of color, who are more likely to experience unintended pregnancy and to seek abortion services.[25] Women of color are significantly overrepresented among women seeking abortion: while 31 percent of all women in the U.S. are Black and Hispanic, they comprise 55 percent of abortion patients.[26] In 2008, almost 16 percent of all women of reproductive age lived below the federal poverty level, and 42 percent of women who obtained abortions had incomes that fell below that line. .[27] Low- and lower-income women who decide to have an abortion must often delay the

[23] *See, e.g.*, Erica Hellerstein, *The Rise of the DIY Abortion in Texas,* ATLANTIC (June 27, 2014, 9:00 AM) http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/; Lindsey Beyerstein, *"Miscarriage Management": The Next Front in the Abortion Wars*, NEW REPUBLIC (Jan. 29, 2014), http://www.newrepublic.com/article/116399/abortion-texas-survives-miscarriage-management; Mary Tuma, *All but Illegal*, THE AUSTIN CHRONICLE (July 25, 2014) http://www.austinchronicle.com/news/2014-07-25/all-but-illegal/.
[24] THE TEXAS POLICY EVALUATION PROJECT, UNIV. OF TEXAS AT AUSTIN, TEXAS STATE ABORTION RATE DECREASES 13 PERCENT SINCE IMPLEMENTATION OF RESTRICTIVE LAW (July 23, 2014), *available at* http://www.utexas.edu/cola/orgs/txpep/releases/hb2-release.php#HB2.
[25] Rachel K. Jones, et al., GUTTMACHER INSTITUTE, CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008 (2010); Christine Dehlendorf, et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1172 (2013); Mia Zolna & Laura Lindberg, GUTTMACHER INSTITUTE, UNINTENDED PREGNANCY: INCIDENCE AND OUTCOMES AMONG YOUNG ADULT UNMARRIED WOMEN IN THE UNITED STATES, 2001 AND 2008 (2012); Katherine Gallagher Robbins & Lauren Frohlich, NATIONAL WOMEN'S LAW CENTER, NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES, 2012 (2013).
[26] Black and Hispanic women comprise 26.5% of U.S. women. Jones et al., *supra* note 27 at 8.
[27] Jones, et al., *supra* note 27 at 8.

procedure in order to raise the necessary funds, which drives up the cost and increases the risk of the procedure.[28] When unnecessary state restrictions force women to make multiple trips to the clinic and/or travel long distances, the cost of the procedure is compounded through lost wages and additional transportation and child care costs.[29] Furthermore, state restrictions that increase cost magnify the effects of racial disparities in access to care: women of color are at a higher risk than white women of living in poverty and have consistently poorer access to regular, high-quality health care services and family planning.[30]

The health and human rights of low-income women and women of color are significantly undermined by state laws that impose medically unnecessary barriers to abortion access. The Women's Health Protection Act would begin to address some of these barriers by dismantling restrictions that target abortion providers, do not promote women's health, and ultimately threaten the well-being of many women, especially those who the most underserved and marginalized.

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[28] Heather D. Boonstra, GUTTMACHER INSTITUTE, THE HEART OF THE MATTER: PUBLIC FUNDING OF ABORTION FOR POOR WOMEN IN THE UNITED STATES (2007); Theodore J. Joyce et al., GUTTMACHER INSTITUTE. THE IMPACT OF STATE MANDATORY COUNSELING AND WAITING PERIOD LAWS ON ABORTION: A LITERATURE REVIEW (2009).
[29] Boonstra, *supra* note 30; Sarah Jane Glynn & Jane Farrell, CENTER FOR AMERICAN PROGRESS, LATINOS LEAST LIKELY TO HAVE PAID LEAVE OR WORKPLACE FLEXIBILITY (2012); Tara Culp-Ressler, *By the Numbers: Why Most U.S. Women Struggle to Afford Abortion*, THINK PROGRESS (May 8, 2013), http://thinkprogress.org/health/2013/05/08/1979831/women-struggle-afford-abortion.
[30] Alexandra Cawthorne, *The Straight Facts on Women in Poverty*, CENTER FOR AM. PROGRESS (Oct. 8, 2008), http://www.americanprogress.org/issues/women/report/2008/10/08/5103/the-straight-facts-on-women-in-poverty; Robbins & Frohlich, *supra* note 27; GUTTMACHER INSTITUTE, FACT SHEET: INDUCED ABORTION IN THE UNITED STATES (July 14, 2014, 10:57 AM), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

RESPONSES OF DR. WILLIE PARKER TO QUESTIONS SUBMITTED BY SENATORS COONS AND BLUMENTHAL

Coons QFRs for Parker_final

1. **Physicians in other parts of the country have reported an increase in the number of women who arrive at doctors' offices having previously tried to self-abort—which we know can lead to death—have you seen a similar increase in your practice?**

Thankfully I have not seen many women who have attempted to self-abort as I primarily see women who make it to the clinic where I practice. I did have one patient, a 34 year old pediatric nurse from the local academic hospital who presented after obtaining what she thought was the abortion pill online and self administering it. She had already determined that the purported medication did not work and was 8 weeks when she presented for care. We determined that she had no deleterious effects from the self-medication, but she was totally intimidated at having to present to the clinic through a throng of protesters, fearful of being recognized as well as having to wait for the mandated delay to elapse. I have seen do –it-yourself instructions on the internet, and while this patient was not harmed, I worry about women trying to accomplish this goal in a safe manner outside of healthcare supervision. This highly educated Mississippi woman demonstrates that women here are no less desperate for abortion access and will take the extreme measures that they deem necessary when they need abortion and it is not available.

2. **You are the sole abortion provider for Mississippi but live in Alabama, two states with some of the highest poverty rates in the country. None of the doctors who live in Mississippi are willing to provide abortion services and 94% of Alabama's counties do not have abortion providers. Looking around the country, I am struck that the most restrictive statutory regimes exist in those states with the highest rates of poverty. How have these abortion restriction impacted the level of access women have to reproductive care and family planning service, and in particular poor and minority women?**

As noted by the demographic characteristics for both of these states, these burdensome laws encumber women with the greatest need for safe, compassionate abortion services. The things you cite correlate tightly with limited access to contraception, medically accurate sex education, and comprehensive primary care, the lacks of which lead to unplanned, unwanted pregnancies or wanted but lethally flawed ones, which is where abortions come from. Abortions do not come from locations of clinics near impoverished communities of color, a preposterous notion. Nor do they occur due to selfish women being indifferent to motherhood, as is sometimes alleged by abortion opponents. Many women who have abortions are already mothers. The lack of the reproductive health determinants that I mentioned create the lived reality of the women I see, women of color and/or poor, despite women of all backgrounds being at risk for needing abortion services. Ironically, my home regional states have not resolved the disparities that are driving the need for the care that I provide, but opponents against abortion have been very effective at putting barriers in the way of women that need the services the most.

3. Both Alabama and Mississippi, like many other states, have enacted laws that require doctors to force women to have ultrasounds. Some laws prevent doctors from using telemedicine to provide care to women. Others have required doctors to use outdated and medically unsafe medical protocols which are all designed to target abortion. How have these restrictions interfered in the doctor-patient relationship?

All of these things interfere greatly with the therapeutic relationship that I have with my patients by forcing both them and me to interact with considerations that have nothing to do with the patient's care. As her physician, my primary responsibility to my patient is to make recommendations and provide services that focus solely on her need and wellbeing. Being prohibited from using technology to facilitate her care in a largely rural state like MS or AL places abortion beyond the reach of women who live in a county without a provider. Forced use of diagnostic modalities that do not add anything to medical decision-making serves the purpose of coercion, and being restricted from prescribing medications in a way that reflect my best medical judgment, interfere with my ability to provide the care that women deserve. None of these laws are evidence based and all serve as means for abortion opponents to abuse regulatory authority.

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR DR. WILLIE PARKER:

Dr. Parker, your perspective as a practicing physician, as a doctor who provides reproductive health care for underserved populations, and as an abortion provider in particular, is very valuable to the ongoing debate about abortion rights in this country. Many legislators who enact abortion laws, and sometimes very harmful laws, have never seen the inside of a clinic. Indeed, many of them will never personally face the question of whether or not to have an abortion, since most are men. Real world experiences like your work providing care to thousands of individual women should carry great weight in today's abortion debates.

1. **In your experience as a medical provider, are there cases that demonstrate the problems with the pretextual restrictions the Women's Health Protection Act guards against? If so, can you please describe a few of them?**

   The types of laws that the WHPA seeks to prevent often work synergistically to greatly encumber women accessing abortion services, assuming that they don't put them beyond their reach altogether. I have seen women miss their opportunity to have an abortion in Mississippi simply because of these laws. I recently had a 23 year old woman with 2 children from the Delta region, a couple of hours away and abjectly poor, who found herself pregnant with the third. She had been forced to delay her appointment to the clinic due to financial challenges, child care, and as a non-driver, her inability to get a ride down to Jackson where we are located. When she finally made it to the mandated counseling visit, her ultrasound showed her to be 16 weeks 0 days, the absolute cutoff for legal abortion at our facility. We apprised her of the gestational age and offered referral to the closest clinic, in Tuscaloosa, AL, 230 miles away. She indicated that she would not be able to travel to the next state, and very sullenly returned to the Delta to continue the pregnancy. If there were no waiting period, I could have done her procedure the day that

she presented. In addition, without the mandatory face to face counseling, the patient could have possibly gotten in earlier for a counseling visit prior to the next session where a doctor would be present. If she had seen me in Washington DC, these would not have been issues.

Another patient experienced unnecessary anguish due to mandated counseling requirements that I provide all patients in Mississippi seeking abortion with the medically false information that they are at increased risk for breast cancer if they have an abortion. The patient was a 35year old woman with a first pregnancy whose mother had a history of breast cancer. Although she had demographic characteristics that increase breast cancer risk, I had to reassure the patient that despite my being required to cover this information, her decision to end her pregnancy would not adversely affect her cancer risk in any way. Having to provide medically inaccurate information to my patients creates the ethical conflict of potentially causing psychological harm to my patients in order to meet the requirements of such laws.

2. **How would the Women's Health Protection Act affect your patients?**

The WHPA would prevent the regulatory abuse that is making it increasingly difficult for my patients to access abortion care. By challenging regulations that parade as safety and preventing the rules that function as barriers to my patients, such as long waiting times, burdensome consent processes, and exposure to medically inaccurate information, my patient when freed from such concerns can focus on getting into care in a timely manner, make sound medical decisions in privacy and consultation with me as their provider, and remain healthy for the benefit of herself and her family.

The recent hearing on the Women's Health Protection Act devoted significant attention to state requirements that abortion providers have hospital admitting privileges. As mentioned in some testimony provided during the hearing, admitting privileges can serve important purposes. Hospitals often review a doctor's educational background, licenses, and experience before granting membership. Such review processes can help ensure that only appropriately qualified doctors provide care. Yet even physicians without admitting privileges, including some abortion providers, must adhere to regulations regarding medical licensing and ensuring patient health and safety. In addition, federal law requires hospital emergency rooms to treat any patient with an emergency condition until the

condition is stabilized. In other words, all patients are entitled to equal access to emergency hospital care, irrespective of whether their treating clinician has admitting privileges. Dr. Parker, can you share your perspective as a reproductive health care physician and explain the challenges you have faced with obtaining admitting privileges in Mississippi?

There is no doubt that regulation of medical practice can play a significant role in assuring the quality of care that a patient receives by making sure that physicians are licensed to provide medical care, and this is usually done by all state medical boards without regard to specialty. Board certification as a secondary criterion for quality assurance also can play a role, but targeted regulations of abortion providers does nothing to enhance the safety of an already extremely safe procedure. Safety standards in outpatient settings should not be higher for abortion clinics than any other clinical setting. Medical boards are best positioned to determined licensing criteria, not hospitals. Hospitals determine staff eligibility based on whether or not a physician's presence on staff will result in admissions to the facility, a fiscal consideration, not a medical one. Admitting privileges, when they are difficult to obtain largely on the basis of politicized perception of abortion care, become an insurmountable barrier to women because doctors are prevented from providing that much needed care. Licensed in the state of Mississippi as well as several other states, to date, I have been unable to secure admitting privileges at hospitals in the vicinity of the clinic where I practice, my effort to comply with recent regulations covering abortion facilities there. Of the hospitals we applied to, several did not respond to our request for application and the ones that did indicated that their decision to not proceed with the application was based on their conclusion that my presence on the staff would be a disruption to the internal and external politics of the institution. I have never had difficulty securing privileges at previous facilities in other states where I have practiced.

While I applied for privileges to be in compliance with the recent regulatory changes, I know both admitting privileges and board specialty requirements to be medically unnecessary and irrelevant to the safety of abortion services. Licensed health care professionals of all specialties can be and are trained to competency in abortion care to meet that need for their patients, and abortion providers and facilities already maintain extremely high standards to insure quality services for the women who need them.

The irrelevance of admitting privileges is based on the fact that in the rare event that an emergent situation arises in a clinic or ambulatory care setting, standard of care irrespective of specialty or type of problem would dictate transferring that patient to the nearest facility that can address that patient's need. As you rightly implied, the Emergency Medical Treatment and Labor Act (EMTALA) creates this expectation, thus patient transfer would happen regardless of whether or not the transferring physician held admitting privileges at the nearest facility and care has to be provided to that patient. Transfer agreements, which most clinics have in place, already facilitate such a situation. Abortion, whether medical or surgical, requires hospitalization 0.3% of the cases, all gestational ages combined, making clear that a hospital admitting privileges requirement proves only to be excessive and burdensome. Transfer agreements with hospitals or physicians have proven more than adequate to get patients to the next level of care when the need arises. Abortion care itself is the safety measure for pregnant women in this country, not the problem.

RESPONSES OF HON. CHRIS TAYLOR TO QUESTIONS SUBMITTED BY SENATORS COONS AND BLUMENTHAL

CHRIS TAYLOR
STATE REPRESENTATIVE ◆ 76th ASSEMBLY DISTRICT

August 6, 2014

Via Electronic & Regular Mail

The Honorable Patrick Leahy,
United States Senator
Attn: Rebecca Cooper, Hearing Clerk
Senate Judiciary Committee
224 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Response to questions for the record concerning the Women's Health Protection Act

Dear Senator Leahy,

Thank you for the opportunity to testify before the Senate Committee on the Judiciary in favor of "S.1696, the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights" on July 15, 2014. It was a true honor.

Enclosed are my responses to the follow up questions from Senator Richard Blumenthal and Senator Chris Coons.

Again, thank you for the opportunity to testify in support of the S. 1696. Please let me know if you have questions or need additional information.

Sincerely,

Representative Chris Taylor
Wisconsin's 76th Assembly District

State Capitol: P.O. Box 8953, Madison, WI 53708
(608) 266-5342 ◆ E-mail: rep.taylor@legis.wi.gov ◆ Web: http://taylor.assembly.wi.gov
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Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR COONS

Question for Ms. Taylor

1. We currently have a situation in this country where a woman's constitutionally protected right to access abortion services depends on the state she lives in, the politics of the legislators in her state, and the amount of money she has. Is this fair, and what impact would passage of the Women's Health Protection Act have on ensuring that a woman's right to choose is respected equally, wherever she may happen to live?

Response:

People's ability to exercise constitutional rights should not be dependent on their zip code. It is extremely unfair that women in my state and in states throughout the country are being denied the ability to exercise their constitutionally-protected rights concerning their personal, private decisions about pregnancy. While states face a myriad of issues warranting diverse responses, the U.S. Constitution guarantees all Americans the most basic and fundamental rights, no matter which state they call home. As a country, we recognize that some rights are too precious to risk losing at the whim of a majority in a state legislature. That is why we have state and federal constitutions.

In Wisconsin, the state legislature has enacted many extreme laws in the last three years that do nothing to protect women's health or advance women's safety, and everything to do with impeding women's access to abortion, including telemedicine bans, medication abortion restrictions requiring unnecessary multiple trips to an abortion provider, increased criminal and civil liability for abortion providers, forced ultrasounds, and hospital admitting privileges which are wholly unrelated to the abortion care women receive. That is why the Wisconsin medical community unambiguously opposed these restrictions, with not one health care provider or entity testifying in support of these restrictions.

In fact, the primary purpose and effect of these restrictions is to shut abortion access down in the state of Wisconsin. For example, when I questioned the two sponsors of the hospital admitting privileges bill in the Assembly Health committee, on which I serve, about whether they would be willing to reconsider this bill if it resulted in shutting health centers down that provide abortions, they stated they would not.

If Wisconsin's admitting privileges requirement is ultimately enforced (it is temporarily enjoined by a federal court), at least one health center that performs one-third of the abortions in Wisconsin will shut down. This is also the only health center that provides abortions post 18 weeks of pregnancy. The remaining three health centers providing abortions estimate that the average three to four week wait for an abortion will be increased to between eight to ten weeks. Women who experience health or other pregnancy complications and need an abortion to preserve their health or lives post 18 weeks will also be required to travel out of state.

A delay of this magnitude clearly impacts all Wisconsin women seeking abortions. But the closing of a health center providing one-third of the abortions in the state will have particularly devastating effects on low-income women. At the trial on the hospital admitting privileges law, an expert on women and poverty in Wisconsin testified about the particularly devastating effects this health care closure and the resulting long wait would have on low-income women, who would be forced to travel to access abortion. These are women who typically rely on public transportation and cannot afford uncompensated work absences or additional child care costs.[1] For poor women, these additional barriers may be insurmountable, and a significant number will not be able to legally obtain the abortion they seek.

Many of these unconstitutional abortion restrictions have been struck down by courts throughout the country. In the meantime, however, legal, medical, and advocacy organizations are forced to spend their time and money fighting these restrictions, not to mention the thousands of tax-payer dollars the state is spending to defend these unconstitutional laws.

While many lawsuits wind their way through our courts, there is no guarantee that the lawsuits will ultimately prevail in protecting women's rights and women's health.

Patients are placed in legal limbo, and their health and lives may be compromised. When restrictions on medication abortion were passed in Wisconsin, which constitutes 25% of all abortions, most health centers stopped offering medical abortion for one year until legal relief was obtained. Women with scheduled appointments were denied access. Women had to reschedule appointments and opt for a different procedure than the one they had determined was their best medical option purely because of politics.

Some of these policies, like the forced ultrasound law, place real barriers between patients and health care providers. In most cases, women will be subjected to an invasive vaginal ultrasound. Women are unable to refuse, including women whose wanted pregnancies go wrong and the majority of sexual assault and incest victims who do not file police reports. Providers have reported that a patient's inability to refuse is creating divisions between the health care provider and patient, creating more tension and stress for the patient. Patients are frustrated that their health care is being dictated not by their best interests as determined by their physician but by politicians. At a minimum, it humiliates and degrades women, treating them like second class citizens who are denied the patient autonomy and personal decision making afforded most other patients.

These are some of the reasons why we need the Women's Health Protection Act. This Act prevents states from taking specific actions that impede women's access to abortion care that are unrelated to women's health and safety. Women in my state and other states that are controlled by politicians who ignore their constitutional rights need the federal government to pass the Women's Health Protection Act to ensure that these rights are a reality for everyone, regardless of where they live.

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[1] Testimony of Jane Collins, a Professor at the University of Wisconsin and an expert on issues faced by women in poverty in Wisconsin, in the federal trial on the Wisconsin admitting privileges requirement, *Planned Parenthood of Wisconsin v. JB Van Hollen*, 13-cv-465-wmc.

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR CHRIS TAYLOR:

1) During the Senate Judiciary Committee hearing on the Women's Health Protection Act, Senator Hatch said "I can't imagine why any state legislature would support this no matter their position on abortion." Representative Taylor, as a duly elected representative of the 76th Assembly District of the State of Wisconsin, how do you respond to that statement?

Response:

State legislators do not have the legal authority to pass bills that violate the constitutional rights of the people they represent. As a member of the Wisconsin state legislature, I take an oath to uphold the state and federal constitutions. This obligation does not cease when considering state laws. My primary obligation is to protect the rights and well-being of my constituents, not to fortify the powers of the state legislature in passing laws that discriminate and violate people's rights. That is why I am a strong supporter of the Women's Health Protection Act.

When one in three women will have an abortion in her lifetime, it is clear that access to safe and legal abortion care is essential to the health and safety of my constituents. As global research clearly indicates, as well as our own prior history, when abortion is inaccessible or illegal it does not end. It just becomes dangerous. Illegal, unsafe abortion is one of the greatest causes of maternal death throughout the world.

The women in my state deserve to exercise the same constitutional rights as women in Illinois, Minnesota, or anywhere else in the United States. Yet some politicians in my state who support medically unnecessary restrictions like forced ultrasounds and hospital admitting privileges for abortion providers, are working overtime to deny women their constitutional right to make their own personal, private health care decisions. This is unacceptable, and it is my obligation to vocally oppose these efforts. That is why women in Wisconsin and throughout our country need the Women's Health Protection Act.

2) As a state legislator, what is your view on the appropriateness of a federal law that would prevent states from enacting laws that undermine access to abortion services?

Response:

It is not only appropriate, but desperately needed as abortion access is restricted to the point of not being accessible in communities and states throughout our country.

It is disheartening that in 2014, women are still struggling to have comprehensive access to reproductive health care. We seem to be having the same battles that our mothers and grandmothers spent generations fighting. It is indeed unfortunate that federal action is necessary

to protect the health and constitutional rights of women in so many states across the country. Not only does a woman's right to make pregnancy decisions currently depend on her zip code, but too often it depends on the day. With new restrictions continually being passed in state legislatures throughout the country, and a plethora of pending lawsuits as a result, it is becoming difficult for women to know what hoops they must jump through, and where they must travel, to access abortion care in their communities and state.

3) Oklahoma State Representative Doug Cox, a former Emergency Room physician, recently wrote an op-ed on the Republican Party's current view of women's health care. Representative Cox lamented his party's view of abortion, stating "What happened to the Republican Party that I joined? The party where conservative presidential candidate Barry Goldwater felt women should have the right to control their own destiny?...What happened to the Republican Party that felt government should not overregulate people until (as we say in Oklahoma) 'you have walked a mile in their moccasins?" Today, State Representative Cox is an anomaly in his party. Representative Taylor, in your opinion, why should a woman's right to make her own health care decisions not be a partisan issue?

Response:

Decisions concerning child bearing are the most personal, private decisions a woman makes in her life. It should not be the business of politicians. In many countries, abortion is appropriately not treated as a political issue, but rather, as a health care issue.

As a woman who has experienced multiple miscarriages and a high-risk pregnancy, my family and I had to make many personal decisions about child bearing. We were in the position to have the best understanding about our personal circumstances. My state representative and state senator were not.

Women choose abortion because of a variety of circumstances. For some women, they are not ready for parenthood. The decision may be influenced by a woman's financial situation, her relationships, or her educational and/or career situation, in addition to many other factors. Not all pregnancies are the same, and there is a story behind every one of these personal, private decisions. Women of all backgrounds, religious affiliations, and political philosophies choose abortion.[i] A woman's pregnancy decision isn't determined by her political party, and her ability to make these decisions should not be determined by ours.

As state legislators, our job is to uphold every person's constitutional rights. Supporting access to legal abortion means that we recognize that a woman who chooses to end a pregnancy—for whatever reasons—deserves safe, professional, accessible medical care. That should be something on which we can all agree. State Representative Cox is right: as elected officials, we should never try to make the most personal, private decisions for anyone else—we haven't walked in their shoes. Interfering in these decisions is government at its biggest and most intrusive.

[i] http://www.guttmacher.org/pubs/fb_induced_abortion.html

RESPONSES OF CAROL TOBIAS TO QUESTIONS SUBMITTED
BY SENATORS GRAHAM AND GRASSLEY

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Relating also to the conscience issue, some groups that advocate for abortion have asserted that federal law already requires that hospitals, including private religious hospitals, must perform abortions in circumstances that someone considers to be "emergencies," however that term might be defined under the laws of a given state or under federal regulatory guidance, now or in the future. The federal law that they cite as support for this assertion is the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act. Do you agree with this characterization of current federal law?*

We are aware that some pro-abortion groups have adopted this tortured misconstruction of federal law. The law in question, EMTALA [42 U.S.C. 1395dd] requires a hospital to treat a patient, regardless of ability to pay, if she shows up at an emergency room with an "emergency medical condition." This law explicitly defines "emergency medical condition" to include a condition "placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy," and it requires the hospital to stabilize the condition before transferring any such patient. The notion that a law that explicitly seeks to protect the "unborn child" from medical jeopardy and that requires hospital personnel to stabilize the conditions of both patients (mother and child), actually requires medical personnel to *kill* that unborn child, is absurd on its face.

Certainly, EMTALA does obligate hospitals to provide emergency treatment for women who are injured while undergoing abortions or attempted abortions, but it does not require health-care providers to violate their consciences by killing one of their patients. The adoption of this interpretation of EMTALA by groups such as the ACLU merely provides another illustration of how far these groups are prepared to go in their attempts to coerce medical personnel into collaborating in the killing of unborn children. S. 1696 would provide these pro-abortion ideologues a much more powerful legal weapon to use for their coercive purposes.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *During the hearing, Senator Blumenthal suggested that S. 1696 contains an exception to protect current laws against government funding of abortion. Do you agree with Senator Blumenthal on this point? If not, please explain why.*

There is no such exception in S. 1696. There are a number of federal laws that limit funding of abortion under various federal programs. The majority of states also have in place laws that exclude elective abortion from various government entitlement programs that provide coverage of medical services in general, or of "family planning" services in particular. Most of these laws would be subject to legal attacks based on the provisions of S. 1696.

Section 4(d) of S. 1696 is a "Limitation" that incorporates four exceptions to the prohibitions contained elsewhere in the bill; these are summarized in endnote no. 6 of my written testimony. One of these exceptions is for "insurance coverage of abortion." This language would apparently shield from S. 1696-based legal attacks those state laws, now enacted by half of the states, that limit coverage of abortion under health insurance plans sold on the Obamacare exchanges. ((Most of these laws were enacted in response to a provision of Obamacare, 42 U.S.C. §18023(a), although some states had enacted such laws even before enactment of Obamacare.)) However, there is no reason to suppose that laws such as the Hyde Amendment would be protected by this reference to "insurance coverage of abortion." The Hyde Amendment is a limitation attached to the annual Department of Health and Human Services appropriations bill, which prohibits funds that flow through that bill from paying for abortions or for health plans that cover abortions, except in cases of rape, incest, or to save the life of the mother. The most important single effect of the Hyde Amendment is to prevent federal reimbursement for elective abortions, or for health plans that cover elective abortion, under Medicaid. But Medicaid is not an "insurance" program as the term is usually used in federal or state law – it is a government health-care entitlement program. It is not at all clear that courts would find that entitlement programs such as Medicaid fall within the scope of what is covered by the phrase "insurance coverage of abortion," especially in view of other language in S. 1696 that instructs the courts that "in interpreting the provisions of this Act, a court shall liberally construe such provisions to effectuate the purposes of the Act." The purposes of the act are clearly to remove impediments to access to abortion, explicitly defined by S. 1696 to include any government policy that increases the costs of abortion to an individual, even indirectly. Thus, any ambiguity will be resolved by nullifying the laws

that impede access to abortion, such as the Hyde Amendment and its state-level counterparts.

The ambiguity is, of course, by design. It is clear that the drafters of S. 1696 wish to keep the door open to attack the Hyde Amendment and the similar laws, in effect in most states, that prohibit government funding of elective abortions under entitlement programs such as Medicaid. If they had really wished to shield such laws from the prohibitions in S. 1696, they could easily have included unambiguous language to do so. Indeed, the antecedent to the "Women's Health Protection Act," which was the "Freedom of Choice Act" (FOCA), when it was approved by the Senate Committee on Labor and Human Resources on April 29, 1993, contained an unambiguous exception for state laws limiting government funding of abortion, which read: "Nothing in this Act shall be construed to . . . prevent a State from declining to pay for the performance of abortions."

Even if, for the sake of argument, one were to accept the notion that the laws that limit Medicaid coverage of abortion would be considered laws dealing with "insurance coverage of abortion," there are other existing prohibitions on government funding of abortion that nobody could argue have anything to do with "insurance coverage," and that clearly would be subject to legal attack and invalidation under S. 1696. To cite just two examples at the federal level: (1) The Helms Amendment of 1973, a provision of the Foreign Assistance Act of 1973 [22 U.S. Code §2151b(f)(1)] prohibits U.S. foreign aid funds for development from being expended for abortion. (2) A major federal "family planning" program, Title X of the Public Health Service Act, contains a provision enacted in 1970 that states, "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." [42 U.S.C. § 300a–6.]

Thus, it is quite clear that S. 1696 would result, at a minimum, in federal taxpayer funding of abortion through both the major domestic family planning program and through U.S. foreign aid programs.

Response from NRLC President Carol Tobias to question from Senator Charles Grassley regarding the relative "safety" of abortion August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Nancy Northup, president and CEO of the Center for Reproductive Rights, in her written testimony to the Committee, on pages 5-6, stated that Mary Spaulding Balch, state legislative director for National Right to Life, recently "openly criticized the [pro-life] movement's cynical focus on women's health because it is so clearly unconnected to the reality of how safe abortion is." Ms. Northup asserted that Ms. Balch "conceded that data show that abortion, even after the first trimester, carries a lower risk of serious complications than vaginal births, cesarean sections, and even plastic surgery procedures such as facelifts and liposuction. And she recognized the absurdity of asserting women's health as a rationale for some of the stringent laws legislators have been leveling at abortion care . . ." These statements by Ms. Northup were all based, according to a footnote, on a single article by Sofia Resnick that appeared on the "pro-choice" advocacy website RH Reality Check on July 2, 2014. Did Ms. Northup's testimony accurately reflect the position of your organization? Please offer any additional observations that would clarify, give context to, or otherwise illuminate the statements made by Ms. Northup or the thrust of the underlying article by Ms. Resnick.*

Response of Carol Tobias, President, National Right to Life Committee:

Is abortion safer than childbirth? Looking at the medical evidence, National Right to Life doesn't think so. Obviously, abortion is not safer for the unborn child, reason enough to oppose the practice. Moreover, claims that the abortion procedure is seven,[1] eleven,[2] fourteen,[3] twenty-three,[4] or "hundreds of"[5] times safer for the mother than childbirth, don't hold up to scrutiny.

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[1] S.A. LeBolt, David A. Grimes, Willard Cates, Jr., "Mortality from abortion and childbirth. Are the populations comparable?" *Journal of the American Medical Association*, Vol. 248, No. 2 (July 1982), pp. 1880191.

[2] Susanne Pichler, "Medical and Social Health Benefits Since Abortion Was Made Legal in the U.S." Planned Parenthood Federation of America, Fact Sheet (December 2004), available at http://mcadams.posc.mu.edu/blog/fact-abortion-medical-social-benefits.pdf, accessed 7/24/14.

[3] E.G. Raymond, David A. Grimes, "The comparative safety of legal induced abortion and childbirth in the United States," *Obstetrics & Gyncecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

[4] Original cite of ACOG Amicus Brief for *Doe v. Bolton*, cited by Willard Cates, Jr. David A. Grimes, L. Lynn Hogue, "Topics for Our Times: Justice Blackmun and Legal Abortion – A Besieged Legacy to Women's Reproductive Health," *American Journal of Public Health*, Vol. 85, No. 9 (September 1995), pp. 1204-6.

[5] Leroy Carhart, speaking on "A Woman's Choice, a Nation Divided," Anderson Cooper 360 Degrees, CNN, June 5, 2009.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 2

Even ignoring the bias of the researchers responsible for publishing these estimates, many of them longtime pro-abortion activists, there are a number of problems with statistics making this claim.

Most of these claims, if they involve data of any kind, rest at some point on maternal mortality rates and abortion mortality figures from the U.S. Centers for Disease Control (CDC). Though the data represent real lost lives, use of these figures is problematic. As CDC Director Dr. Julie Gerberding acknowledged in a July 20, 2004 letter (attached): "These measures are conceptually different and used by the CDC for different public health purposes."[6]

As the CDC letter states, "maternal mortality is computed as all maternal deaths per 100,000 live births," while "the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions." The Pregnancy Mortality Surveillance System used by the CDC to track maternal mortality says that "a pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[7]

Under such circumstances, efforts to contrast maternal and abortion mortality are akin to comparing apples to oranges. Why?

> 1) Most dramatically, if pregnancy-related maternal deaths *include maternal deaths from abortions*, this makes pregnancy in general appear more dangerous by including those maternal abortion deaths along with those that occur during childbirth.
>
> 2) While abortion maternal mortality is compared to the total number of abortions, the pregnancy-related maternal death statistic is *not* compared to the total number of pregnancies – it is based on the number of live births, omitting miscarriages and induced abortions. The inaccurately smaller denominator inflates the value of the numerator, making the fraction -- in this case, maternal mortality -- seem higher than it actually is, e.g., ½ is greater than 1/3.

Moreover, to accurately compare mortality rates from abortion and childbirth requires that we have complete and accurate data on deaths related to each outcome. While an attempt has been made to identify and collect data on pregnancy-related deaths,[8] efforts to get a full count of abortion-related deaths are hampered by a number of problems.

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[6] Letter of July 20, 2004 from Julie L. Gerberding, M.D., M.P.H., Director of U.S. Centers for Disease Control, to Walter M. Weber, American Center for Law & Justice.

[7] CDC webpage for Pregnancy Mortality Surveillance System at http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html, accessed 7/29/14.

[8] The Centers for Disease Control and Prevention began its Pregnancy Mortality Surveillance System in 1986. See information of the government program at http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html, accessed 7/24/14.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 3

While women giving birth are followed for a year after, women who have abortions and die may never be counted in U.S. abortion mortality statistics.[9] If they contract a fatal bacteria or bleed to death as a result of their abortion procedure, the death will be attributed to the infection or the hemorrhage, but there may not even be any notation of the abortion, or perhaps even the pregnancy on the death certificate.[10]

On occasion, it may be that the omission is deliberate, in order to spare families embarrassment or the reputation of abortionist involved,[11] but with the advent of chemical abortions, it is entirely possible that the physician handling the fatal complication may have no knowledge of the abortion.[12]

Given the problems and limitations of U.S. maternal mortality data, any claim of abortion's relative safety against childbirth is suspect with many abortion related deaths unreported and uncounted.[13]

A much better gauge comes from countries which track each patient encounter across the entire health system, so that individual outcomes can be reported over time even where there are multiple providers.

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[9]Many government and medical sources are cited in examples by David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy,* Vol. 20, No. 2 (2002), pp. 279-327.

[10] *Ibid*, and A.P. Mackay, R. Rochat, J.C. Smith, C.J. Berg, "The check box: determining pregnancy status to improve maternal mortality surveillance." *American Journal of Preventive Medicine*. Vol. 19, Supplement 1 (July 2000), pp. 35-9.

[11] David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy,* Vol. 20, No. 2 (2002), pp. 279-327.

[12] One group, Women on Waves, specifically tells women that if they need to go to the hospital they do not need to say that they took misoprostol pills to induce an abortion.

> Misoprostol causes a miscarriage. The symptoms of a miscarriage and an abortion with pills are EXACTLY the same and the treatment is EXACTLY the same. **You do not need to say that you took the medicines**. If you took the medicines as instructed at www.womenonwaves.org, they dissolve and there is no test that can tell a doctor or nurse that you took medicines.

http://www.womenonwaves.org/en/page/711/in-collection/702/using-medications-pills-to-end-an-unwanted-pregnancy-in-the-usa, accessed 7/24/14.

[13] In *Victims of Choice* (1996), private investigator Kevin Sherlock examined death certificates and other public information and matched these against state statistics and found that there were many abortion related deaths that were not reported.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 4

Studies from Finland, where there has been a nationwide and modern healthcare system and reporting in place for a number of years, provide more reliable data.

Linking data from national birth, death, abortion, and hospital discharge records in Finland from 1987 to 2000 for all deaths for females of reproductive age (15-44), Mika Gissler and colleagues from the National Research and Development Centre for Welfare and Health found data showing mortality rates at one year out for aborting women more than three times what it was for women giving birth.[14]

One thing the Finnish data makes plain is that pregnancy-related mortality is more than just a matter of the relative safety of a given medical procedure. And in this regard, the heavy psychological and social costs of abortion over childbirth become readily apparent.

In a second study using the same data set, Gissler and colleagues found that mortality rates for abortion were 11 times higher for homicide, more than six times higher for suicide, and even more than five times higher for unintentional injuries than they were for pregnancy or birth one year after the event. For each cause, the mortality rate was also higher for abortion than it was for non-pregnant women or those dealing with miscarriage or even ectopic pregnancy.[15]

State data from California are consistent with this result. A study looking at maternal deaths associated with Medicaid-eligible women having abortions or delivering babies in 1989 one year out found the aborting women nearly three times (2.88) as likely to die a violent death than those giving birth. Researchers found a good portion of this higher rate associated with suicide.[16]

Activist researchers defending the abortion industry may have reason to be selective in their data sets, but when outcomes are more consistently and completely tracked, it is clear that abortion is *not* safer than childbirth.[17]

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[14] Mika Gissler, Cynthia Berg, Marie Hélène Bouvier-Colle, Pierre Buekens, "Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000," *American Journal of Obstetrics and Gynecology*, Vol. 190, No. 2 (Feburary 2004), pp. 422-7.

[15] Mika Gissler, Cynthia Berg, Marie Hélène Bouvier-Colle, Pierre Buekens, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European Journal of Public Health*, Vol. 15, No. 5 (October 2005), pp. 459-463.

[16] David C. Reardon, Priscilla Coleman, "Pregnancy-associated mortality after birth," Letter to the Editors, *American Journal of Obstetrics and Gynecology*, Vol. 191, No. 4 (October 2004), pp. 1506-7.

[17] There is a dramatic inconsistency between abortion advocates'claims concerning the physical safety (for the mother) of abortion, coupled with their repeated assertions that health regulations proposed for abortion are unnecessary, on the one hand, and their oft-repeated argument that if legal protection against abortion is provided to unborn children in the future, a result will be maternal mortality from illegal abortion comparable to what occurred in the pre-penicillin early years of the 20th century, on the other hand. As comprehensively demonstrated

That said, there are practical and principled reasons why National Right to Life believes that it is not wise to make the relative safety of childbirth over abortion the over-arching theme for advancing pro-life legislation. If one treats the abortion debate purely as a matter of relative safety, it makes the policy beholden to whatever the latest popular study might say, no matter how poor the data or methodology.

NRLC's state legislative director Mary Spaulding Balch, J.D., speaking at National Right to Life's convention in Louisville in June 2014, pointed out that there are studies that exist showing procedures with higher mortality rates than abortion (if the nearly 100% mortality of the unborn child is excluded).

Balch also included statistics from one hospital in India showing a higher mortality rate from cesarean sections than from vaginal deliveries, which she noted would be not be expected to lead to a statute prohibiting c-sections.[18] That context has been largely missing in most coverage of those remarks.

Defenders of abortion will produce, as the need requires, inadequately backed studies, such as the latest by Raymond and Grimes.[19] The mainstream news media and the medical establishment can be expected to cite claims that "abortion is X times safer than childbirth" as an undisputed fact, without reflecting the gaps in the data on which these claims are based.

The debate over relative safety should not obscure the fundamental problem with abortion, which is that it is the intentional destruction of human life.

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by Cynthia McKnight in "Life Without Roe: Making Predictions About Illegal Abortions" (available at www.nrlc.org/uploads/stateleg/LifeWithoutRoe1992.pdf) "the continuing decrease in maternal deaths related to abortion–both legal and illegal–was the result, not of the legalization of abortion, but of continued medical progress.

[18] The study reported a maternal death risk of 27 per 13, 637 c-sections versus 19 per 30,215 vaginal deliveries However, the cited article [G. Kamilya, S.L. Seal, J. Mukherji, S.K. Bhattacharyya, A. Hazra, "Maternal mortality and cesarean delivery: an analytical observational study," *The Journal of Obstetrics and Gynaecology Research*, Vol. 36, No. 2 (April 2010), pp. 248-53] reports a study specifically intended to fill "a dearth of data from developing countries" and covers results from one hospital in Kolkata, India from 2003 to 2006. It cannot be directly applied to the United States; indeed, the article itself cites a "'literature review' from developed countries [which] concluded that there may not be an increased risk of maternal mortality with elective CD compared to VD." In any event, neither the maternal mortality rate associated with vaginal delivery nor that associated with cesarean sections reported in this one hospital in India can reliably be used in direct comparison with maternal mortality from abortion in the United States.

[19] E.G. Raymond, David A. Grimes, "The comparative safety of legal induced abortion and childbirth in the United States," *Obstetrics & Gynecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 6

Pro-lifers care about the life and safety of the mother, because we care about the life of each and every human being, no matter their age or stage of development. But it will not be enough to make abortion safe or safer for the mother, since it still fundamentally entails the death of the innocent child.

One expects that there will always be risk involved in both abortion and childbirth. Though the psychological ramifications for those women having abortions or giving birth will be quite divergent and are likely to entail significant consequences, it is true that within both groups most women are unlikely to encounter any immediate medical crises. There is much dispute over whether the aborting women or the childbearing women are likely to experience the most complications and negative consequences. National Right to Life firmly believes that the heavier burden will be borne by those who abort.

But even for a woman who suffers no immediate physical consequences, there is a huge difference between an outcome that leaves her with a dead baby and a live one. The lives of both the mother and the child are precious to National Right to Life, and so we will continue in our efforts to oppose abortion and to see every child welcome in life and protected in law.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

JUL 20

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:

1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions) in the United States have been published only since the 1970s.
2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 150 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRASSLEY: *Nancy Northup, president and CEO of the Center for Reproductive Rights, repeatedly indicated that a law would be permissible under S. 1696 if regulated abortion is done in the same manner as other "similar" procedures. She said, "I think what's really critical about the bill . . . is right from the start, if this is something that is treating medically similar practices and procedures and services the same, there's no objection, nothing's going to be struck." The bill itself uses the term "medically comparable procedures," and in your written testimony, you discuss the ambiguity of the term "medically comparable," and difficulties in applying that term to abortion. Taking this into consideration, consider this possibility: Law X is a state law that regulates all centers in which surgical procedures are performed, and although Law X does not mention abortion, surgical abortion centers are obviously within the scope of the law. Let's even go a step further and stipulate, purely for purposes of my question, that a federal court finds that for purposes of reviewing this Law X under the terms of the federal law, S. 1696, abortion is indeed a "medically comparable procedure." Is Ms. Northup correct in suggesting that, once a court has concluded that Law X treats abortion the same as other "medically comparable procedures," Law X is therefore permissible under S. 1696?*

Regarding the manner in which S. 1696 would operate, Ms. Northup's testimony was an exercise in indirection. Under S. 1696, even a law that treats abortion exactly the same as other "medically comparable procedures" is presumptively invalid, if that law in any way diminishes access to abortion, or is claimed to do so.

For purposes of this analysis, one should ignore the verbose "findings and purposes" section of the bill, and go directly to key operative language, which is found in Section 4 of the bill. Section 4(b)(1), headed "Other prohibited measures or actions," provides that any "measure or action" that restricts abortion is unlawful if it "singles out abortion services" <u>or</u> if it would "make abortions services more difficult to access . . ." Likewise, Section 4(b)(2) says that a law is *prima facie* unlawful if the plaintiff demonstrates that the measure "singles out the provision of abortion services" *or* "impedes women's access to abortion services . . ."

In her verbal testimony, Ms. Northup sought to leave the impression that an abortion-impacting law is presumptively invalid only if it both singles out abortion *and* diminishes access – but in reading a statute, the difference between "or" and "and" is often all

important, and in S. 1696, the conjunction is "or." In short, S. 1696 is clearly and deliberately structured to create two separate and distinct routes for attacking a state or federal law that directly or indirectly affects abortion providers.

The "Law X" postulated in the question treats abortion exactly the same as other surgical procedures. Yet that fact would be essentially irrelevant under the actual language of S. 1696, because Law X would simply be attacked under the separate and distinct prohibition on laws that diminish "access" to abortion.

Section 4(b)(3) provides a list of seven "factors for a court to consider in determining whether a measure or action impedes access to abortion services." The first factor on the list is "whether the measure or action interferes with an abortion provider's ability to provide care and render services in accordance with her or his good-faith medical judgment." That single factor alone is so open-ended – essentially directing the federal courts that the "medical judgment" of any given abortionist should be deemed to trump a state's regulatory requirements – that the rest of the list hardly matters. Still, it should be noted that the rest of the list condemns, among other things, any regulations that might "delay some women in accessing abortion services" or are "reasonably likely to directly or indirectly increase the cost of providing abortion services or the cost for obtaining abortion services . . ."

Once a law is found to be *prime facie* invalid, *either* because it "singles out" abortion *or* because it is deemed to affect the provision of abortion services "directly or indirectly," it will be nullified unless the government can demonstrate by "clear and convincing evidence" (a high standard of proof) that the measure "significantly advances the safety of abortion services or the health of women," *and* that these interests "cannot be advanced by a less restrictive alternative measure or action."

Thus, a challenged law will not be saved by production of "clear and convincing" proof that it does no harm to the health of women (or actually advances health and safety of women, but not "significantly"), and that it advances other important governmental interests – for example, the value that a state sees in the life of an unborn child, at least after viability, or the sincerely held conscience rights of pro-life doctors, nurses, and other health care providers. In fact, the challenged law will not be saved even by production of "clear and convincing" proof that it actually protects the "health of women," or even by a demonstration that it "significantly advances" the health of women, unless the government can also prove that there is no "less restrictive alternative measure . . ." of advancing safety. Section 5 of the bill further instructs that "a court shall liberally construe" all of these requirements "to effectuate the purposes of the Act" – those purposes being, of course, to remove any requirement that would directly or indirectly

delay access to or increase the cost of any abortion, sought for any reason, at any point in pregnancy.

In summary: S. 1696 is not a formula for requiring that abortion be treated exactly the same as other "medically comparable procedures." (As I explained in my written testimony submitted for the July 15 hearing, that would be bad enough, since abortion is different from all other "medical procedures" and the U.S. Supreme Court has recognized that difference, as do most Americans.) Rather, S. 1696 would shield abortion providers from regulation and oversight to a unique degree, with the judgment of abortion providers substituted for the judgment of legislative and regulatory bodies that regulate all other fields of medical practice.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *At the hearing I asked Ms. Northup whether a waiting period for elective abortion would be permissible under S. 1696. She said it would depend on various factors, yet she evaded my repeated requests that she name a single state waiting-period law that might survive under the bill. Do you believe that a state law requiring a waiting period prior to an elective abortion could survive under the prohibitions that S. 1696 would impose, and if not, why not?*

The waiting-period or reflection-period laws are specific to abortion, and therefore are presumptively invalid under S. 1696's prohibition on singling out abortion. If a state somehow crafted a law that required a waiting period not only for abortion but also for all other "medically comparable procedure[s]," that law would simply be attacked under the separate and distinct alternative prohibition contained in S. 1696, which renders presumptively invalid any law that directly or indirectly reduces "access" to abortion. The bill explicitly provides that "whether the measure or action is reasonably likely to delay some women in accessing abortion services" is a factor to be considered by a court "in determining whether a measure or action impedes access to abortion services for purposes of" the prohibition. It seems self-evident that a mandatory delay violates this prohibition.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *In your testimony to the Committee, both verbal and written, you asserted that S. 1696 would result in invalidation of federal and state laws that protect individual doctors, nurses, and other health-care providers, and usually private institutions as well, from being penalized for declining to participate in the providing of abortions. These are often referred to as "conscience protection laws," although some of the critics of such laws call them "refusal clauses." During the question period at the hearing, when I suggested to Nancy Northup, president and CEO of the Center for Reproductive Rights, that the bill would result in invalidation of the conscience laws, she said, "I don't agree. This legislation doesn't address the issue of conscience objection." However, she did not explain how these laws could survive scrutiny under the tests imposed by the bill, and she was evasive when I asked her if she would endorse an amendment to S. 1696 exempting these laws from the scope of the bill. Do you have any comment on Ms. Northup's claim that the bill "does not address" the issue of conscience protection laws, and could you please explain the process of judicial analysis that you believe would result in invalidation of these laws under S. 1696?*

S. 1696 "doesn't address" conscience protection laws only in the sense that they are not explicitly mentioned, but of course this is completely irrelevant, since they clearly fall within the general prohibitions in the bill, which render presumptively invalid any laws that either treat abortion differently from other "medically comparable procedures" <u>or</u> that directly or indirectly reduce "access" to abortion services.

I will use as examples the two conscience protection laws in effect in South Carolina. South Carolina Code Ann. § 44-41-50 states in part:

> (a) No physician, nurse, technician or other employee of a hospital, clinic or physician shall be required to recommend, perform or assist in the performance of an abortion if he advises the hospital, clinic or employing physician in writing that he objects to performing, assisting or otherwise participating in such procedures. Such notice will suffice without specification of the reason therefor.
>
> (b) No physician, nurse, technician or other person who refuses to perform or assist in the performance of an abortion shall be liable to any person for damages allegedly arising from such refusal.
>
> (c) No physician, nurse, technician or other person who refuses to perform or assist

> in the performance of an abortion shall because of that refusal be dismissed, suspended, demoted, or otherwise disciplined or discriminated against by the hospital or clinic with which he is affiliated or by which he is employed. A civil action for damages or reinstatement of employment, or both, may be prosecuted by any person whose employment or affiliation with a hospital or clinic has been altered or terminated in violation of this chapter.

South Carolina Code Ann. § 44-41-40 states:

> "No private or nongovernmental hospital or clinic shall be required to admit any patient for the purpose of terminating a pregnancy, nor shall such institutions be required to permit their facilities to be utilized for the performance of abortions. No cause of action shall arise against any such hospital or clinic for refusal to perform or to allow the performance of an abortion if the institution has adopted a policy not to admit patients for the purpose of terminating pregnancies; provided, that no hospital or clinic shall refuse an emergency admittance."

These statutes clearly provide certain specified immunities, with respect to refusal to participate in abortion, that do not apply to other "medically comparable procedures." Therefore, under S. 1696, anyone challenging such a law would easily establish a *prima facie* case that the laws are invalid. The laws would then be nullified unless the state can convince a federal judge, by clear and convincing evidence, that these laws significantly increase the safety of abortion practice or otherwise advance women's health, and that there is no "less restrictive" way to accomplish those purposes. But of course, these laws were enacted for the purpose of protecting conscience rights. It will avail the state nothing to show that they do no harm to women's health – they will be invalidated.

Nor would it change the situation if the state legislature were to enact new laws that would apply to a broader range of medical procedures. Any conscience law that could be invoked by a health care provider to avoid participation in providing abortions would be subject to attack under the alternate prohibition in S. 1696, which is the prohibition on laws that directly or indirectly reduce "access" to abortion – whether or not they single out abortion. It would be easy for those attacking the new law to show that it was being used or would be likely to be used by health care providers who object to participating in abortion. It is self evident that the effect "is reasonably likely to result in a decrease in the availability of abortion services in the State," at which point the law is presumptively invalid under S. 1696.

RESPONSE OF CAROL TOBIAS,
PRESIDENT, NATIONAL RIGHT TO LIFE COMMITTEE

August 4, 2014

QUESTION FROM SENATOR GRAHAM: *Regarding the impact of S. 1696 on the ability of states to limit late abortions: In her testimony, Nancy Northup, president and CEO of the Center for Reproductive Rights, suggested that S. 1696 simply reiterates the current "constitutional standard," which, she suggested in her written testimony, draws a sharp demarcation at "viability." Do you agree with Ms. Northup's reading on what the current "constitutional standards" are, regarding limits on late abortions, and do you agree with those who suggest that S. 1696 does nothing more than codify the current "constitutional standard" with respect to regulation of abortion?*

It is striking that in purporting to explain to the Committee the "constitutional standard" regarding regulation of abortion, particularly late abortion, Nancy Northup made no reference in either her written or verbal testimony to the most recent U.S. Supreme Court decision concerning abortion – *Gonzales v. Carhart*, the 2007 ruling in which the Supreme Court upheld the federal Partial-Birth Abortion Ban Act [550 U.S. 124 (2007)].

When Congress was still considering enactment of that statute, Northup's organization – among others – told Congress that it was unconstitutional, because it placed an "undue burden" on abortion before "viability," and because it contained no open-ended "health" exception. In short, they said pretty much the same things they are now saying about the Pain-Capable Unborn Child Protection Act, S. 1670/H.R. 1797, and about the Pain-Capable Unborn Child Protection bills that have been considered in various state legislatures and enacted in ten states, beginning with Nebraska in 2010.

Does Northup neglect to mention *Gonzales* because she considers the Supreme Court's holdings in *Gonzales* to be insignificant, or irrelevant to determining the current "constitutional standard"? This seems unlikely. In her dissent to *Gonzales,* Justice Ruth Bader Ginsburg (the Supreme Court justice who most vigorously articulates the doctrines also embraced by the Center for Reproductive Rights) vehemently denounced Justice Kennedy's majority opinion, which she clearly viewed as a highly significant shift in the Court's doctrine on regulation of

abortion. Justice Ginsburg wrote:

> The Court's hostility to the right *Roe* and *Casey* secured is not concealed. . . . A fetus is described as an "unborn child," and as a "baby," . . . second-trimester, previability abortions are referred to as "late-term," . . . and the reasoned medical judgments of highly trained doctors are dismissed as "preferences" motivated by "mere convenience." . . . Instead of the heightened scrutiny we have previously applied, the Court determines that a "rational" ground is enough to uphold the Act. . . And, most troubling, *Casey*'s principles, confirming the continuing vitality of the "essential holding of *Roe*," are merely "assume[d]" for the moment . . . rather than "retained" or "reaffirmed."

Law Professor Khiara M. Bridges of Boston University, who was previously an academic fellow with the Center for Reproductive Rights, elaborated on the perceived shift in Supreme Court doctrine in her article "Capturing the Judiciary: *Carhart* and the Undue Burden Standard" (*Washington & Lee Law Review*, 67 Wash & Lee L. Rev. 915, Summer 2010). (Prof. Bridges specifically thanked the Center for Reproductive Rights "for providing financial support during the writing of this article.") Referring to the ruling as *Carhart,* Bridges wrote:

> Note that when Blackmun [in *Roe v. Wade*] announces one of the fundamental holdings of the decision, he refers to previable fetuses as in possession of "potential life" and postviable fetuses as in possession of a, without qualifications, "life." Viability, then, is the point at which the *potential life* of the fetus emerges as a *life,* thereby affording the fetus a whole or quasi-whole membership within the human community – and thereby making it a legitimate target for regulations designed to protect it. If we accept the above reasoning as justification for assigning constitutional significance to viability, then one understands as highly significant Justice Kennedy's casual assertion in [*Gonzales v.*] *Carhart* that the "fetus is a living organism while within the womb, whether or not it is viable outside the womb," as well as his relatively cavalier description of the pre- and post-viability abortion procedures at issue as concerning "a particular manner of ending fetal *life*." **With these simple pronouncements, the majority asserts the *insignificance* of viability as a site distinguishing potential life from unqualified life.** With this pronouncement, *Carhart*

> makes the "bright line" of viability no more than an arbitrary moment, a moment among moments, within the continuous, always already "life" of the fetus. **As such, *Carhart* can be read to eliminate the significance of viability as a marker, and therefore eliminate the significance of the distinction between the pre-viable and post-viable stages of pregnancy.** What follows from the evanescence of the distinction between pre- and post-viable stages of pregnancy and the differing levels of gravity that have been attributed to them is that the justification for curbing the ability of the state to proscribe abortions outright during pre-viability is also eliminated. [boldface added for emphasis]

Consider also the analysis of Randy Beck, associate professor of law at the University of Georgia Law School, a former clerk to Justice Anthony Kennedy, in his essay "*Gonzales,* Casey, and the Viability Rule" (*Northwestern University Law Review*, Vol. 103, No. 1, 2009). Beck notes that Justice Kennedy, in his dissent in *Stenberg* in 2000, 530 U.S. 914, 962, wrote that "[a] State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others."

Beck goes on to argue that in the 2007 *Gonzales* ruling, Kennedy and the other four justices in the majority merely "assumed" the continued application of the viability doctrine but did not actually reaffirm it. (Even in the 1992 *Casey* ruling, which reaffirmed the "core holdings" of *Roe v. Wade*, "the plurality's retention of the viability rule can be viewed as dicta," Beck asserts -- meaning language that was not essential to the issues in the case and that therefore has no precedential force.) More importantly, Beck argues that the overall logic of the *Gonzales* ruling will make it difficult for the Court to articulate a convincing constitutional principle as to why future laws protecting unborn children *prior to viability* are constitutionally invalid.

> The Court's conclusion [in *Gonzales v. Carhart*] that Congress can legitimately protect the previable fetus from a brutal death through the intact D&E [partial-birth abortion] procedure raises the question why a legislature may not protect the same fetus from other brutal abortion techniques. The possible distinction the majority perceived between intact D&E and standard D&E abortions offers little assistance in justifying the viability

> rule. To say that a legislature *may* distinguish between the two procedures for *legislative* purposes does not show why it *must* distinguish between them on *constitutional* grounds. If a legislature may view the previable fetus as a being that warrants protection against the intact D&E procedure, it should be able to protect the same fetus against the standard D&E. The dignity of the not-quite-viable fetus does not change depending on the method by which it will be aborted.
>
> Prior to *Gonzales*, if the Court sought to justify the viability rule, it would have needed to present a principled constitutional theory interrelating state power and fetal entitlement such that the state interest in protecting fetal life (a) exists at the outset of pregnancy, (b) grows in strength as the pregnancy progresses, but © does not become strong enough to warrant a prohibition of abortion until the precise moment that the fetus can survive outside the womb. In the post-*Gonzales* world, the task of establishing the legitimacy of the viability rule has become significantly more demanding. Now if the Court wishes to justify the viability rule in a manner consistent with its precedents, it will need an even more subtle and discriminating constitutional analysis, capable of explaining why the state may ascribe sufficient value to a previable fetus to protect it against death by one means, but may not value it sufficiently to protect it against death by other means. It must offer a principled constitutional theory interrelating state power and fetal entitlement, such that the state interest in protecting fetal life (a) exists at the outset of pregnancy, (b) grows in strength as the pregnancy progresses, (c) warrants protecting a previable fetus against an intact D&E abortion due to the similarity of that fetus to a newborn infant, but nevertheless (d) does not warrant protecting the fetus from other abortion methods until it can survive outside the womb.

Going all the way back to *Roe v. Wade*, the U.S. Supreme Court has recognized a compelling state interest in protecting the life of the unborn child after "viability." But the current Supreme Court recognizes that there are other compelling state interests pertaining to unborn children, and recognizes that they begin prior to "viability." Justice Anthony Kennedy – widely understood to be the decisive fifth vote in abortion cases – has written:

> [In *Casey v. Planned Parenthood,* 1992] We held it was inappropriate for

> the Judicial Branch to provide an exhaustive list of state interests implicated by abortion. 505 U.S. at 877. *Casey* is premised on the States having an important constitutional role in defining their interests in the abortion debate. It is only with this principle in mind that Nebraska's interests can be given proper weight. . . .
>
> States also have an interest in forbidding medical procedures which, in the State's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful, to life, including life in the human fetus. . . . A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others. *Stenberg v. Carhart*, 350 U.S. 914, 961-62 (2000)(Kennedy, J., dissenting)

While those statements were made while Justice Kennedy was in the minority in *Stenberg*, which struck down Nebraska's Partial-Birth Abortion Ban Act in 2000, in 2007, with a differently composed Court, he wrote for the majority in *Gonzales v. Carhart*.

It should be noted that the federal Partial-Birth Abortion Ban Act was upheld although it made no distinction based on viability:

> "The [Partial-Birth Abortion Ban] Act does apply both previability and postviability because, by common understanding and scientific terminology, a fetus is a living organism while within the womb, whether or not it is viable outside the womb." *Gonzales*, 550 U.S. at 147.

Indeed, in her dissent, Justice Ginsburg complained that the Court's ruling "blurs the line, firmly drawn in *Casey*, between previability and postviability abortions."

Thus, while Nancy Northup in her testimony attempted to maintain the pretense that the Supreme Court continues to adhere to a rigid demarcation at "viability," both the majority ruling and the dissent in *Gonzales* provide clear evidence that this is not the case. As a result, we believe that the Supreme Court would uphold, for example, the Pain-Capable Unborn Child Protection Act (S. 1670), which would generally protect unborn children of 20 weeks fetal age and greater, based on

findings that by this stage of development (if not sooner) they are capable of experiencing pain while being aborted.

Responses of Dr. Monique V. Chireau to Questions Submitted by Senator Grassley

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

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

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

- 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

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

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. © 2004 by The American College of Obstetricians and Gynecologists.)

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.

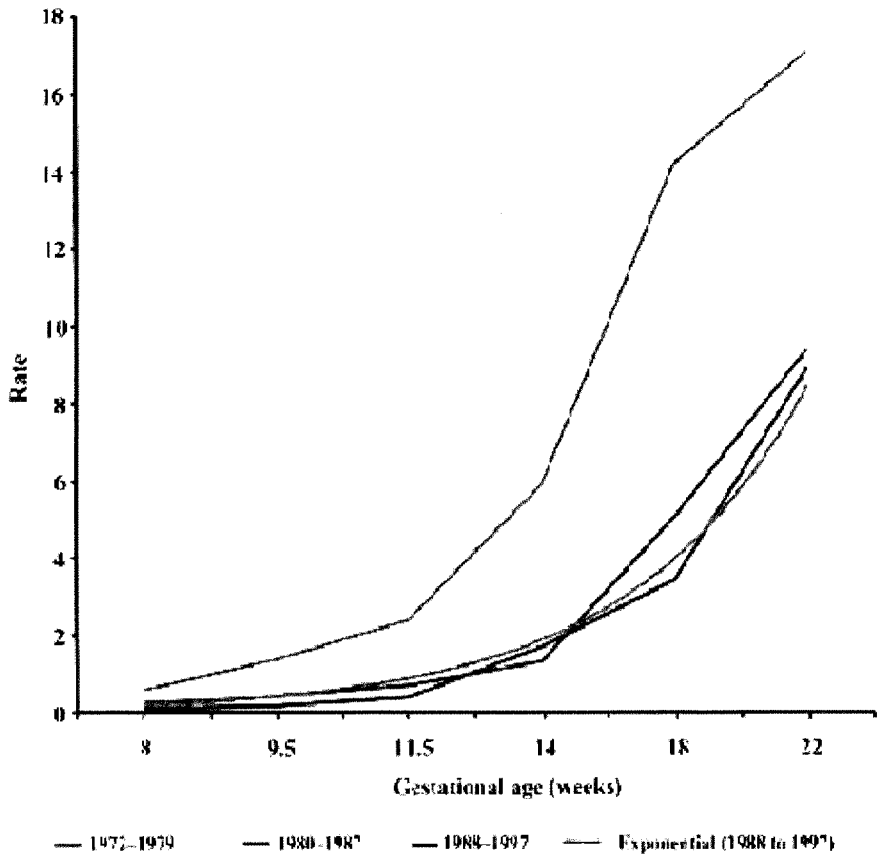

Figure 1. Legal induced abortion mortality rates with plot of exponential model, by gestational age—United States 1972–1979, 1980–1987, and 1988–1997.

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

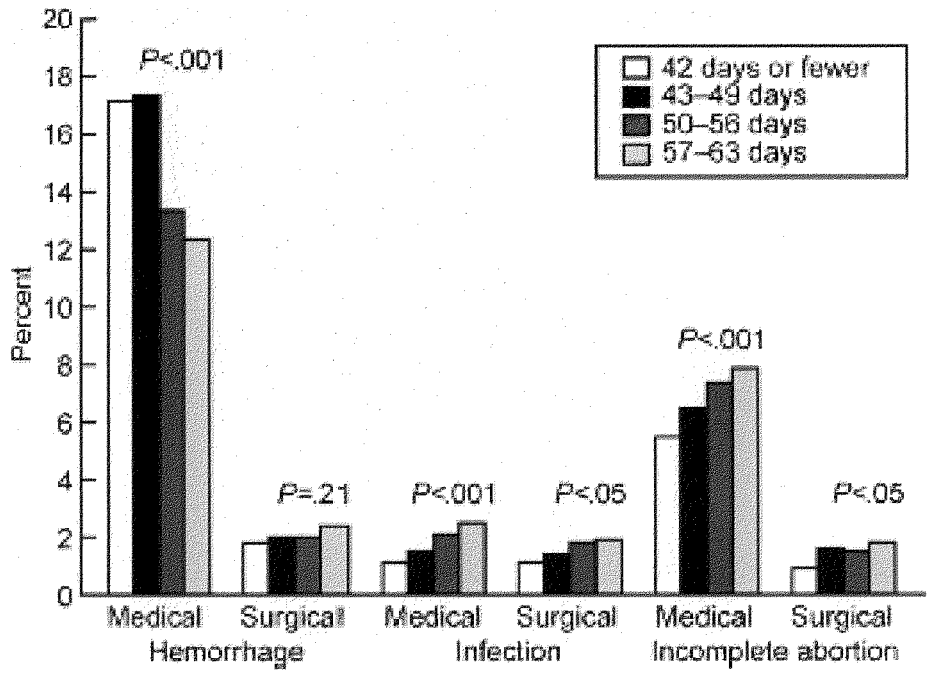

Fig. 1. Complications according to the duration of gestation in the medical and surgical cohorts (%).

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]

National Institute for Health and Welfare (THL), PO Box 30, 00271 Helsinki, Finland [2]NHV, Nordic School of Public Health, 12133 SE-40242 Gothenburg, Sweden [3]Department of Obstetrics and Gynaecology, University Hospital of Oulu, Kajaanintie 50, 90230 Oulu, Finland

*Correspondence address. Tel: +358-29-524-7265; Fax: +358-20-610-7227; E-mail: reija.klemetti@thl.fi

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
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CLINICAL OPINION www.AJOG.org

GENERAL GYNECOLOGY

A statement on abortion by 100 professors of obstetrics: 40 years later

One Hundred Professors of Obstetrics and Gynecology

In this Journal in 1972, 100 leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade. They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility. They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists. Forty years later, 100 professors examine the statement of their predecessors in light of medical advances and legal changes and suggest a further course of action for obstetrician gynecologists.

Key words: abortion, law, teaching hospital

Forty years ago, leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade (Supplementary Data available at www.AJOG.org).[1] They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility.[1] They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists.

Since then, we have advanced the fields of reproduction and family planning. Thanks to these developments, women can now prevent pregnancy with safer and more effective forms of contraception (most recently long-acting reversible methods), with simple and sensitive hormonal and sonographic methods to determine pregnancy status and duration, and with new methods of infertility treatment and prenatal testing that rely on the option of terminating intended pregnancies that are diagnosed as abnormal. To terminate pregnancies, clinicians now use misoprostol and mifepristone for "medical abortion" (which in 2009 accounted for 16.5% of terminations in the United States and can be office-based) and use sonographic guidance of intrauterine procedures along with new methods for inducing cervical dilation and uterine contraction; patients benefit from innovations in counseling and new approaches to pain control.[2-6] Studies of abortion practice and outcomes are also much more sophisticated than they were 40 years ago.[7,8]

We have had 40 years of medical progress but have witnessed political regression that the 100 professors did not anticipate. In 2011 alone, 24 states passed 92 legislative restrictions on abortion.[9] Waiting periods after consent are now law in 26 states. Alabama, Arizona, Florida, Kansas, Louisiana, North Carolina, Oklahoma, and Texas require patients to view ultrasound images and, in Arizona, Louisiana, Mississippi, and Texas, to listen to fetal heart beats.[10] Laws in 27 states force physicians to provide deceptive counseling including false statements about risks of breast cancer, infertility, and mental health. They include laws to limit second-trimester abortion under the guise of protecting the fetus from pain (Alabama, Idaho, Indiana, Kansas, Louisiana, Nebraska, and Oklahoma).[11] Laws directed specifically at medical education in Arizona, Kansas, and Texas prohibit abortion training in public institutions and another 7 states ban abortion in public hospitals, precluding training in them.[12]

What vision of the future of legalized abortion did the 100 professors have? How accurately did they estimate the need for safe, legal abortion and anticipate their colleagues' willingness and commitment to meeting it? They wrote, "In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we believe it helpful to [respond] to this increasingly liberal course of events...by contributing to the solution of an imminent problem."[1] Forty years later, the change is not liberal. Its effects will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices. We review our predecessors' 1972 statement and judge how it comports with what actually occurred and with legislation that has been adopted over the 40 years since their writing and the passage of Roe v Wade.

The 100 professors were remarkably prescient in anticipating the need for 1 million legal abortions and today's abortion rate of 1 in 4 pregnancies.[13,14] They predicted that teaching hospitals with specialized outpatient facilities could meet the demand and believed that abortions were the responsibility of hospitals. But today, 90% of abortions, which include the 10% that are in the second trimester, are done away from hospitals.[15] Many hospitals enforce fetal and maternal health restrictions that

From the 100 Professors (Appendix).

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are not based in the law but are contrived and enforced by the same kind of "ethics committees" that were common before the professors' 1972 statement.[1] Some institutions offer terminations only to save a woman's life; others will perform the procedure under no circumstances at all. At the same time, many states have passed legislation to shut down the freestanding clinics that are now responsible for most abortions by enacting cumbersome and expensive building regulations that are disguised as patient safety requirements.[16] There are now 25 states that, under the guise of patient safety, restrict abortions to hospitals that have their own restrictions or to specialized facilities.

In our view, hospitals have disregarded the responsibility that our academic predecessors expected them to assume. Although most first-trimester and many second-trimester abortions can be done safely and efficiently in a clinic setting, some second-trimester abortions, particularly those that are complicated by medical conditions, should be done in a hospital with rapid access to the operating room, interventional radiology, blood bank, and other emergency interventions.[17] Hospitals and expert clinicians are essential for the education of students and training residents who care for complicated cases and for treating complications.

The 100 professors went on to say that physicians should learn uterine aspiration, which is an outpatient procedure that today accounts for 82.3% of abortions, and local anesthesia and analgesia, which includes conscious sedation, so that complications and expense of general anesthesia would be reduced.[6] Today, some hospitals confine pregnancy termination, even routine first and uncomplicated second-trimester spontaneous and induced abortions, to operating rooms and have credentialing rules that prohibit the use of conscious sedation for these patients.[18] Ignoring the 100 professors' counsel not only dramatically increases patients' recovery time and expense, but also adds significant and unnecessary staffing and clinical costs that discourage hospitals from providing abortions at all.

Regarding hospital policies and the role of "abortion committees," the 100 professors wrote "therapeutic abortion boards will have no place...in states with laws which stipulate that abortion decisions are to be made by the physician and his [her] patient."[1] The 100 professors commented on the physician's duty to counsel regarding abortion: "There are patients...who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies." At that time, the professors would have been thinking of rubella and did not know that advances in prenatal diagnosis would give obstetricians the opportunity and responsibility to make their patients aware of a wide range of genetic anomalies and to offer abortion if requested. The 100 professors certainly would not have envisioned the legislation recently proposed in Oklahoma to entitle physicians to withhold information in cases of known fetal deformity because a knowledgeable patient might choose termination.

Writing about doctors with conscientious objections, the 100 professors said that these physicians must be excused from performing abortion but must refer patients to colleagues who can care for them. Recent "conscience clause" legislation does not require referral for abortion, and some states (Colorado, Ohio, Wisconsin, Michigan, and Texas) specifically prohibit referral for abortion by physicians who work in institutions that receive state funding for women's health services.[19] The American College of Obstetricians and Gynecologists, which discussed the limits of objection, recommends that "Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled."[20] Despite this guidance, many physicians are now prohibited by law from referring patients to vital services. In Texas, for example, referral for abortion can result in denial of contraceptive funding.

The 100 professors predicted that space and resources for hospitals to provide abortion would result from "...the lessened number of septic abortions."[1] The Centers for Disease Control and Prevention and others subsequently documented a steep decline in hospital admissions and morbidity and mortality rates from illegal abortion promptly after Roe v Wade made abortion legal in all the states.[21]

The savings in lives and money from legalization were soon forgotten, and many hospitals now claim they cannot afford to provide abortions even if they wanted to because, among other arguments, reimbursement rates are too low (but abortion is certainly not the only service in this category), free-standing clinics provide faster and cheaper services with which hospitals cannot hope to compete (but some hospitals are able to provide cost-effective abortions), and hospital employees, notably nurses, refuse to provide abortion care (unlikely true of all or most nurses).

Some hospitals with abortion services still face legislative challenges. Even though many residency programs have integrated abortion training successfully, individual states and, recently the US Congress, have legislated restrictions on abortion training in disregard of Accreditation Council on Graduate Medical Education training mandates.[22,23] These restrictions ultimately threaten women's health by denying residents training in uterine evacuation, which further reduces access to safe abortion.

The 100 professors considered the consent process for abortion, stating that "...it has been ruled by [some] courts that an adult woman is free to make this decision by herself."[1] However, several state legislatures have interfered in the consent process by requiring that irrelevant, even untrue, information be given by the physician (eg, abortion causes breast cancer and fetal pain) and enacting burdensome waiting periods that increase risks and costs.[9,11] They further predicted "that the courts will someday decide that "any girl who is physically mature enough to conceive should, ipso facto, be granted the freedom to determine the fate of her pregnancies." Yet politicians in 37 states have restricted freedom of access of minors to abortion by implementing parental consent or notification laws,

often with clumsy, prolonged "judicial bypass" requirements that lead to dangerous delays.[24]

The professors addressed the need for postabortion contraception to decrease the need for abortion, endorsing it as "an integral part of any abortion program,"[1] but today the most effective contraceptives are still not easily accessible immediately after abortion when women most want them. Although the American College of Obstetricians and Gynecologists, Planned Parenthood, and other organizations promote postabortion use of long-acting reversible contraception, the family planning funding regulations of many states do not pay for immediate postabortion methods, and several states (eg, Indiana and Texas) and the US House of Representatives have attempted to eliminate family planning from their budgets entirely.[19]

Finally, the 100 professors recommended that "abortion should be made equally available to the rich and the poor."[1] Ironically, shortly after the 1973 Roe v Wade decision that our predecessors anticipated, the Hyde Amendment prohibited the use of federal dollars for abortion so that women in the military or who have received Medicaid have had severely limited access to abortion for nearly 40 years, unless they can pay themselves or happen to live in one of the 13 states that use their own funds for abortion.[25] Richer women, on the other hand, usually have private health insurance for abortions but there, too, the US Congress threatens women's health by insisting that the Affordable Care Act restrict even private payers from directly including abortion.

In consideration of current legislative threats to the autonomy of our patient relationships, to evidence-based medical practice, to the training of our students and residents, and ultimately to the health of our patients, we 100, including 2 of the original signers, join the 100 of 1972 in affirming our academic responsibilities to (1) teach future practitioners about all methods of contraception and about uterine evacuation throughout pregnancy, which ranges from miscarriage management to emergent evacuations and the treatment of complications in accordance with our professional mandate from Accreditation Council for Graduate Medical Education; (2) provide evidence-based information to all patients who seek family planning or pregnancy termination; (3) provide evidenced-based information to legislators who propose laws requiring inaccurate information or unindicated procedures for women seeking to terminate a pregnancy; (4) insist that the hospitals where we care for women and teach students and residents admit patients who require hospital-based pregnancy terminations, and (5) ensure the availability of all methods of contraception, particularly long-acting reversible contraception methods, to reduce the need for abortion.

REFERENCES

1. A statement on abortion by one hundred professors of obstetrics (copyright Elsevier). Am J Obstet Gynecol 1972;112:992-8.
2. Winner BW, Peipert JF, Zhao Q, et al. Effectiveness of long-acting reversible contraception. N Engl J Med 2012;366:1998-2007.
3. Gabbe SG, Niebyl JR, Simpson JL, et al. Obstetrics: normal and problem pregnancies. Philadelphia: Saunders, Elsevier Inc; 2012.
4. Veltman-Verhulst SM, Cohlen BJ, Hughes E, Heineman MJ. Intra-uterine insemination for unexplained subfertility. Cochrane Database Syst Rev 2012;9:CD001838.
5. Perrucci A. Decision assessment and counseling in abortion care: philosophy and practice. Lanham, MD: Rowman & Littlefield; 2012.
6. Pazol K, Creanga AA, Zane SB, Burley KD, Jamieson DJ. Centers for Disease Control and Prevention (CDC). Abortion surveillance: United States, 2009. MMWR Surveill Summ 2012;61:1-44.
7. Munk-Olsen T, Laursen TM, Pedersen CB, Lidegaard O, Mortensen PB. Induced first-trimester abortion and risk of mental disorder. N Engl J Med 2011;364:332-9.
8. Raymond E, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol 2012;119:215-9.
9. Guttmacher Institute. States enact record number of abortion restrictions in 2011. Available at: http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html. Accessed June 5, 2012.
10. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries. Lancet 2004;363:1007-16.
11. Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal pain: a systematic multidisciplinary review of the evidence. JAMA 2005;294:947-54.
12. Guttmacher Institute. Counseling and waiting periods for abortion. Available at: http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf. Accessed June 22, 2012.
13. White KW, Grossman D, Hopkins K, Potter J. Cutting family planning in Texas. N Engl J Med 2012;367:1179-81.
14. Jones RK, Zolna MRS, Henshaw SK, Finer LB. Abortion in the United States: incidence and access to services, 2005. Perspect Sex Reprod Health 2008;40:6-16.
15. Bazelon E. The new abortion providers: The New York Times. Available at: http://www.nytimes.com/2010/07/18/magazine/18abortion-t.html?pagewanted=all&_r=0. Accessed Nov. 9, 2012.
16. NARAL Pro-Choice America Web site. Targeted regulation of abortion providers (TRAP). Available at: http://www.prochoiceamerica.org/what-is-choice/fast-facts/issues-trap.html. Accessed June 25, 2012.
17. Diedrich J, Steinauer J. Complications of surgical abortion. Clin Obstet Gynecol 2009;52:205-12.
18. Associated Press. Federal judge continues to block Mississippi anti-abortion law: Fox News. Available at: http://www.foxnews.com/us/2012/07/11/federal-judge-continues-to-block-mississippi-anti-abortion-law/. Accessed Jan. 11, 2013.
19. Guttmacher Institute Web site. State family planning funding restrictions. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SFPFR.pdf. Accessed June 26, 2012.
20. American College of Obstetricians and Gynecologists. The limits of conscientious refusal in reproductive medicine: ACOG Committee Opinion no. 385. Obstet Gynecol 2007;110:1203-8.
21. Cates W, Grimes DA, Schultz K. Abortion surveillance at CDC: creating public health light out of political heat. Am J Prev Med 2000;19:12-7.
22. Freedman L, Landy U, Steinauer J. Obstetrician-gynecologist experiences with abortion training: physician insights from a qualitative study. Contraception 2010;81:525-30.
23. Guttmacher Institute. Monthly state update: major developments in 2012. Available at: http://www.guttmacher.org/statecenter/updates/index.html#Training. Accessed Nov. 9, 2012.
24. Guttmacher Institute. Parental involvement in minors' abortions. Available at: http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf. Accessed June 22, 2012.
25. American Civil Liberties Union. Public funding for abortion. Available at: http://www.aclu.org/reproductive-freedom/public-funding-abortion. Accessed Nov. 9, 2012.

Appendix

100 Professors

Dr David F. Archer
Professor of Obstetrics and Gynecology
Eastern Virginia Medical School
Norfolk, VA

Dr Amy (Meg) Autry
President-elect, Association of Professors of Gynecology and Obstetrics
Professor of Obstetrics, Gynecology and Reproductive Sciences
University of California, San Francisco
San Francisco, CA

Dr Robert L. Barbieri
Kate Macy Ladd Professor and Chair
Department of Obstetrics and Gynecology
Brigham and Women's Hospital
Harvard Medical School
Boston, MA

Dr Jonathan S. Berek
Laurie Kraus Lacob Professor and Chair
Department of Obstetrics and Gynecology
Stanford University
Stanford, CA

Dr Sarah L. Berga
Professor and Chair
Associate Dean Women's Health Research
Department of Obstetrics and Gynecology
Wake Forest University
Winston-Salem, NC

Dr Ira M. Bernstein
John Van Sicklen Maeck Professor and Chair
Department of Obstetrics and Gynecology
Senior Associate Dean for Research
University of Vermont
Burlington, VT

Dr Michael Brodman
Professor and Chair
Department of Obstetrics, Gynecology and Reproductive Science
The Mount Sinai Medical Center
New York, NY

Dr Haywood Brown
Professor and Chair
Department of Obstetrics and Gynecology
Duke University
Durham, NC

Dr Pierre Buekens
W.H. Watkins Professor
Tulane University School of Public Health and Tropical Medicine
New Orleans, LA

Dr Serdar E. Bulun
John J. Sciarra Professor and Chair
Department of Obstetrics and Gynecology
Northwestern University
Chicago, IL

Dr Ronald T. Burkman
Professor of Obstetrics and Gynecology
Tufts University
Springfield, MA

Dr Winston A. Campbell
Professor and Interim Chair
Department of Obstetrics and Gynecology
University of Connecticut Health Center
Farmington, CT

Dr Linda F. Carson
Professor and Head
Department of Obstetrics, Gynecology and Women's Health
University of Minnesota
Minneapolis, MN

Dr Aaron B. Caughey
Professor and Chair
Department of Obstetrics and Gynecology
Oregon Health and Science University
Portland, OR

Dr Gautam Chaudhuri
Distinguished Professor and Executive Chair
Department of Obstetrics and Gynecology
University of California, Los Angeles
Los Angeles, CA

Dr David Chelmow
Leo J. Dunn Distinguished Professor and Chair
Department of Obstetrics and Gynecology
Virginia Commonwealth University Medical Center
Richmond, VA

Dr Frank Chervenak
Professor and Chair
Department of Obstetrics and Gynecology
Cornell University
New York, NY

Dr Daniel L. Clarke-Pearson
Robert A. Ross Distinguished Professor and Chair
Department of Obstetrics and Gynecology
University of North Carolina
Chapel Hill, NC

Dr Mitchell Creinin
Professor and Chair
Department of Obstetrics and Gynecology
University of California, Davis
Sacramento, CA

Dr Mary D'Alton
Willard C. Rappleye Professor and Chair
Department of Obstetrics and Gynecology
Columbia University
New York, NY

Dr Vani Dandolu
Associate Professor and Chair
Department of Obstetrics and Gynecology
University of Nevada School of Medicine
Reno, NV

Dr Philip D. Darney
Distinguished Professor
Department of Obstetrics, Gynecology and Reproductive Sciences
University of California, San Francisco
San Francisco, CA

Dr Richard Derman
Endowed Chair of Obstetrics and Gynecology
Christiana Care Health Services
Newark, DE

Dr Deborah A. Driscoll
Luigi Mastroianni, Jr Professor and Chair
Department of Obstetrics and Gynecology
University of Pennsylvania
Philadelphia, PA

Dr David A. Eschenbach
Professor and Chair
Department of Obstetrics and Gynecology
University of Washington
Seattle, WA

Dr James E. Ferguson
The W. Norman Thornton, Jr Professor and Chair
Department of Obstetrics and Gynecology
University of Virginia School of Medicine
Charlottesville, VA

Dr Harold E. Fox
Dr Dorothy Edwards Professor and Chair
Department of Obstetrics and Gynecology
Johns Hopkins University
Baltimore, MD

Dr Arnold J. Friedman
Chair, Department of Obstetrics and Gynecology
Beth Israel Medical Center
New York, NY

Dr Melissa Gilliam
Professor of Obstetrics, Gynecology and Pediatrics, Associate Dean for Diversity
Division of the Biological Sciences
The University of Chicago
Chicago, IL

Dr Todd Griffin
Associate Professor and Chair
Department of Obstetrics and Gynecology
Stonybrook Medicine
Stony Brook, NY

Dr David A. Grimes
Clinical Professor
Department of Obstetrics and Gynecology
University of North Carolina
Chapel Hill, NC

Dr Daniel R. Grow
Professor and Deputy Chair
Department of Obstetrics and Gynecology
Tufts University
Boston, MA

Dr Linda Giudice
Distinguished Professor and Chair
Department of Obstetrics, Gynecology and Reproductive Sciences
University of California, San Francisco
San Francisco, CA

Dr Arthur Haney
Professor and Chair
Department of Obstetrics and Gynecology
University of Chicago
Chicago, IL

Dr Wendy F. Hansen
Professor and Chair
Department of Obstetrics and Gynecology
University of Kentucky
Lexington, KY

Dr Christopher Harman
Professor and Chair
Department of Obstetrics, Gynecology and Reproductive Sciences
University of Maryland
Baltimore, MD

Dr Linda J. Heffner
Professor of Obstetrics and Gynecology
Boston University School of Medicine
Boston, MA

Dr Paul Hendessi
Interim Chair and Clinical Associate Professor
Department of Obstetrics and Gynecology
Boston Medical Center
Boston, MA

Dr William Allen Hogge
Milton C. McCall Professor and Chair
Department of Obstetrics, Gynecology, and Reproductive Sciences
University of Pittsburgh
Pittsburgh, PA

Dr Ira R. Horowitz
John D. Thompson Professor and Chair
Department of Gynecology and Obstetrics
Emory University
Atlanta, GA

Dr Jeffrey Jensen
Leon Speroff Professor of Obstetrics and Gynecology
Oregon Health and Science University
Portland, OR

Dr Timothy R.B. Johnson
Professor and Chair
Department of Obstetrics and Gynecology
University of Michigan
Ann Arbor, MI

Dr Donna Johnson
Professor and Chair
Department of Obstetrics and Gynecology
Medical University of South Carolina
Charleston, SC

Dr Julia Johnson
Professor and Chair
Department of Ohstetrics and Gynecology
University of Massachusetts Medical School
Worcester, MA

Dr Harry S. Jonas
Professor Emeritus and Dean Emeritus
University of Missouri-Kansas City
Kansas City, MO

Dr Howard W. Jones III
Professor and Chair
Department of Obstetrics and Gynecology
Vanderbilt University
Nashville, TN

Dr David Keefe
Stanley H. Kaplan Professor and Chair
Department of Obstetrics and Gynecology
New York University Medical Center
New York, NY

Dr Sarah J. Kilpatrick
Professor and Chair
Department of Obstetrics and Gynecology
Cedars-Sinai Medical Center
West Hollywood, CA

Dr Mark B. Landon
Professor and Chair
Department of Obstetrics and Gynecology
Ohio State University
Columbus, OH

Dr John W. Larsen
Professor and Chair
Department of Ohstetrics and Gynecology
The George Washington University
Washington, DC

Dr Douglas W. Laube
Professor and Past Chair
Department of Obstetrics and Gynecology
University of Wisconsin—Madison
Madison, WI

Dr Lee A. Learman
Clarence E. Ehrlich Professor and Chair
Department of Obstetrics and Gynecology
Indiana University School of Medicine
Indianapolis, IN

Dr Kimberly K. Leslie
Professor and Head
Jennifer R. Niebyl Endowed Chair
Department of Obstetrics and Gynecology
University of Iowa
Iowa City, IA

Dr Edward Linn
Associate Professor and Chair
Department of Obstetrics and Gynecology
Cook County Health and Hospitals System
Northwestern University
Chicago, IL

Dr James H. Liu
Arthur H. Bill Professor and Chair
Department of Reproductive Biology
Case Western Reserve University
Cleveland, OH

Dr Curtis Lowery
Professor and Chair
Department of Obstetrics and Gynecology
University of Arkansas for Medical Sciences
Little Rock, AR

Dr George A. Macones
Professor and Chair
Department of Obstetrics and Gynecology
Washington University in St Louis
St. Louis, MS

Dr Veronica Mallet
Professor and Founding Chair
Department of Obstetrics and Gynecology
Texas Tech University
Lubbock, TX

Dr Dev Maulik
Professor and Chair
Department of Obstetrics and Gynecology
University of Missouri–Kansas City
Kansas City, MO

Dr Irwin R. Merkatz
Professor and Chair
Department of Obstetrics and Gynecology and Women's Health
Albert Einstein College of Medicine
Bronx, NY

Dr Daniel R. Mishell Jr
Endowed Professor of Obstetrics and Gynecology
University of Southern California
Los Angeles, CA

Dr Owen Montgomery
Chair
Department of Obstetrics and Gynecology
Drexell University
Philadelphia, PA

Dr Valerie Montgomery Rice
Dean and Executive Vice President
Morehouse School of Medicine
Atlanta, GA

Dr Thomas Moore
Professor and Chair
Department of Reprodnctive Medicine
University of California, San Diego
San Diego, CA

Dr Laila Muderspach
Associate Professor and Chair
Department of Obstetrics and Gynecology
University of Southern California
Los Angeles, CA

Dr Anita L. Nelson
Professor of Obstetrics and Gynecology
Harbor Hospital
University of California, Los Angeles
Los Angeles, CA

Dr Jennifer R. Niebyl
Professor and Vice-Chair
Department of Obstetrics and Gynecology
University of Iowa Hospitals and Clinics
Iowa City, IA

Dr Errol R. Norwitz
Louis E. Phaneuf Professor and Chair
Department of Obstetrics and Gynecology
Tufts University
Boston, MA

Dr Valerie Parisi
Professor of Ohstetrics and Gynecology
Dean, School of Medicine
Wayne State University
Detroit, MI

Dr Kirtly Parker Jones
Professor and Vice Chair of Educational Affairs
Department of Obstetrics and Gynecology
University of Utah
Salt Lake City, UT

Dr Maureen G. Phipps
Associate Professor and Interim Chair
Department of Obstetrics & Gynecology
Brown University
Providence, RI

Dr Manuel Porto
Professor and the E.J. Quilligan Endowed Chair
Department of Obstetrics and Gynecology
University of California, Irvine
Irvine, CA

Dr Gabriella Pridjian
C. Jeff Miller Professor and Chair
Department of Obstetrics and Gynecology
Tulane University
New Orleans, LA

Dr J. Gerald Quirk
Professor of Obstetrics, Gynecology and Reproductive Medicine
Stony Brook University
Stony Brook, NY

Dr Janet S. Rader
Jack A. and Elaine D. Klieger Professor and Chair
Department of Obstetrics and Gynecology
Medical College of Wisconsin
Milwaukee, WI

Dr William F. Rayburn
Randolph Seligman Professor and Chair
Department of Obstetrics and Gynecology
University of New Mexico
Albuquerque, NM

Dr Richard Reindollar
Professor and Chair
Department of Obstetrics and Gynecology
Dartmouth-Hitchcock Medical Center
Hanover, NH

Dr Hope A. Ricciotti
Acting Chair and Associate Professor
Beth Israel Deaconess Medical Center
Harvard Medical School
Boston, MA

Dr Laurel Rice
Professor and Chair
Department of Obstetrics and Gynecology
University of Wisconsin
Madison, WI

Dr Gloria Richard-Davis
Professor and Chair
Department of Obstetrics and Gynecology
Meharry Medical College
Nashville, TN

Dr Juana I. Rivera-Vinas
Professor and Chair
Department of Obstetrics and Gynecology
University of Puerto
San Juan, PR

Dr Nanette Santoro
Professor and E Stewart Taylor Chair
Department of Obstetrics and Gynecology
University of Colorado
Aurora, CO

Dr Andrew J. Satin
Professor and Vice Chair
Department of Gynecology and Obstetrics
Johns Hopkins University
Baltimore, MD

Dr Lynnae Millar Sauvage
Professor and Chair
Department of Obstetrics, Gynecology and Women's Health
University of Hawaii
Honolulu, HI

Dr William D. Schlaff
Professor and Chair
Department of Obstetrics and Gynecology
Thomas Jefferson University
Philadelphia, PA

Dr Jack Sciarra[a]
Professor and Chair Emeritus
Department of Obstetrics and Gynecology
Northwestern University Medical School
Chicago, IL

Dr Robert K. Silverman
Professor and Chair
Department of Obstetrics and Gynecology
SUNY-Upstate Medical University
Syracuse, NY

Dr Carl V. Smith
Professor and Chair
Department of Obstetrics and Gynecology
University of Nebraska
Omaha, NE

Dr Leon Speroff
Professor Emeritus of Obstetrics and Gynecology
Oregon Health and Science University
Portland, OR

Dr Morton Stenchever[a]
Professor and Chair Emeritus
University of Washington
Seattle, WA

Dr Jerome F. Strauss, III
Professor and Dean
Department of Obstetrics and Gynecology
Virginia Commonwealth University
Richmond, VA

Dr Phillip Stubblefield
Emeritus Professor of Obstetrics and Gynecology
Boston University
Boston, MA

Dr Hugh S. Taylor
Anita O'Keeffe Young Professor and Chair
Department of Obstetrics, Gynecology and Reproductive Sciences
Yale University
New Haven, CT

Dr J. Peter Van Dorsten
Professor and Past Chair
Department of Obstetrics and Gynecology
Medical University of South Carolina
Charleston, SC

Dr Eugene Washington
Vice Chancellor of UCLA Health Sciences
Dean of the David Geffen School of Medicine
University of California, Los Angeles
Los Angeles, CA

Dr Gerson Weiss
Professor and Chair
Department of Obstetrics and Gynecology
The University of Medicine and Dentistry of New Jersey
Newark, NJ

Dr Carolyn Westhoff
Professor of Obstetrics, Gynecology, and Public Health
Columbia University
New York, NY

Dr Robert Stanford Williams
Harry Prystowsky Professor and Chair
Department of Obstetrics and Gynecology
University of Florida
Gainesville, FL

Dr James Woods
Henry A. Thiede Professor and Chair
Department of Obstetrics and Gynecology
University of Rochester
Rochester, NY

Dr Jerome Yankowitz
James M. Ingram Professor and Chair
Department of Obstetrics and Gynecology
University of South Florida
Tampa, FL

[a]Original signer of 1972 list.

1425 K Street, NW, Suite 350
Washington, DC 20005
Office: (202) 419-1444
Fax: (202) 587-5601
www.abortioncarenetwork.org

Board of Directors
Dallas Schubert
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Kelly Martin Flynn
Vice Chair
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Maryland

Jen Moore Conrow
Penn Family Planning

Julianna Gonen
Center for Reproductive Rights
DC

Erin-Aja Grant
Philadelphia Women's Center
Pennsylvania

Peg Johnston
Chair Emerita
Access for Women
New York

Tammi Kromenaker
Chair Emerita
Red River Women's Clinic
North Dakota

Charlotte Taft.
Director
New Mexico

July 2014

Chairman Leahy, Senator Grassley, Senator Blumenthal and Members of the Committee,

The Abortion Care Network is a national 501 (c) (3) organization whose members are excellent independent abortion providers and pro-choice allies. We work to support our members, to promote access to quality abortion care, and to shift the stigma that surrounds abortion.

Many of our clinic members have served the women in their communities for over four decades. They have endured the most prolonged and deadly attacks on any professional group in our nation's history. Their dedication to women's health and welfare has sustained them in offering services under circumstances that few other professionals could withstand.

In the past several years anti abortion forces have found a strategy that makes state government an arm of their movement. We know that their ultimate goal is illegal abortion, which is indisputably dangerous for women's health. So it is truly galling to watch law after law passed under the guise of caring for women's health while really designed to inhibit access to safe abortion.

We know that abortion is, and always has been, a normal and necessary part of women's reproductive lives. Independent clinics serve good women of every race, faith, age, economic station, and culture. We have made early abortion one of the safest of all outpatient medical procedures. ACN clinics work with women and their families every day. We hold their hands listen to their stories.

The stories in this testimony represent just a glimpse of what women go through in order to access their constitutional right – a glimpse of what undue burden looks like for women. We hope you will recognize the importance of this issue to women's lives and will take all possible measures to reinstate fairness for women.

Most Sincerely,

Charlotte Taft
Executive Director
ctaft@abortioncarenetwork.org
505-490-2084

United States Senate

Committee on the Judiciary

Hearing

"S.1696, The Women's Health Protection Act:

Removing Barriers to Constitutionally Protected Reproductive Rights"

Prepared Statement of Abortion Care Network

July 15, 2014

Washington, DC

Chairman Leahy, Senator Grassley, Senator Blumenthal and Members of the Committee,

It is not easy to be an abortion provider. Since Roe was decided more than forty years ago, we have been harassed, threatened, shot at and fire bombed. We wear bullet proof vests and drive ever changing routes to work. We walk daily through a gauntlet of yelling, jeering protestors who call us unspeakable things.

So why do we continue to do it? We do it because we care deeply about the health and well being of the women and families of our communities. We continue to show up, day after day, year after year because we are health care providers who understand that abortion is a part of the full range of reproductive health care services to which all women have a right and deserve access. We brush off the threats and intimidation because we know that abortion, as a critical component of reproductive justice, is necessary to a just and equitable society, one where all people are valued and can fully participate. We do it because we love our work. It is an honor and a privilege to care for women as they make profound and complex decisions about pregnancy for themselves and their families. We proudly raise our voices in the face of stigma that shames our patients and silences our supporters.

We submit this testimony on behalf of the Abortion Care Network, a non-profit organization of independent abortion providers and our allies. The Abortion Care Network protects access, promotes quality care and combats abortion stigma, by providing support, connection and resources to its members. Independent providers provide the majority of the abortions nationwide, and have been at the forefront of

abortion care since the 1970's. We are responsible for many of the innovations and advancements in abortion provision, and have been models of holistic and patient centered care.

Our primary goal, as abortion providers, is to provide the best possible care to the people of our communities. However, in states across the country restrictive legislation is limiting, and, in some cases eliminating, our ability to provide that care.

Requiring women to make multiple, unnecessary visits to a provider before accessing abortion care is based on the condescending notion that women haven't thought adequately about their decision. Laws that require these additional visits deliberately create serious hardships to those who must arrange for childcare, travel and time away from work. Mandated ultrasounds and discussion of a fetal heartbeat cause unnecessary anguish, and add to the potential emotional burden of an abortion. Medication abortion laws that mandate the use of non-evidence based protocols force doctors to operate outside of the bounds of best medical practice. State mandated, inaccurate information about the correlation between breast cancer and abortion, fetal pain, or risk to fertility, force them to lie to their patients. These laws insult women, disregard their moral agency as human beings, and pose real hurdles to access. Such restrictive laws are not found anywhere else in medical care.

And yet, women continue to jump the hurdles in search of the constitutionally guaranteed right to care they need and deserve. So, legislators take aim directly at clinics themselves with unnecessary and unreasonable regulations. These laws, passed under the guise of patient safety, are meant simply to make it impossible to continue to operate, to force clinics to close, and reduce access. In some states, clinics must look, feel, and operate like full-scale hospitals, even though abortion is among the safest of medical procedures. Doctors who perform abortions are forced to have admitting privileges at hospitals where they don't meet the minimum number of admittances to qualify. Transfer agreements between clinics, who will rarely transfer a patient, and hospitals within a certain distance are required. These transfer agreements are banned with public hospitals, so clinics are left with few or no options. When compliance is impossible, clinics are forced to close their doors.

Who suffers from these laws? Women do. Women who are doing their best to care for themselves, their children and their families. Women have always, since the beginning of time, found ways to control the timing and size of their families. Without the ability to do so they cannot participate fully in every aspect of society. We know, because history has proven it, that when made illegal or inaccessible, abortion does not go away, it simply is rendered unsafe. When the hurdles become too high to jump, or the distance between the few remaining open clinics too far to travel, women will take their unplanned pregnancies into their own hands.

We have a choice. We can be a society that shames and stigmatizes, a society where women die from unsafe abortion care. Or we can be one that compassionately supports, and insures women access to the highest quality care. We are currently on a steep and

slippery slope to the former. The Women's Health Protection Act will help us to become the latter.

Over the years, the providers of the Abortion Care Network have heard and witnessed many stories. We see first hand the impact restrictive laws have on real lives, how they exacerbate already challenging situations, making them unnecessarily harder and more devastating. The following scenarios are based on years of experience with patients and their loved ones. They are meant to walk you through complex experiences woman in this country face every day.

Kathy's Story

Kathy is a 29 year-old mother of three, and an elementary school teacher from a small city outside of Cleveland, Ohio. Her husband, Jim, was laid off from his construction job in 2009, and, unable to find full-time work, picks up jobs here and there when he can. When Kathy discovers she is pregnant, she and Jim talk long and hard about what to do. The family is already under financial stress and another child would make things that much more difficult. Kathy loves being a mother more than anything but already feels she doesn't have enough time and energy to give to her kids. After much discussion and more than a few tears, Kathy and Jim decide the best thing for their family is to have an abortion.

The prospect is scary to Kathy. Most of what she knows about abortion comes from the heated debates she sees on the news. The idea of the clinic and the procedure itself is frightening. She does, however, have one friend who she knows had an abortion a few years ago. She had gone to a large clinic in Cleveland, where she was treated very well and with kindness. She had opted for a medication abortion, and from what she has told Kathy about it, Kathy know this is the route she would like to take. She knows she is very early in her pregnancy, and would much prefer going through the experience at home with Jim, than a surgical procedure in the clinic.

Kathy hopes to be able to make the appointment for a Saturday, so that she won't have to take any time off work. When she calls the clinic, however, she is told that because of the state mandated 24 hour waiting period, she must come twice. Kathy's heart sinks at this news. She hates to take time off work: she needs to save her days off for when the kids get sick, and she really doesn't like leaving her classroom, even for a day.

But she goes ahead and makes the appointment for Thursday of the next week, and requests the day off work, saying one of the kids has a doctor's appointment.

That next Thursday, Kathy and Jim make the 45-minute drive to Cleveland. Arriving at the clinic they are horrified to find protestors outside, who shove pamphlets through their car windows and yelling out to them, "Don't murder your baby, your baby loves you", "Dad, don't let her kill her baby" It's all Kathy can do to drag Jim into the building and keep him from punching someone.

Once inside, Kathy works through all the components of her first day appointment. Her insurance will not cover abortion, so she must pay out of pocket. The ultrasound dates her at 6 weeks, and while in the ultrasound room she is told, per state law, that there is a

heart beat present and she has the option to view the ultrasound and the heart beat. Kathy chooses not to look, feeling it would make her sadder than she already is. She knows there is a heartbeat present; if there weren't she wouldn't need to be there.
After ultrasound, Kathy has a session with a counselor, where they talk through her decision and how she's feeling. Kathy begins to feels somewhat better, still sad, but confident she is making the right choice. She informs the counselor that she would like to have a medication abortion, as her friend did. At this point Kathy learns that the law governing medication abortion in Ohio has changed since her friend's abortion. The new law allows medication abortion only through 7 weeks, and while Kathy is within the window, they will have to move quickly. She also learns that because of the state law, she cannot take the medication at home, but will have to come back three more times, once to take the first pill, again to take the second pills, and yet again to check and make sure the abortion was complete. She is also told that with this protocol, she could start cramping and bleeding in the car on the way home, she learns that the procedure is more expensive than she thought, as the State proscribed protocol requires three times the necessary dose, and the pills are expensive.
Kathy is devastated. The idea of a surgical procedure scares her, and she wanted to have her abortion at home, in private, with her husband. But she simply can't take more days off work to keep driving back to Cleveland, and the idea of the abortion starting in the car is scarier than the surgical procedure. Kathy talks through her fears with the counselor, and is relieved when she learns what a simple first trimester abortion involves– no incisions, no stitches. Kathy opts to come back Saturday for a surgical abortion. They finish the paperwork and head back home.
Saturday, Kathy drops the kids at a friends house and she and Jim head for Cleveland again. This time they think they are prepared for the protestors, but the crowd is even louder and more threatening than it was on Thursday. Escorts walk them into the building.
Kathy is relieved to find that the procedure is quick and relatively painless. Everyone is very kind and gentle. After some time sipping juice and eating crackers Jim drives her home. They are sad, but they are mostly relieved, grateful to go home to the kids they love.

Laura's Story

Laura and Tom were thrilled to be pregnant. They had both always wanted children. They had already told all their friends and family, had a baby shower, and finished painting a nursery in their Phoenix home. Laura had been referred to a doctor who practiced in a hospital near them. Their visits to the doctor were routine for the first few months, but when the he refused to give them a picture of their sonogram they were worried. They decided to consult with Laura's Uncle—an OB who lived across the state. Laura's mother went with them to the appointment. The pregnancy was at 22 weeks, and the ultrasound revealed the unimaginable—the fetus had holo anencephaly—it was completely without a brain.

They were all devastated. Laura's uncle explained that the fetus would likely not survive until birth, and would certainly die soon after. In the absence of a brain, there was no chance that the baby could feel pain. Laura was inconsolable. She and Tom couldn't imagine that their dreams were so shattered. They wanted to know why such a terrible deformity couldn't be detected until so late. When her uncle explained that it should have been evident on earlier ultrasounds, Tom was furious and ready to sue. Her uncle then explained that the state of Arizona, like nearly a dozen other states, protects a physician who withholds information about fetal abnormalities if he thinks a woman may consider abortion. They were speechless.

When Laura asked what would happen next, her uncle explained that the pregnancy could continue through a full 40 weeks. She became frantic at the thought of continuing a doomed pregnancy for more than four more months with everyone congratulating her and wanting to touch her stomach, when she would know all the time that there wasn't anything she could do to save her baby.

Then Laura's uncle explained that they had no other option in Arizona, where abortion is no longer legal after 20 weeks. He explained that Arizona, like several other states, have passed such bans, fueled by the claim that a fetus can feel pain at 20 weeks. Tom wanted to know if it was true that a fetus could feel pain at 20 weeks. The doctor explained that dozens of studies have proven that it is not true, but that the myth gets perpetuated by those who wish to ban abortions altogether.

Laura's mother wondered if they would make an exception in a case like Laura's where there was no hope for the fetus.

The doctor explained that, under the law, the circumstances don't matter.

Laura spoke again about her wish to be able to say goodbye to her daughter and let her go in peace. The doctor told them about an excellent facility in another state where they could still go to have an abortion. He explained that this doctor and his staff were very experienced in working with women whose pregnancies have gone very badly awry. He assured them that the clinic would understand that this is a big loss and would talk with them about how they could support each other.

Tom and Laura made all the travel arrangements. They were fortunate that they had the funds to travel and to afford a more expensive medical procedure, and that they were able to take time off work. The facility was warm and inviting and the staff was extremely kind. Laura and Tom were very touched by the other women in the waiting room of the clinic—each with her own unique story. The doctor explained the procedure Laura would go through and assured them that he and his staff would do everything they could to make a very painful emotional experience as safe and easy as possible. Laura's abortion went smoothly. They went home in great sorrow and anger knowing that unnecessary state laws had turned what was already a tragic situation into one that was much more traumatic, expensive and difficult than it needed to be. As they held hands on the plane ride back Tom and Laura vowed to share their story.

Maria's Story

Maria lives with her family in McAllen, Texas. She, and her husband Jose, are undocumented immigrants from Mexico. They have three children, all born in the United

States. Her husband is a daily farm laborer and Maria works as a house cleaner a couple of days a week, leaving her kids with a neighbor.
The family struggles to put food on the table, and the stress from lack of money and the fear of deportation has made her husband increasingly anxious and angry. She and the children are often afraid of him. She sometimes wonders if it would be better if they went back home to Mexico, but always dismisses the idea. The violence and lack of opportunity there are worse than what they face in Texas, and she wants something better for her children.
When Maria finds herself pregnant for the fourth time she knows immediately that she cannot have another child.
Maria comes from a deeply Catholic family. She knows that if she talks to Jose about the possibility of an abortion, he will say no. And yet she knows what she must do. She knows there is a clinic in McAllen that she can go to, one where she will be treated well, and that may even find her help to pay for the abortion.
But when Maria calls the clinic she is told that it has been forced to close due to a new Texas law that requires abortion doctors to have admitting privileges at local hospitals, a requirement this clinic was unable to meet. She is told she must travel to San Antonio or Corpus Christi.
Maria knows this is impossible. She has no car, she has little money. She cannot leave for any length of time without her husband knowing. She also knows there are immigration checkpoints on the road that she cannot pass through.
And yet Maria knows that having another child is also impossible. She feels it is wrong to bring another child into the family under their present circumstances. She will have to figure out another way to end this pregnancy. She knows from listening to other women that there are pills she can use to make her body miscarry. She knows little about the pills, the proper way to use them, or whether or not they will work, and yet she feels she has no other choice.
Maria takes all the money she has been secretly saving and buys the pills in the local market. She must trust that the pills are what the man says they are and that they are safe. She must trust the instructions. She can only hope that they will work and that she will be OK.

Maria's story is now the reality in the Rio Grand Valley of Texas. It is also quickly becoming the reality in states across the country like Alabama, Ohio, Mississippi and Louisiana. In these states and others, clinics are closing or are facing closure, due to unnecessary admitting privileges and transfer agreement laws, and unreasonable Ambulatory Surgical Center regulations.

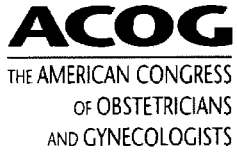
These closures will leave huge swaths of the country without an abortion provider, with hundreds of miles between clinics. In some cases, closures will also result in lost access to other critical reproductive health care services, such as birth control and cancer screenings. This lack of services would be deemed completely unacceptable in any other area of health care. It is also a violation of women's constitutional rights.

Women facing unplanned pregnancies who know, deep in their hearts, that another child will be detrimental to their lives and their children's lives will be stuck with no good choices. Women, who know that continuing a pregnancy may cost them a relationship, their education, or their job, will be forced to make desperate decisions. If they are people of means and have resources at their disposal, they may be able to travel to get the services they need. Others, who don't know how they will come up with the money for the abortion itself, much less transportation and lodging, will not. Some will continue the pregnancy and have a child they did not want or are unprepared and ill-equipped to care for. Some will travel over the border, or to the local market, or go online to obtain pills, alleged to produce an abortion, without medical supervision. Some may visit one of the unscrupulous back alley providers that will inevitably pop up in the wake of clinic closure. Some will take more desperate, drastic measures that will land them in emergency rooms, bleeding and with sepsis. Some will die.

The ability to control one's reproduction and to have safe access to comprehensive reproductive health care, including abortion, is an essential human right that is recognized by international bodies and conventions. Reproductive rights are inextricably linked to other fundamental human rights, such as the right to a standard of health and living, the right to work, and the right to an education. We, the United States of America, are in danger of denying both access to safe reproductive care and other, related human rights. The members of the Abortion Care Network have daily, intimate knowledge of both the benefits of good access, and the harm that lack of access can do to the people of our communities and our country. The Women's Health Protection Act will ensure that access is not determined by your zip code, or your bank account, but is guaranteed by standards of justice and humanity. It is imperative that this Act becomes law.

Respectfully Submitted,

Dallas Schubert, Chair
Charlotte Taft, Executive Director
Abortion Care Network



Testimony Submitted for the Record

Hal C. Lawrence III, MD. FACOG
Executive Vice President and CEO
American Congress of Obstetricians and Gynecologists

Hearing on S. 1696, The Women's Health Protection Act
US Senate Committee on the Judiciary

July 15, 2014

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW, WASHINGTON DC 20024-2188
Phone: 202/638-5577

Thank you, Chairman Leahy and Ranking Member Grassley, for the opportunity to submit testimony regarding the scientific and medical perspective on why so many state laws regulating the provision of abortion care in the name of women's health and safety, promote neither health nor safety, and why the American Congress of Obstetricians and Gynecologists (ACOG) strongly supports S. 1696, the Women's Health Protection Act.

ACOG represents 57,000 board-certified ob-gyns and partners in women's health. A large part of our work is the development and dissemination of clinical guidelines and quality improvement tools to help our members provide the highest quality care, including abortion care, to our patients. This testimony provides you and the Committee with several examples of restrictive state laws that do nothing to further women's health and safety, and which in fact can have the exact opposite effect. These include laws that:

1) Require health care providers to practice according to outdated, rather than the best and most current, medical guidelines;
2) Prohibit use of telemedicine advancements for abortion, technology that is especially important in underserved and rural areas;
3) Require abortion providers to maintain admitting privileges at local hospitals, a business arrangement that only serves to reduce the number of providers, not to improve patient safety; and
4) Require health care providers to perform tests and procedures on our patients that are not medically necessary.

All these types of laws put physicians in the terrible predicament of either adhering to medical ethics by providing high quality care that's in the best interest of their patients, or facing legal punishments which may include fines, loss of licensure, and even jail time.

1) Laws Mandating the Use of Outdated Clinical Protocols for Medication Abortions

There are several reasons why a woman may opt for a medical abortion over a surgical abortion:

- It is less invasive,
- It avoids anesthesia, and
- It takes place in the privacy of her home, a consideration that may be especially important now that the US Supreme Court has ruled against safe perimeters protecting women entering abortion clinics.

In 2000, the FDA approved use of mifepristone, together with misoprostol, to end early pregnancies. Barring any medical contraindications, there are several evidence-based protocols for medication combinations to induce termination, including use of mifepristone. During the initial office visit, a woman will receive counseling about her options. If a woman is certain that she wants to terminate the pregnancy, and she is early in her pregnancy, meaning no later than 63 days of gestation as determined by clinical evaluation or ultrasound, she may be a candidate for a medical abortion. Medical abortion requires no special pretreatment lab tests beyond those generally needed for assessment of any early pregnancy. A nurse at the medical facility can give

the patient an initial dose of mifepristone, and misoprostol will be taken at home to complete the abortion.[1]

Science and clinical evidence show that medical abortion works well for the majority of patients. Like all drugs, mifepristone carries some risks, but it is as safe, or safer, than many other drugs used today, including Tylenol and Viagra. Rates of infection and serious complications following a medical or surgical abortion procedure are extremely low. In the US, between 2001 and April 2011, there have been eight infection related deaths following the use of mifepristone and misoprostol. All were due to rare infections which have also been reported following childbirth, both vaginal and by c-section, and pelvic, abdominal or orthopedic surgery. According to FDA adverse report data, approximately 1.52 million women used mifepristone in the US, resulting in a fatality rate due to infection of 0.0005%, which is extremely low.[2] In fact, medical abortions can have safety advantages over surgical abortions for women who are extremely obese, have large uterine fibroids, certain uterine malformations, or a stenotic (narrow) cervix.[3,4] However, in an attempt to scare women and further restrict access to the medication, three states have passed laws which require physicians to prescribe an inferior regimen established 14 years ago, over newer, well-researched protocols.[5]

Since FDA approval in 2000, and as a result of continued medical research, a number of evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications compared to the 2000 protocol. In March 2014, ACOG issued *Practice Bulletin Number 143 on the Medical Management of First-Trimester Abortion*. The conclusions are premised on recent studies that have shown the superiority of evidence-based regimens as compared to the 14 year old regimen set forth on the FDA-approved label.[6,7,8] Practice Bulletin No. 143 concluded that:

- Based on efficacy and adverse effect profile, evidence-based protocols for medical abortion are superior to the FDA-approved regimen. Vaginal, buccal, and sublingual routes of misoprostol administration increase efficacy, decrease continuing pregnancy rates, and increase the gestational age range for use as compared with the FDA-approved regimen.
- Lower doses of mifepristone (200 mg) have similar efficacy and lower costs compared to those regimens that use mifepristone at 600 mg.
- Women can safely and effectively self-administer misoprostol at home as part of a medical abortion regimen, eliminating the need for women to return to a health care facility for the administration of misoprostol as outlined on the FDA-approved label.

In addition to these conclusions, data also indicate that the overall risk of serious infection with medical abortion is very low and that buccal administration of misoprostol may result in a lower risk of serious infection compared with vaginal administration.[9] In fact, evidence-based regimens through at least 63 days of gestation are safer and more effective than the regimen described on the FDA-approved label when used up to 49 days of gestation.[10] As with any medical care, treatments that are safer and more effective are medically preferable.

The FDA does not require label updates for new protocols unless there are new safety concerns, which there aren't in this case. So, physicians' use of the most recent evidence-based protocols

for mifepristone is considered "off-label". The FDA allows "off-label" use of registered products when updated medical evidence supports such use.[11] In fact, "[u]p to 20% of all drugs are prescribed off-label and among some classes of cardiac drugs, off-label use can be as high as 46%."[12] Laws, such as Arizona's which mandates physician conformance with the out-of-date protocol on the FDA final printing labeling (FPL) instructions, are based on a complete misunderstanding of the role of the FDA in approving medications.

An FPL is an informational document meant to provide physicians with guidance about how to use a drug, as of the time of FDA approval. It is common for sound medical practice to advance beyond what is described on FDA drug labels. The FPL does not impose binding obligations on physicians or restrict the medical profession's ability to develop new uses for the approved drug. The FDA has, itself, noted that "[g]ood medical practice and the best interests of the patient *require* that physicians use legally available drugs, biologics, and devices to their best knowledge and judgement."[13]

A drug manufacturer needs only to demonstrate the safety and efficacy of a drug for a particular use in order to earn initial FDA approval for marketing the medication. Manufacturers are not required to seek FDA approval for additional uses.[14] Indeed, the FDA itself has observed that "[t]he term 'unapproved uses' is, to some extent, misleading."[15] The FDA has regulatory authority over the manufacturers of drugs and medical devices; it does not—and cannot—regulate physicians and the practice of medicine.

So, to be clear: there is no medical basis to prohibit a physician's use of the most up-to-date, evidence-based medication abortion protocol. Laws mandating protocols that are contrary to best medical practice are dangerous to our patients' health. Even laws that mandate a protocol that is valid at the time of the law's enactment are a bad idea. Medical knowledge continues to advance after a law's passage.

2) Laws Restricting Use of Telemedicine for Medical Abortion

The 15 states' laws that bar the use of telemedicine in the provision of medical abortion on the pretext of safety concerns related to medication abortion, are simply unwarranted.[16] Telemedicine is already used successfully in cardiac care and the treatment of post-traumatic stress disorder, and is a useful tool in ensuring access to reproductive care for many women. ACOG encourages the effective use of telemedicine to expand access to the full array of high quality health care services for women, especially those in traditionally underserved areas.[17]

One such telemedicine program for medical abortion in Iowa helps ensure women in rural areas access to this care. In this program, a woman has an in-person visit with a nurse who collects necessary clinical information, provides detailed counseling regarding pregnancy options including the potential risks and benefits of each, and engages with the patient in the informed consent process. An ultrasound is performed by a trained technician to document gestational age. A physician at another site reviews the patient's medical history and ultrasound images, and meets with the woman via video teleconference. If the physician and patient agree that she is eligible for a medical abortion, the physician enters a computer password remotely, which unlocks and opens a drawer in front of the patient and her nurse containing the medication. The

woman takes the first dose in the nurse's presence, and the remaining medications at home. The woman is scheduled for a follow-up visit in two weeks.

A recent study of this telemedicine program, published in ACOG's *Obstetrics and Gynecology* journal[18], found that women participating in this setting were no more likely to have a complication than women who saw a doctor in person. Laws that restrict access to this care interfere with the provider-patient relationship, chip away at women's access to care, and isolate reproductive care from other needed care.

3) Laws Requiring Hospital Admitting Privileges for Abortion Providers

Another set of harmful laws are Targeted Regulation of Abortion Providers (TRAP) laws. These laws single out abortion providers for regulations, with a goal of forcing abortion providers out of practice. A typical example is requiring abortion providers to obtain admitting privileges at local hospitals.

First, it's important to know that abortion is one of the safest surgical procedures performed in the United States. The overall risk associated with childbirth is approximately fourteen times higher than abortion.[19] Over 90% of abortions in the United States are performed in outpatient settings[20] and almost all complications that arise after an abortion can be, and are, treated on an outpatient basis. Hospitalization due to an abortion is rare. There is a less than 0.3% risk of major complications following an abortion that might need hospital care[21] and a recent study found that the risk of major complications from first trimester abortions by aspiration is even less, 0.05%.[22]

Having to obtain admitting privileges imposes a stricter requirement on abortion providers than on physicians that perform much riskier out-of-hospital procedures, including those that use general anesthesia. For example, the mortality rate associated with a colonoscopy is more than 40 times greater than that of abortion[23,24], yet gastroenterologists do not have to secure admitting privileges to local hospitals.

In the rare instance when a woman experiences a complication after an abortion and needs hospital care, emergency room physicians or, if necessary, the hospital's on-call specialist, are trained to evaluate such situations the same way they are trained to deal with complications arising from any other medical procedure. In fact, the transfer of care from the abortion provider to an emergency room physician is consistent with the developments in medical practice dividing ambulatory and hospital care in the medical field more broadly.[25] That is, throughout modern medical practice, often the same physician does not provide both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" that provide care only in a hospital setting. Continuity of care is achieved through communication and collaboration between the health care providers which does not depend on all providers having hospital privileges.[26]

Hospital privileges establish a business relationship between the hospital and the physician, in part based on the number of procedures and admissions the physician is expected to bring to the hospital annually. Given the safety margin of abortion, including the very slim chance of complications, it's rare that an abortion provider may have to admit a patient. Privileges often also require the physician to live or practice in close vicinity to the hospital, further limiting

access to care for women in remote areas.

4) Laws that Mandate Medically Unnecessary Ultrasounds Prior to Abortion

Twelve states have active laws on the books requiring providers to perform ultrasounds before an abortion can be performed, and in some cases forcing the provider to show and describe to women the image, often under the pretext that these laws protect and enforce a patient's right to informed consent.[27] In reality, these laws are medically unnecessary, contrary to medical ethics, and in violation of our patients' right to informed consent.

North Carolina's Woman's Right to Know Act, for example, includes a Display of Real-Time View Requirement, requiring a physician to perform an ultrasound on a pregnant woman at least four hours (and not more than 72 hours) prior to an abortion procedure, to place the image in the woman's view, and to provide a detailed description of the image—even if the woman asks the physician not to display and describe the image, and even if the physician believes that forcing this experience on the patient would harm her. The district court, in a case brought to overturn the Act, correctly found that this requirement serves no medical purpose and should be invalidated, recognizing it as antithetical to principles of informed consent and unduly interfering with the patient-physician relationship.

Informed consent
The principles of informed consent forbid physicians from acting over the objections of competent patients, and ensure that a patient has the freedom to determine the information she does—and does not—wish to hear, particularly where the information provides no medical benefit. It is contrary to good medical practice and to the ethics of informed consent to force physicians to convey information that will harm their patients. Informed consent is rooted in the concepts of self-determination and autonomy, and is based on the principle, fundamental in medicine and jurisprudence, that patients have the right to make decisions regarding their own bodies.[28] Informed consent ensures that each patient is provided the information she needs to meaningfully consent to medical procedures.[29,30] Informed consent includes freedom from external coercion, manipulation, or infringement of bodily integrity. Informed consent has two essential elements: (1) comprehension and (2) free consent.[31] Both of these elements together constitute an important part of a patient's "self-determination." "Comprehension" requires that the physician give the patient adequate information about her diagnosis, prognosis, and alternative treatment choices, including the option of no treatment.[32,33]

Yet mandatory ultrasound laws force a physician to perform the procedure and deliver mandated information even over the patient's objection and even when the physician believes in his or her medical judgment that it is against the best interests of the patient to receive the information. These laws require that this information must be delivered when a patient is at her most vulnerable: in the midst of a medical procedure while the patient lies undressed on an examination table, with a probe on her abdomen or inserted into her vagina. Most informed consent discussions occur with the patient fully dressed sitting in the physician's office. And no other procedure in medicine requires that the physician show a patient images from her own body in order for her to comprehend her diagnosis and treatment options. For example, performing an angiogram before the placement of a stent is a medically appropriate preoperative procedure, but

there is no requirement that the patient view the screen before consenting to the operative procedure. Some patients choose to view medical images, others prefer not to. So too with abortion, there are simply no circumstances in which a patient's viewing of the fetus is medically necessary, and forcing her to do so unquestionably violates her autonomy and the physician's medical ethics. "Free consent" requires that the patient have the ability to choose among options; it is incompatible with being coerced or unwillingly pressured by forces beyond oneself.[34]

As an ethical doctrine, informed consent is a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care. A core principle of informed consent is that it is the patient that decides how much, or how little, information he or she wants to receive. It has long been recognized that patients can still provide informed consent while declining to receive certain information, so long as their declination is a result of free choice. If a patient chooses not to consider certain information, that is a decision a physician should respect. Advocates for the North Carolina law argued that women in their state have the ability to not see or hear the ultrasound image or the physician's words, that they can wear earplugs or close their eyes. This argument lays bare the absurdity of these requirements and clarifies that they are truly not passed to help women be better informed.

Therapeutic Privilege

In some cases, forcing a woman to view and hear these images may actually do her harm. Therapeutic privilege is the limited privilege of a physician to withhold information from a patient when, in the physician's best medical judgment, the information about the patient's medical condition and options will seriously harm the patient. For example, a physician may decline to show a cancer patient a positron emission tomography ("PET") scan showing the advanced developmental stage of the cancer because, in the physician's best medical judgment, the image would cause the patient unnecessary distress and anxiety.

Similarly, some patients seeking abortions may be seriously harmed by seeing an ultrasound image and hearing a description of it. Some women make the difficult decision to have an abortion after learning that they are carrying a fetus with severe abnormalities; having to listen to a physician explain the details of the fetus' deformities could be extremely upsetting. Others become pregnant as the result of rape. To subject those women to a forced narrative script describing the ultrasound after having already been physically assaulted and traumatized would be cruel and unnecessary. In these cases, the physician— not the State—is best positioned to determine what's best for his or her patient based on the particular circumstances of each case.

Not Medically Necessary

Many patients who have decided to have an abortion have already had at least one ultrasound performed. Most women undergo an ultrasound as part of their initial obstetric appointment; high risk patients or those carrying a fetus with abnormalities invariably undergo ultrasound to better assess fetal viability. State laws forcing physicians to perform another ultrasound on their patients are medically unnecessary. In no other area of medicine are physicians required to breach medical ethics by subjecting a patient to a medical procedure that the patient does not want to undergo and which is not medically appropriate or necessary. In fact, in any other area of medical practice, forcing an unnecessary medical procedure upon an unwilling patient would constitute medical malpractice.

Protect the Patient-Physician Relationship from Legislative Interference

This and other laws focused on limiting women's access to safe and legal abortions puts government between a patient and her physician. A physician's primary mission is to serve as a patient's advocate, exercising all reasonable means to ensure that the most appropriate care is provided to each individual patient based on his or her specific needs and circumstances. Serving the best interests of the patient also means respecting the right of individual patients to make their own choices about their health care. Laws that for no medical reason treat abortion providers or abortion facilities differently than others – or restrict the ability of women to access safe, legal abortion care are unacceptable public policy, leaving physicians with a terrible choice: Follow their ethical obligation to provide the best possible care for their patients using their sound medical judgment OR comply with the law by treating their patients according to the flawed judgment of their state legislatures. Physicians who choose to provide the best possible care for their patients in these cases may be faced with fines, jail time, and loss of licensure.

We urge the Senate Judiciary Committee and the US Congress to protect the patient-physician relationship from unnecessary government intrusion and pass S. 1696, the Women's Health Protection Act. Laws that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives, or medicines physicians can perform, prescribe, or administer harm our patients, are detrimental to the patient-physician relationship, and are a wholly inappropriate expansion of government's reach into the personal lives and health care of Americans.

[1] American College of Obstetricians and Gynecologists, Practice Bulletin No. 143, *Medical Management of First-Trimester Abortion* (March 2014)
[2] Food and Drug Administration, *Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011*
[3] Schaff et al., *Methotrexate and Misoprostol When Surgical Abortion Fails*, 87 Obstetrics & Gynecology 450, 450-452 (1996)
[4] Creinin, *Medically Induced Abortion in a Woman With a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379-1380 (1996)
[5] Guttmacher Institute State Policies in Brief Fact Sheet, *Medication Abortion,* (July 1, 2014)
[6] Cleland et al., *Signficant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166 (Jan. 2013)
[7] Ngo et al., *Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: A Systematic Review*, 89 Bull. World Health Org. 360 (May 2011)
[8] Schaff, *Mifepristone: Ten Years Later*, 81 Contraception 1, 1-7 (January 2010)
[9] Cleland et al., 121 Obstetrics & Gynecology at 166-171; Mary Fjerstad et al., *Rates of Serious Infection after Changes in Regimens for Medical Abortion*, 361 N. Eng. J Med. 145, 145-51 (2009)
[10] After 49 days of gestation, the efficacy of the regimen described on the FDA-approved label declines significantly, and the likelihood of continuing pregnancy increases. Creinin & Spitz, *Use of Various Ultrasonographic Criteria to Evaluate the Efficacy of Mifepristone and Misoprostol for Medical Abortion*, 181 Am. J. Obstetrics & Gynecology 1419, 1419-1424 (1999). However, regimens using vaginal, sublingual and buccal misoprostol provide efficacy rates up to 63 days of gestation that exceed the approximately 92% efficacy of the regimen described on the FDA-approved label up to 49 days of gestation. Spitz et al., *Early Pregnancy Termination with Mifepristone and Misoprostol in the United States*, 338 N. Eng. J. Med. 1241, 1241-1247 (1998); Regina Kulier et al., *Medical Methods for First Trimester Abortion (Review)*, Cochrane Collaboration (John Wiley & Sons, Ltd. ed. 2011); Schaff, 81 Contraception at 1-7; Cleland et al., 121 Obstetrics & Gynecology at 166-171
[11] FDA Drug Bulletin, Vol. 12, No. 1, *Use of Approved Drugs for Unlabeled Indications*, 5 (Apr. 1982) (off-label use "may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature")
[12] AMA National Task Force on CME Provider/Industry Collaboration Fact Sheet, Vol. 2, Issue 3, On-Label and Off-Label Usage of Prescription Medicines and Devices, and the Relationship to CME, available at https://cme.wustl.edu/forms/On_Label_and_Off_Label_Usage_of_Prescription_Medicines_and_Devices_and_the_Relationship_to_CME.pdf
[13] FDA Information Sheet, *"Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices, available at* http://www.fda.gov/regulatoryinformation/guidances/ucm126486.htm (emphasis added).
[14] FDA Drug Bulletin, Vol. 12, No. 1, *Use of Approved Drugs for Unlabeled Indications*, 5 (April 1982) (noting that "without the initiative of the drug manufacturer whose product is involved" new use regimens may never be added to approved drug labeling)
[15] Ibid.
[16] Guttmacher Institute State Policies in Brief Fact Sheet, *Medication Abortion,* (July 1, 2014)
[17] American College of Obstetricians and Gynecologists, Committee Opinion No. 586 *Health Disparities in Rural Women* (March 2009)
[18] Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. *Effectiveness and acceptability of medical abortion provided through telemedicine.* Obstet Gynecol 2011;118:296–303
[19] Elizabeth G. Raymond & David A. Grimes *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 Obstetrics & Gynecology 215, 215 (February 2012)
[20] Rachel Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008,* 43 Persp. on Sexual & Reprod. Health 41, 46 (2011)
[21] Stanley K. Hensha;-v., *Unintended Pregnancy and Abortion: A Public Health Perspective,* in A Clinician's Guide to Medical and Surgical Abortion I 1, 21 (Maureen Paul et al., eds., 1999).
[22] Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by_ Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a Calif9rnia Legal Waiver,* 103 Am. J. Pub. Health 454, 458 (March 2013). Similarly,

the risk of hospitalization from a medical abortion is 0.06%. Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion,* 121 Obstetrics & Gynecology 166, 169 (January 2013)

[23] Cynthia W. Ko et al., *Complications of Colonoscopy: Magnitude and Management,* 20 Gastrointestinal Endoscopy Clinics of N. Am. 659, 659-71 (October 2010)

[24] Raymond, *supra* note 5 at 216 (finding mortality rate of 0.6 per 100,000); Karen Pazol et al., Centers for Disease Control and Prevention, *Abortion Surveillance- United States, 2009,* Morbidity and Mortality Weekly Report 61: 1-44, Table 25 (Nov. 23, 2012); *available at* http://www.cdc.gov/mmwr/pdf/ss/ss6108.pdf (last visited Jul. 12, 2014) (finding national legal induced abortion case fatality rate for 2003-2009 of 0.67 per 100,000).

[25] ACOG, Committee on Patient Safety & Quality Improvement, Opinion No. 459, *The Obstetric Gynecologic Hospitalist* (July 2010).

[26] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (March 2001)

[27] Guttmacher Institute State Policies in Brief Fact Sheet, *Requirements for Ultrasound,* (July 1, 2014)

[28] Laurie, *Recognizing the Right Not to Know: Conceptual, Professional, and Legal Implications*, 42 J. L. Med. Ethics 1, 54 (2014) ("[C]onsent and refusal serve as a means to control what happens to our bodies and, by extension, our tissues and data as intimate adjuncts to ourselves and our sense of personal identity."); *see also* Minkoff & Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, Hastings Center Report 39, No. 5 (2009), at 21 (Informed consent "is grounded in the principle of respect for persons, which affirms an individual's consequent right to autonomous decision-making.")

[29] ACOG Committee on Ethics, Committee Opinion *No. 439 Informed Consent*, (August 2009)

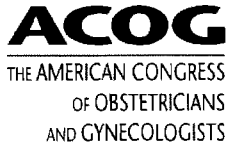
[30] AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent* ("Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.").

[31] ACOG Committee on Ethics, Committee Opinion *No. 439 Informed Consent*, (August 2009)

[32] AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent*

[33] *Whitlock v. Duke Univ.*, 637 F. Supp. 1463, 1467 (M.D.N.C. 1986) (In order for informed consent to be valid, it must be "competent, voluntary, and understanding." (internal citations omitted)).

[34] ACOG Committee on Ethics, Committee Opinion *No. 439 Informed Consent*, (August 2009)



Supplemental Testimony Submitted for the Record

Hal C. Lawrence III, MD, FACOG
Executive Vice President and CEO
American Congress of Obstetricians and Gynecologists

Hearing on S. 1696, The Women's Health Protection Act
US Senate Committee on the Judiciary

July 21, 2014

Thank you, Chairman Leahy and Ranking Member Grassley for the opportunity to provide testimony in follow-up to the July 14, 2014 hearing on S. 1696, the Women's Health Protection Act. We hope ACOG's comments below will be helpful to the Committee in clarifying several inaccuracies found in the testimonies submitted by those in opposition to S. 1696. As the Nation's leading authority in women's health, our role is to ensure that policy discussions and decisions are based on the best available medical knowledge.

Fetal Pain:
Rigorous scientific reviews of the evidence on fetal pain in the Journal of the American Medical Association (JAMA), by the Royal College of Obstetricians and Gynaecologists, and in the Journal of Maternal-Fetal and Neonatal Medicine concluded, as recently as 2012, that fetal perception of pain is unlikely before the third trimester.[1 2 3] While abortion opponents present studies which support the claim of fetal pain prior to the third trimester, the literature cited to support a 20-week ban is less scientifically sound than the aforementioned scientific reviews.

Abortion and Breast Cancer:
As ACOG's Committee Opinion No. 434 *Induced Abortion and Breast Cancer Risk* concludes:

"The relationship between induced abortion and the subsequent development of breast cancer has been the subject of a substantial amount of epidemiologic study. Early studies of the relationship between prior induced abortion and breast cancer risk were methodologically flawed. More rigorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk."

"In 2003, the National Cancer Institute convened the Early Reproductive Events and Breast Cancer Workshop to evaluate the current strength of evidence of epidemiologic, clinical, and animal studies addressing the association between reproductive events and the risk of breast cancer. The workshop participants concluded that induced abortion is not associated with an increase in breast cancer risk. Studies published since 2003 continue to support this conclusion."[4]

Abortion and Mental Health:
Testimony submitted in opposition to S. 1696 asserts that women suffer from deleterious mental health effects after abortion. A thorough review by the American Psychological Association's Task Force on Mental Health and Abortion in 2008, and subsequent update in 2009, necessitates a correction and much more careful understanding. The report found that:

"Major methodological problems pervaded most of the research reviewed. The most rigorous studies indicated that within the United States, the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy is no greater than the risk among women who deliver an unwanted pregnancy.

Evidence did not support the claim that observed associations between abortion and mental health problems are caused by abortion per se as opposed to other preexisting and co-occurring risk factors. Most adult women who terminate a pregnancy do not experience mental health problems. Some women do, however. It is important that women's varied experiences of abortion be recognized, validated, and understood."[5]

Abortion and Risk of Infection:
One witness claimed that as many as 1 in 5 women will experience an infection after having an abortion. It appears that this claim in part originates from a 1977 journal article, which cites other, even earlier findings that infections after midtrimester amnioinfusion range from 1.5% to 18.5%. Amnioinfusion abortions are rarely performed in the United States (US), so these data are irrelevant and intentionally misleading. More recent data actually shows that the rate of upper genital tract infection after induced abortion, regardless of method, is generally very low, less than 1% in most clinical settings in the US.[6] Another, even more recent study demonstrated a complication rate of 1.3% in 1st –trimester surgical abortions, with less than 0.05%—of major complications requiring hospital care.[7]

Another witness cited a Finnish study that found that "20% of the women in the medical abortion group and 5.6% of those in the surgical abortion group had at least one type of adverse event." What the witness however fails to disclose – and which the authors of the study themselves acknowledge – is that "many of the 'complications' are not really such, but rather concerns or adverse events that bring women back to the health care system."[8] Because the registry system, whose data was used for the study, does not differentiate between an actual adverse event and merely a follow-up initiated by the patient, these consultations are inaccurately coded as complications. Additionally, the outcome of hemorrhage was undefined. The authors did not report on blood transfusion, which is an objective measure of severe hemorrhage, again likely overstating adverse outcomes.

Abortion and Mortality:
While a witness was correct in stating that the overall mortality rate for women obtaining legally induced abortions increases exponentially by 38% for each additional week of gestation, the witness failed to state that the baseline is the mortality rate for women having an abortion at or before 8 weeks gestation. The mortality rate per 100,000 at that point is 0.1, so a 38% increase actually results in a very small real increase.[9] The mortality rate for women having abortions at or after 21 weeks is 8.9. While higher than for earlier abortions, this rate is still less than the maternal mortality rate of 12.7 per 100,000 among women who carry pregnancies to completion.[10] It is also important to note that only 1.5% of abortions occur after 20 weeks.[11] The witness uses her misrepresentation to bolster the justification for ultrasound dating. However, if anything, any statistically significant increase in mortality supports the need to eliminate unnecessary barriers which delay women seeking access to abortion care.

Abortion and Prematurity:
All major medical groups worldwide that have studied this issue concur that no *causal* relationship exists. This includes the World Health Organization, Royal College of Obstetricians and Gynaecologists, American College of Obstetricians and Gynecologists, American Public Health Association, American Academy of Pediatrics, and the March of Dimes.[12]

Abortion and Placenta Previa:
No causal link has been established, and no major medical association has concluded that a causal association exists. Some studies have suggested an association between abortion and this rare complication, while others have not. In contrast, the link between cesarean birth and abnormal placentation is well established, and a dose-response relationship exists. The more cesarean deliveries a woman has, the greater her risk of having dangerous placental abnormalities linked with hemorrhage, sometimes requiring hysterectomy as treatment.[13]

Abortion and Adolescents:
Opponents of the bill raise concerns about the disproportionate, adverse effects of abortion on teenagers. However research has shown that overall side effects and safety of aspiration abortion and Dilation & Extraction were similar between age groups. Younger women actually face a decreased risk of the following possible complications: uterine perforation, requiring major surgery, and mortality.[14] While younger women did have an increased risk for cervical laceration, this complication is not a cause of problems in later pregnancies. Women giving birth for the first time are also more likely to have cervical and vaginal tears during delivery. This is also not linked to later adverse outcomes. While opponents of the bill point out studies reporting complications of abortions, they fail to mention that teen pregnancies carried to term in fact come with more potential complications.[15 16]

Thank you again for the opportunity to provide you and the Committee with scientific facts on these important issues. We stand ready to provide you with factual information on medical issues that come before the Committee to ensure that scientific facts and medical evidence drive the consideration of this and other health care legislation. We look forward to working with you in support of S. 1969.

[1] Lee SJ, et al. *Fetal pain: A systematic multidisciplinary review of the evidence*. JAMA 2005;294:947-954.
[2] Bellieni & Buonocore. *Is Fetal Pain A Real Evidence?* 25 J. Maternal-Fetal & Neonatal Med. 1203, 1205 (2012).
[3] Royal College of Obstetricians and Gynaecologists. *Fetal Awareness: Review of Research and Recommendations for Practice 11*. Mar.2010.
[4] American College of Obstetricians and Gynecologists Committee Opinion No. 434. *Induced Abortion and Breast Cancer Risk*. Obstet Gynecol 2009;113:1417–8.
[5] Major, B, et al. *Abortion and mental health: Evaluating the evidence*. American Psychologist, 64(9), 863-890, 2009.
6 Society for Family Planning, *Clinical Guidelines Prevention of infection after induced abortion*. Contraception. 2011 Apr; 83(4):295-309.
[7] Weitz TA et al. *Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver*. American Journal of Public Health, 2013, 103(3):454–461.
[8] *Immediate complications after medical compared with surgical termination of pregnancy*. Obstet Gynecol. 2010, 115(3):author reply 660-1.
[9] Bartlett LA et al. *Risk factors for legal induced abortion-related mortality in the United States*. Obstet Gynecol. 2004, 103(4):729–737.
[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Women's Health USA 2011*. 2011.
[11] Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States*, Aug. 2011 at http://www.guttmacher.org/pubs/fb_induced_abortion.html (last visited Oct. 15, 2012).
[12] Royal College of Obstetricians and Gynaecologists. *The care of women requesting induced abortion. Evidence-based clinical guideline number 7*. Nov. 2011.
[13] Bowman ZS, et al. *Risk Factors for Placenta Accreta: A Large Prospective Cohort*. Am J Perinatol 2013.
[14] Renner, RM, et al. *Provision of Abortion Care for Adolescent and Young Women: A Systematic Review*. IPAS, 2013.
[15] Grimes DA. *Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to 1999*. Am J Obstet Gynecol 2006;194:92-4.
[16] American Academy of Pediatrics. *Practice Guideline Briefs: AAP Report on Pregnancy in Adolescents*. Am Fam Physician. 2005 Oct 1;72(7):1398-1400.

University of California
San Francisco
School of Medicine

Department of Obstetrics, Gynecology and Reproductive Sciences

ANSIRH
Advancing New Standards in Reproductive Health
1330 Broadway, Suite 1100
Oakland, CA 94612

tel: 510/986-8990
fax: 510/986-8960

Website:
www.ansirh.org

United States Senate
Committee on the Judiciary

Hearing
"S.1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights"

Prepared Statement of the UCSF Advancing New Standards in Reproductive Health Program
July 15, 2014
Washington, DC

Dear Chairman Leahy and Ranking Member Grassley:

Advancing New Standards in Reproductive Health—ANSIRH— is a program of the Bixby Center for Global Reproductive Health at the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology and Reproductive Sciences. We conduct research to ensure that reproductive health care and policy are grounded in evidence. ANSIRH's multi-disciplinary team includes clinicians, researchers and scholars in the fields of sociology, demography, psychology, epidemiology, nursing and public health. I am presenting to the Judiciary Committee on behalf of the faculty of ANSIRH our research findings on the effect of abortion restrictions on women's health and wellbeing. We have summarized our published research to date which may include restrictions not explicitly covered by the WHPA. Based on our research, we conclude that removing restrictions on abortion that are not based on evidence will improve women's health and wellbeing.

Consequences of denying women abortions based on gestational age
Denial of abortion care due to gestational limits occurs across the country as a consequence of state laws and abortion facility policy; an estimated 4,000 women are denied abortion services each year due to advanced gestational age.[1] By comparing the outcomes of women who were denied abortions because they were just beyond the gestational limit of an abortion facility and women who received the procedure, we found more common and more serious physical complications from birth compared to abortion. In addition, we find a greater frequency of domestic violence, poverty, and reliance on public assistance among women who carry an unwanted pregnancy to term compared to women who have abortions.[2]

Pre-viability bans
Bans on abortions after 20 weeks will disproportionately affect the most vulnerable women.[3] Most women (80%) having abortions after 20 weeks fall into one of the following groups: women raising children alone (47%); women with a history of substance use, heavy drinking, and/or depression (30%); women who experienced recent conflict or violence with their partner (24%); women who had trouble deciding what to do about the pregnancy followed by trouble accessing services (22%) and women under age 20 who had never given birth (12%). Our research on the potential impact of Georgia's 20 week abortion ban demonstrates that, if the ban goes into effect,

women of lower socioeconomic status and African American and Hispanic women will be disproportionately affected. Women seeking abortion after 20 weeks in Georgia are residents from states across the South. If the 20 week ban goes into effect, Florida will have the only post-22 week outpatient abortion care in the South. [4]

Post-viability bans
As later abortion care is not widely available in the U.S., bans after 24 weeks affect residents of states beyond the state in which the ban is enacted. Abortion care after 24 weeks is no longer available in Georgia as of January 2013. Women from throughout the South, as well as the Midwest and Northeast, are likely to be affected.[5]

Abortion bans that lack exceptions for women's health or life
Our research on obstetric care in Catholic hospitals, which prohibit abortions for any reason including maternal health, demonstrates that such restrictions lead to confusion around what practices are acceptable, and in some cases, substandard patient care. Women endure unnecessary tests, waiting or transfers, and health risk during miscarriage when the hospital's religious restrictions equate miscarriage management with abortion. Furthermore, some women with fatal fetal anomalies must endure the risks of pregnancy for up to five additional months even when the fetus will certainly die and termination would be safer and emotionally preferable for the woman.[6]

Admitting Privilege and Transfer Agreement Laws
Our analysis of post-abortion emergency department visits and complications among nearly 55,000 abortions covered by the California Medi-Cal program in 2009 and 2010 demonstrated that admitting privilege and transfer agreement laws would have limited impact on patient safety. Abortion is very safe and is associated with few serious complications. Among all abortions in the study, which included first and second trimester or later abortions, 0.03% (15 cases) resulted in ambulance transfers to emergency departments on the day of the abortion. Among all abortions, the total complication rate diagnosed and/or treated at all sources of care was 2.1%. Major complications, defined as hospitalizations, surgeries and transfusions, were rare at a rate of 0.23% of all abortions.[7]

Physician-only laws
Regulations that identify the health care professionals who can provide abortion care should be based on education, training and clinical competency rather than a particular licensure. Our research demonstrates that nurse practitioners (NPs), certified nurse midwives (CNMs) and physician assistants (PAs) provide aspiration abortion care with clinically equivalent complication rates to that of physician providers.[8] This study also found that abortion care is extremely safe. Among the 11,487 first-trimester clinic-based procedures examined in the study, the overall complication rate was 1.3% and the major complication rate, defined as having involved hospital admission, surgery, or a blood transfusion, was 0.05%.

Restrictions on Medical Training for Abortion Procedures
Our research on abortion training for ob-gyn residents demonstrates that the skills learned during this rotation are essential for all ob-gyns, not only those intending to provide abortions in their medical practices. This training prepares doctors to treat women suffering from miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman. Bans on abortion training in residency programs will hamper their ability to provide essential care for women facing a variety of reproductive issues.[9]

Mandatory Ultrasound Laws
ANSIRH's research demonstrates that laws requiring women to view their ultrasounds before an abortion and would have a very limited effect on women's decision-making around abortion. Our study among 15,575 visits to a large US abortion provider demonstrated that, given the option to view the ultrasound, most women (57%) chose not to view.[10,2] When we examined whether viewing the ultrasound affected women's abortion decisions, we found that nearly all pregnancies (98.8%) were terminated: 98.4% of pregnancies among women who viewed their ultrasound

images and 99.0% of pregnancies among the patients who did not, with the difference attributable to women who were less decided about having an abortion being more likely to view.[11,3]

State-Mandated Counseling
Abortion regulations mandating state-approved counseling are based on the notion that current counseling practices fail to adequately inform women about the risks and benefits of the procedure. A study of 718 abortion patients from 30 US facilities revealed that the majority of women found counseling to be helpful. However, women who received counseling from abortion facilities in states requiring provision of specific information and/or state-approved written materials were significantly less likely to have found counseling helpful, compared with women receiving care at facilities in states without such restrictions.[12] Furthermore, the great majority of women are highly confident in their decision to terminate a pregnancy when they present at an abortion facility. Data from 5,109 abortion patients at a large US clinic demonstrated that, for 87% of the abortions sought, women had high confidence in their decision before receiving any counseling.[13]

Multiple visit requirements
Requiring women to complete an in-person informational visit in advance of an abortion does not appear necessary as most women are certain of their decision when they seek abortion care. The requirement also creates logistical challenges for women, requires them to tell more people about the abortion, adds costs for this already financially insecure population, and results in delays of more than a week between the initial visit and the abortion. [14]

Mandatory Waiting Periods
Our study of Utah's abortion waiting period suggests that requiring women wait 72 hours between an information visit and receiving an abortion actually results in delays of more than a week between the two visits. Waiting an additional week results in an extended period of nervousness about the procedure, ongoing nausea and pregnancy symptoms, and disruption of work and school responsibilities. For a very small number of women, this delay results in exceeding the gestational limit for abortion at the facility. This can put them at a gestation at which they can no longer afford the cost of the procedure and thus must continue the pregnancy.[15]

Reasons-based Abortion Bans
The reasons women seek abortion are complex and interrelated and include financial reasons, timing, partner-related reasons, and the need to focus on existing children. Almost two-thirds of women in one study reported multiple reasons for seeking an abortion.[16] Restricting access to abortion is the primary motivation for sex-selective abortion bans. Research demonstrates that sex-selective abortion bans are not associated with changes in sex ratios at birth. An analysis of sex ratios five years before and after sex-selective abortion bans enacted in Illinois and Pennsylvania were not associated with changes in sex ratios in those states.[17]

I thank you for your attention to the evidence. Based on this body of research, I don't believe that most restrictions on abortion improve women's health or wellbeing. Removing unnecessary restrictions can improve women's access to medical care.

Sincerely,

Diana Greene Foster, PhD.
Acting Director and Director of Research, ANSIRH
Associate Professor, Bixby Center for Global Reproductive Health
University of California, San Francisco

REFERENCES

[1] Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. (2013). Denial of Abortion Because of Provider Gestational Age Limits in the United States. American Journal of Public Health.
[2] American Public Health Association Annual Meeting 2012. 4241.0 Pivotal research on denial of abortion care: UCSF Turnaway studies, part 2
[3] Foster DG, Kimport K. Who seeks abortions at or after 20 weeks? Perspect Sex Reprod Health. 2013 Dec; 45(4):210-8
[4] Roberts SCM, Upadhyay U, Gould H, Weitz TA, Foster DG. Characteristics of women who would be affected by Georgia's ban on later abortions. Presentation. American Public Health Association. Boston, MA. November 2013
[5] Roberts SCM, Upadhyay U, Gould H, Weitz TA, Foster DG. Characteristics of women who would be affected by Georgia's ban on later abortions. Presentation. American Public Health Association. Boston, MA. November 2013
[6] Freedman LR, Stulberg DB. Conflicts in Care for Obstetric Complications in Catholic Hospitals. American Journal of Bioethics Primary Research. Vol 4 Iss 4, 2013
[7] Upadhyay UD, Desai S, Zlidar V, Weitz TA, Grossman D, Anderson P, et al. Incidence of Post-abortion Emergency Department Visits and Complications Among Nearly 55,000 Abortions Covered by the California Medi-Cal Program. Presented at: Department of Obstetrics, Gynecology, & Reproductive Sciences, University of California, San Francisco Grand Rounds; January 28, 2014, 2014.
[8] Weitz, T. A., Taylor, D., Desai, S., Upadhyay, U. D., Waldman, J., Battistelli, M. F., & Drey, E. A. (2013). Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. *American journal of public health*, *103*(3), 454-461.
[9] Lori R. Freedman, PhD, Uta Landy, PhD, and Jody Steinauer, MD, MAS, When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals, 98 American Journal of Public Health 1774 (2008).
[10] Kimport K, Upadhyay UD, Foster DG, Gatter M, Weitz TA. Patient viewing of the ultrasound image prior to abortion. *Contraception* 2013;88(5):666-70.
[11] Gatter M, Kimport K, Foster DG, Weitz TA, Upadhyay UD. Relationship between ultrasound viewing and proceeding to abortion. *Obstetrics and gynecology* 2014;123(1):81-7.
[12] Gould H, Foster DG, Perrucci AC, Barar RE, Roberts SC. Predictors of abortion counseling receipt and helpfulness in the United States. Women's Health Issues. 2013 Jul-Aug; 23(4):e249-55.
[13] Foster DG, Gould H, Taylor J, Weitz TA. Attitudes and decision making among women seeking abortions at one U. S. clinic. Perspect Sex Reprod Health. 2012 Jun;44(2):117-24.
[14] Roberts SCM. Turok D. Combellick S. Upadhyay U. Women's experiences with Utah's 72 hour waiting period for abortion care. Poster. National Abortion Federation Annual Meeting. April 2014, San Francisco.
[15] Roberts SCM. Turok D. Combellick S. Upadhyay U. Women's experiences with Utah's 72 hour waiting period for abortion care. Poster. National Abortion Federation Annual Meeting. April 2014, San Francisco.
[16] Biggs MA, Gould H, Foster DG. Understanding why women seek abortions in the US. BMC Women's Health. 2013; 13:29.
[17] Citro, B, Gilson J, Kalantry, S, Stricker, K. Replacing Myths with Facts: Sex-selective abortion laws in the United States. Chicago: The University of Chicago Law School, 2014.

345 Whitney Avenue
New Haven, CT 06511
p: 203.865.5158 · f: 203.624.1333
www.ppsne.org

Planned Parenthood of Southern New England

TO: Senator Patrick Leahy, Chair, US Senate Committee on the Judiciary
Senator Charles Grassley, Ranking Member

Written Testimony of Planned Parenthood of Southern New England
July 15, 2014
US Senate Committee on the Judiciary Hearing on the *Women's Health Protection Act*

Unlike states where politically-motivated restrictions have been placed on reproductive health care, Connecticut can point to positive social outcomes, because these services are seen through the lens of public health, not politics.

A strong body of law exists in CT protecting access to reproductive health care:

- Connecticut is a state where lawmakers and state public health officials, as well as advocates and health care providers have long agreed upon the importance of preserving confidential access to reproductive health care.
- Connecticut has a strong longstanding body of statute allowing confidential access to a range of sensitive health care including STD and HIV testing, mental health services, drug and alcohol abuse counseling, contraceptive and abortion access, which includes specific protections for minors who need to access these services.

Good state policy results in public health outcomes *we all can agree upon*:

- The sensitive nature of reproductive health services, combined with the unfortunate culture of silence that can surround the use of them, make it vital that individuals who need care have sure and direct pathways to providers, not additional barriers, costs, shame or judgment, or expensive, unnecessary medical procedures.
- Because services are conveniently located and funding for services is available, during the past few months medical staff at Planned Parenthood of Southern New England were able to diagnose 14 life threatening medical conditions, from ectopic pregnancy to breast and cervical cancer to choriocarcinoma.
- As a result of good state public policy surrounding reproductive health care, the number of abortions in Connecticut has decreased dramatically. Between 2008 and 2013 alone, the CT State Department of Health reported that the number of abortions obtained by women under age 20 decreased by 58% and decreased by 67% to women under age 18.

- Abortion is a safe and common medical procedure with about one in three American women experiencing an abortion by age 45. It is also among the safest medical procedures with less than 0.05% of procedures leading to complications that might involve hospital care.[1]

CT has obtained these results through sensible oversight not increased barriers to reproductive health care:

- The State of Connecticut Department of Public health both licenses and inspects all outpatient clinics offering reproductive health services.
- The State of CT does not require the unnecessary or excessive regulations regarding physical plant and layout that some states have adopted, targeting these rules specifically at centers where abortion is offered.
- Providers in Connecticut are guided by professionally accepted medical standards of care, not by politically driven laws that impact their profession and practice of medicine by requiring them to offer particular information or procedures. For instance, most abortion providers offer ultrasound as a standard practice, not because lawmakers have mandated that it be performed.

[1] Weitz,TA et al. American Journal of Public Health, 2013, 103(3): 454-461

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 15, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing on behalf of the Center for Reproductive Rights to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

Although the Supreme Court of the United States held in *Roe v. Wade* that a woman has the constitutionally protected right to decide whether or not to terminate her pregnancy, and nearly one in three women in this country will exercise that right, a woman's ability to safely and legally end a pregnancy is being steadily eroded, such that it is now dependent on where she happens to live.

The attached testimony outlines how states are restricting access to abortion under the pretext of protecting women's health, while they are in fact jeopardizing women's health by shutting down access to essential reproductive health care.

The Women's Health Protection Act would ensure that laws and regulations that truly advance health and safety are maintained, while dangerous regulations passed under pretext that stifle access to abortion care and endanger women's lives would be prohibited. We applaud the introduction of this essential legislation and thank you for the opportunity to submit our testimony in support.

Nancy Northup
President & CEO
Center for Reproductive Rights

120 Wall Street
New York, New York 10005
Tel. 917 637 3600 Fax. 917 637 3666
www.reproductiverights.org

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 11, 2014

Dear Chairman Leahy and Ranking Member Grassley:

We, the undersigned organizations, represent health care and public health professionals who care for women and their families every day. We write in support of the Women's Health Protection Act of 2013 (S. 1696).

For decades, politicians across the country have passed harmful restrictions on abortion in an attempt to roll back a woman's ability to make health care decisions for herself. In many states, the effect has been catastrophic. Abortion care has become virtually impossible to obtain for far too many women. In fact, six states - Arkansas, Mississippi, Missouri, North Dakota, South Dakota, and Wyoming - currently only have one abortion clinic.

Every woman has her own unique circumstances and must be able to make personal medical decisions, including the decision to have an abortion, without political interference. As health care providers and public health professionals, we work every day to make sure women receive the high-quality health care they need in a safe, respectful environment. Political intrusion into the patient-provider relationship is dangerous.

Abortion access has been in peril for several years. In recent years, however, politicians have increasingly sought new ways to interfere with the patient-provider relationship and undermine women's access to abortion care. State legislatures have been more active than ever in passing burdensome requirements that single out abortion providers and services and do nothing to advance women's health or safety. Politicians are not medical experts and yet politicians have written these laws with the end goal of having safe, legal abortion difficult or even impossible to access.

For example, states have approved:

- Requirements that health care providers perform tests and procedures even if they are not medically necessary;
- Measures that force health care providers to follow outdated medical guidelines rather than follow the current standard of care;
- Prohibitions on using telemedicine advancements for abortion;
- Regulations for women's health centers that are burdensome and medically unnecessary and serve only to make it harder for clinics to stay open;

- Requirements that physicians providing abortion maintain admitting privileges at local hospitals, despite the safety of abortion and the fact that admitting privileges are not necessary in the event of a complication;
- Measures that require a woman who has decided to have an abortion to make multiple unnecessary trips to the abortion provider; and
- Legislation forcing a woman to visit an anti-abortion "crisis pregnancy center."

These restrictions target abortion providers and women seeking abortion care with regulations and requirements that are not imposed on any other health care providers. Moreover, these laws and policies have been passed under the guise of protecting women, and in fact fail to improve women's health or safety because they are not based on medical and scientific evidence. These requirements greatly impede women's access to safe and legal abortion.

As groups representing health care and public health professionals across the country, we understand that abortion access is fundamental to women's health. Abortion is a safe medical procedure and complications are rare. These restrictions prevent health care providers from offering abortion care, limiting women's access to safe and comprehensive reproductive health care.

It is time to put a stop to laws that are unrelated to scientific evidence and are counter to the health care needs of patients. We need a federal law that will protect all women's access to abortion so that health care providers can deliver the best possible care. A woman's ability to obtain a safe and legal abortion should not depend on her zip code. We need the Women's Health Protection Act. We thank you for calling a hearing on this critical legislation and pledge our support in working toward its passage.

Sincerely,

American Congress of Obstetricians and Gynecologists
American Medical Student Association
American Medical Women's Association
American Nurses Association
American Public Health Association
Association of Reproductive Health Professionals
Medical Students for Choice
National Abortion Federation
National Family Planning & Reproductive Health Association
National Physicians Alliance
Physicians for Reproductive Health
Planned Parenthood Federation of America
Society for Maternal-Fetal Medicine

July 14, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley,

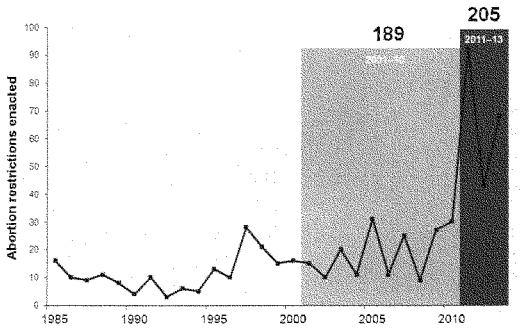
Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in support of the Women's Health Protection Act of 2013, S. 1696, for the July 15, 2014 hearing entitled: The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights.

The Guttmacher Institute is an independent, not-for-profit organization focusing on sexual and reproductive health research, policy analysis and public education in the United States and internationally. The Institute's work is considered authoritative and is cited as much by opponents of reproductive rights as by advocates of those rights. Guttmacher monitors, analyzes and regularly updates the status of state laws regarding a range of reproductive health and rights issues, including restrictions on access to abortion care. Moreover, the Institute has collected and analyzed a great deal of information on abortion incidence and trends nationwide.

The avalanche of restrictive state abortion laws, especially since 2010, demonstrates why the time is now for a federal law such as the Women's Health Protection Act (WHPA) to address the fact that in wide swaths of the country, access to abortion care is increasingly difficult if not impossible for many women.

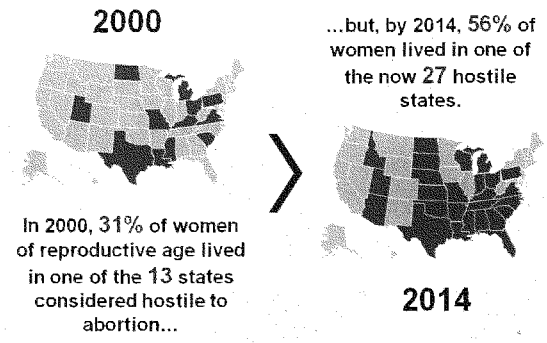
The primary purpose of the WHPA is to guard a woman's right and ability to access safe, legal abortion services and ensure that providers and health care facilities are not targeted by unwarranted restrictions. The bill would invalidate unnecessary and burdensome regulations known as targeted regulation of abortion providers (TRAP) and overturn policies on medication abortion that make it more difficult for women to access early abortion. The bill would also outlaw previability abortion bans and invalidate any laws that compel women to make multiple trips to the provider for reasons unrelated to medical necessity, be it state-dictated counseling or mandatory ultrasounds. Young women, poor women and women of color bear the brunt of the obstacles to care that these types of laws are creating and therefore have the most to gain from the bill's enactment into law.

Trends in State Laws. An unprecedented wave of state-level abortion restrictions swept the country over the past three years, as is described in the Institute's *Guttmacher Policy Review* article, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs*. In 2011–2013, legislatures in 30 states enacted 205 abortion restrictions—more than the total number enacted in the entire previous decade. No year from 1985 through 2010 saw more than 40 new abortion restrictions; however, each year between 2011 and 2013 topped that number.



In terms of sheer numbers, this wave of new restrictions has shifted the abortion policy landscape dramatically. To assess how and where the volume of abortion restrictions changed over time, analysts at the Guttmacher Institute identified 10 categories of major abortion restrictions and considered whether—in 2000 and 2014—states had in place at least one provision in any of these categories. A state was considered "supportive" of abortion rights if it had enacted provisions in no more than one of the restriction categories, "middle ground" if it had enacted provisions in two or three, and "hostile" if it had enacted provisions in four or more.

According to the analysis, the overall number of states hostile to abortion rights—and the proportion of U.S. women living in those states—has grown substantially since 2000, while the number of supportive and middle-ground states has shrunk:

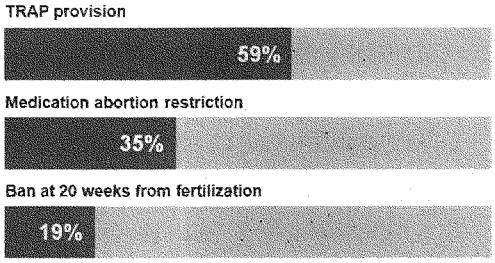


Antiabortion leaders disingenuously insist that these restrictions are necessary to protect women's health and safety. The safety of abortion, however, is well established. Rather, these restrictions burden women and potentially threaten their health. And they prevent providers from engaging in practices that are accepted as mainstream in other medical specialties. Simply put, restrictions on abortion make the procedure more costly—financially and in terms of women's health and safety.

Abortion Rate Is Declining. Antiabortion activists have been quick to jump on the recent wave of restrictions as the explanation for the reported decline in abortion in recent years. A Guttmacher study released earlier this year found that the U.S. abortion rate dropped 13% between 2008 and 2011, and had reached its lowest level since 1973. The dramatic drop during this most recent period cannot be explained by the recent rash of state restrictions, however, according to the *Guttmacher Policy Review* article *U.S. Abortion Rate Continues to Decline While Debate over Means to the End Escalates*. First, the abortion decline mostly predated the wave of new abortion restrictions. Moreover, since the drop in the abortion rate was accompanied by a steep drop in the birthrate too, it is clear that it was the drop in the overall pregnancy rate that was the underlying factor. The evidence shows that improved contraceptive use, including use of highly effective methods like the IUD and implant, was likely the main driver of the abortion decline by helping to reduce women's need for abortion care.

Women Pay the Price. Even though abortion restrictions appear not to have been a major factor in the most recent abortion decline, the analysis warns that such laws can have a severe financial and emotional impact on women even when falling short of deterring them from having an abortion. In 2014, 59% of women of reproductive age live in one of the 26 states with TRAP laws and 35% of women live in one of the 16 states that limit access to medication abortion. And research shows that the most coercive laws, those that significantly raise the economic cost for women seeking abortion care, can have a

measurable impact on abortion incidence by making abortion unattainable for the poorest and most vulnerable women.



Proportion of women of reproductive age living in state with abortion restriction

"Abortion opponents may try to cloak their policies in prowoman rhetoric, but the simple fact remains that these laws are intended to push reproductive decision making in one direction: toward pregnancy and childbearing," as the article explains. "Viewed this way, the question is not whether coercive approaches 'work' in reducing abortion incidence. Rather, these coercive approaches are unacceptable in principle. U.S. women and couples have been increasingly successful at achieving their goal of having small families, and they increasingly are doing so without relying on abortion. Even with abortion services legal and accessible to women who need them, abortion can become more rare—for all the right reasons."

Given the demonstrated hostility toward abortion rights in so many states, it is clear that enactment of the WHPA is necessary and urgent. In blocking key aspects of the concerted nationwide antiabortion campaign that neither promotes women's health nor can reduce the need for abortion, enacting the WHPA would begin to restore respect for and protection of women's health and dignity no matter where in the United States they live.

Thank you for the opportunity to provide these comments.

Sincerely,

Susan A. Cohen
Acting Vice President for Public Policy
Guttmacher Institute

United States Senate

Committee on the Judiciary

Hearing

"S.1696, The Women's Health Protection Act:

Removing Barriers to Constitutionally Protected Reproductive Rights"

July 15, 2014

Washington, DC

Testimony of: Kelly Blanchard, President; Amanda Dennis, Associate; Kate Grindlay, Senior Project Manager; Daniel Grossman, Vice President for Research; and Britt Wahlin, Director of Development and Communications

Ibis Reproductive Health
17 Dunster Street, Suite 201
Cambridge, MA. 02138
admin@ibisreproductivehealth.org
617-349-0040

Dear Chairman Leahy and Ranking Member Grassley:

We, at Ibis Reproductive Health (Ibis), offer this testimony in strong support of H.R. 3471: The Women's Health Protection Act of 2013. Ibis is a nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide. Our core activity is clinical and social science research on sexual and reproductive health issues receiving inadequate attention in other research settings and where gaps in the evidence exist. One of our priority research areas is exploring and documenting the impact of laws restricting access to or the provision of abortion care.

Since abortion was legalized in the United States (US) in 1973, states have created hundreds of laws limiting whether, when, and under what circumstances a woman may obtain an abortion.[1] In recent years, abortion restrictions passed at an alarming rate; from 2011 to 2013 states enacted 205 new restrictions on abortion, more than were enacted in the entire previous decade.[2]

Summary impact of laws restricting abortion

Those who propose and pass abortion restrictions often claim that the laws are designed to protect the health and well-being of women and their children.[3-5] However, a large and growing body of peer-reviewed, high-quality research shows that restricting abortion does not benefit women or their children. Instead, restrictions on abortion can lead to a number of emotional, financial, and physical harms. Some restrictions delay or make it more difficult to access abortion care, leading to negative emotional and financial outcomes and decreased well-being as women try to navigate abortion care hurdles.[6-11] Delays also increase the risks and costs of the abortion procedure. Other restrictions block access to abortion all together, interfering with women's abilities to make their own reproductive decisions and preventing their achievement of life plans and goals. Women denied abortion care are also at increased risk of experiencing poverty, physical health impairments, and intimate partner violence.[6,9, 12-20] Below, we provide more detailed information about the negative impacts of a selection of the abortion restrictions that would be addressed by The Women's Health Protection Act of 2013. We start with restrictions that we have researched extensively and then address restrictions studied by other well-respected researchers.

Impact of restricting telemedicine

Fifteen states require that a clinician be physically present when providing medication abortion, and in one additional state, Iowa, there is pending litigation.[21] These laws restrict the use of telemedicine, which is the delivery of health care services at a distance using information and communication technology. However, there are no data to support these restrictions. On the contrary, our research evaluating the use of telemedicine for medication abortion services in Iowa found that telemedicine provision of medication abortion is safe, effective, and acceptable to women and providers.[22-23] Ninety-nine percent of telemedicine patients had a successful abortion, and adverse events, such as going to the emergency room or needing a blood transfusion, were rare, occurring among 1% of patients seen either by telemedicine or in a face-to-face visit. While satisfaction with the abortion was high among all patients (91% reported they were 'very satisfied'), telemedicine patients were more likely to report they would recommend the service to a friend compared with face-to-face patients.[22] Our research has also shown that telemedicine availability resulted in women accessing abortion services at earlier gestational ages and increased access to services for women living in remote parts of the state.[24] Telemedicine is increasingly being used across medical specialties, and more than half of US hospitals use telemedicine in some way.[25] Restrictions on telemedicine for medication abortion are not evidence based, and limit women's access to high-quality abortion care, particularly in rural areas.

Impact of requiring women to make one or more medically unnecessary visits prior to abortion

In 35 states, women seeking an abortion must undergo counseling before obtaining an abortion. Eleven of these states require that counseling be provided in person, which means that women must make two separate trips to a facility to obtain an abortion.[26] We collaborated with the Guttmacher Institute and conducted an extensive review of the peer-reviewed literature evaluating the impact of these restrictions. We reviewed 12 papers in depth and determined that having to make one or more medically unnecessary visits prior to an abortion can delay a woman's access to abortion, and increase a woman's mental and physical distress. Our review also showed that these restrictions can increase the proportion of second-trimester abortions, which increases risks and costs of the procedure.[8] New research conducted since the literature review was completed shows that requiring women to make one more medically unnecessary visits prior to an abortion can bave a negative effect on their emotional well-being.[27]

Impact of requiring doctors to adhere to outmoded and less effective medication abortion regimens
Three states require that medication abortion be administered in accordance with the outdated US Food and Drug Administration labeling.[21] This forces doctors to administer early abortion medications in a way that does not reflect the best clinical evidence, denies women access to new, evidence-based regimens for care not reflected in the label, and reduces the number of providers able to offer medication abortion.[28] Although the labeling in the US does not reflect it, extensive clinical evidence and global best practice show that a reduced dose of mifepristone and home use of misoprostol is the gold standard.[29] It is common for health care providers to practice evidence-based medicine using approved medicines off-label in the US. Many women prefer medication abortion—in 2011, 36% of abortions before nine weeks' gestation were medication abortions[30]—and requiring an outmoded and less effective regimen for medication abortion singles out the procedure and ties the hands of health care providers trying to offer high-quality care, while having no medical benefit.

Impact of imposing ambulatory surgical center standards on facilities providing abortion
Currently, 26 states require that facilities providing abortion must meet the standards for ambulatory surgical centers (ASCs).[31] ASCs are outpatient facilities where patients can obtain surgical care without being in a hospital setting. Generally, ASCs provide much riskier and more invasive procedures than abortion providers. Meeting the extensive standards of an ASC can involve expensive changes to a clinic's physical infrastructure/building, such as expanding room sizes or corridors beyond what is necessary for patient care. Imposing ASC standards on facilities providing abortion care can reduce the number of providers able to stay open and offer care, limiting women's access to abortion. These standards also increase the cost of care, which can further impede access.[6]

Impact of imposing gestational age limits on abortion
Forty-two states restrict abortion beyond a certain gestational age.[32] Gestational age limits can prevent women from being able to access care and force them to continue unwanted pregnancies. They also force women needing abortions to spend time and money to travel to other states for their abortion care.[7] Not being able to access care because of gestational age limits can also reduce women's self-esteem and life satisfaction, and increase feelings of regret and anger.[7,17-19]

Compounding impacts of abortion restrictions
The overwhelming majority of states have more than one restriction on abortion in place.[33] This means that most women seeking care must navigate a number of different laws seeking to limit timely access to a legal and safe medical service. Facing numerous abortion restrictions simultaneously can delay access to care and increase the difficulty of obtaining care (if, for example, a woman has to take off work and arrange childcare to comply with multiple visit requirements). When abortion is delayed and the logistical challenges of accessing the service increase, the out-of-pocket costs of the procedure also increase. Increasing the cost of the procedure can interfere with women's personal medical decisions, undermine women's autonomy by putting care out of financial reach, delay women even further from obtaining abortion care while they search for the financial resources to pay for abortion out-of-pocket, force women and their families to endure financial hardships to afford care, and force women who cannot afford abortion care to continue unwanted pregnancies,[9-11,34] which can push women into poverty.[14]

Conclusion

An extensive body of high-quality, peer-reviewed research has documented the significant harmful effects of abortion restrictions for women and their families. Women need a federal law that will protect them from these harmful restrictions, and put their health and rights first. If enacted, The Women's Health Protection Act of 2013 will prevent legislators from limiting women's ability to get high-quality, evidence-based health care and ensure women can access constitutionally-protected services. Passing the law would enable women to implement their own private, medical decisions and allow medical providers to follow best practices and offer safe, legal, high-quality health care. We urge the committee to support this fight for the health and well-being of women and their families. Please give support to this historic piece of legislation.

References

1) NARAL Pro-Choice America. Who decides? The status of women's reproductive rights in the United States, 23rd edition. *NARAL Pro-Choice America*; 2014. Available at: http://bit.ly/1hnhhez. Accessed June 25, 2014.
2) Nash E, Gold RB, Rowan A, Rathbun G, Vierboom Y. Laws affecting reproductive health and rights: 2013 state policy review. *Guttmacher Institute*; 2014. Available at: http://bit.ly/19D9l9h. Accessed June 25, 2014.
3) Texas 83rd Legislature. Senate Bill 5: An act relating to the regulation of abortion procedures, providers, and facilities; providing penalties. Available at: http://bit.ly/SZt0c0. Accessed June 25, 2014.
4) Oklahoma Legislature. Enrolled Senate Bill 1274: The heartbeat informed consent act. Available at: http://bit.ly/1k9jw9q. Accessed June 25, 2014.
5) State of Arizona, House of Representatives, 50th Legislature. House Bill 2036: An act relating to abortion. Available at: http://1.usa.gov/1nM8Eyl. Accessed June 25, 2014.
6) The University of Texas at Austin. The Texas Policy Evaluation Project: How abortion restrictions would impact five areas of Texas. *The University of Texas at Austin*; August 2013. Available at: http://bit.ly/1hj0Xzx. Accessed June 25, 2014.
7) Jones BS, Weitz TA. Legal barriers to second-trimester abortion provision and public health consequences. *American Journal of Public Health*. 1999;99(4):623-630.
8) Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard K. The impact of state mandatory counseling and waiting period laws on abortion: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1pFcVmG. Accessed June 25, 2014.
9) Henshaw SK, Joyce TJ, Dennis A, Finer LB, Blanchard K. Restrictions on Medicaid funding for abortions: A literature review. *Guttmacher Institute*; 2009. Available at: http://bit.ly/1alMlcA. Accessed June 25, 2014.
10) Dennis A, Blanchard K. A mystery caller evaluation of Medicaid staff responses about state coverage of abortion. *Women's Health Issues*. 2012;22(2):e143-e148.
11) Dennis A, Blanchard K. Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study. *Health Services Research*. 2013;48(1):236-252.
12) Joyce TJ, Henshaw SK, Dennis A, Finer LB, Blanchard K. The impact of laws requiring parental involvement for abortion: A literature review. *Guttmacher Institute*; April 2009. Available at: http://bit.ly/1pFcVmG. Accessed June 25, 2014.
13) Chibber KS, Foster DG. Receiving versus being denied an abortion and subsequent experiences of intimate partner violence. APHA Annual Meeting & Expo; October 30, 2012; San Francisco.
14) Foster DG, Roberts SCM, Mauldon J. Socioeconomic consequences of abortion compared to unwanted birth. APHA Annual Meeting & Expo; October 30, 2012. San Francisco.
15) Foster DG, Dobkin L, Biggs MA, Roberts S, Steinberg J. Mental health and physical health consequences of abortion compared to unwanted birth. APHA Annual Meeting & Expo; October 30, 2012. San Francisco.
16) Grossman D, Holt K, Peña M, et al. Self-induction of abortion among women in the United States. *Reproductive Health Matters*. 2010;18(36):136-146.
17) Upadhyay UD, Weitz TA, Jones RK, Barar RK, Foster DG. Denial of abortion because of provider gestational age limit in the United States. *American Journal of Public Health*. August 2013; epub ahead of print.
18) Biggs MA, Upadhyay UD, Steinberg JR, Foster DG. Does abortion reduce self-esteem and life satisfaction? *Quality of Life Research*. April 2014; epub ahead of print.
19) Rocca CH, Kimport K, Gould H, Foster DG. Women's emotions one week after receiving or being denied an abortion in the United States. *Perspectives on Sexual and Reproductive Health*. 2013;45(3):122-31.
20) Gold RB, Nasb E. TRAP laws gain political traction while abortion clinics—and the women they serve—pay the price. *Guttmacher Policy Review*. 2013;16(2):7-12.
21) Guttmacher Institute. State policies in brief: Medication abortion. *Guttmacher Institute*; June 2014. Available at: http://bit.ly/1ke23vY. Accessed June 6, 2014.

22) Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and acceptability of medical abortion provided through telemedicine. *Obstetrics & Gynecology*. 2011;118(2, Part 1):296-303.
23) Grindlay K, Lane K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. *Women's Health Issues*. 2013;23(2):e117-22.
24) Grossman DA, Grindlay K, Buchacker T, Potter JE, Schmertmann CP. Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa. *American Journal of Public Health*. 2013;103(1):73-8.
25) American Telemedicine Association. Telemedicine frequently asked questions. Available at: http://bit.ly/1qP7C4n. Accessed July 17, 2014.
26) Guttmacher Institute. State policies in brief: Counseling and waiting periods for abortion. *Guttmacher Institute*; June 2014. Available at: http://bit.ly/U17fJC. Accessed June 6, 2014.
27) The Texas Policy Evaluation Project. Impact of abortion restrictions in Texas: Research brief. Available at: http://bit.ly/1o6r8Ic. Accessed July 18, 2014.
28) Linnane R. Wisconsin law increases abortion delays, risk. *WisconsinWatch.org*; 2013. Available at: http://bit.ly/1o7LfFS. Accessed June 25, 2014.
29) World Health Organization. Safe abortion: Technical and policy guidance for health systems. Geneva: World Health Organization; 2012.
30) Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. *Perspectives on Sexual and Reproductive Health*. 2014;46(1):3-14.
31) Guttmacher Institute. State policies in brief: Targeted regulation of abortion providers. *Guttmacher Institute*; June 2014. Available at: http://bit.ly/LzzolX. Accessed June 6, 2014.
32) Guttmacher Institute. State policies in brief: State policies on later abortions. *Guttmacher Institute*; June 2014. Available at: http://bit.ly/1isGcj3. Accessed June 6, 2014.
33) Guttmacher Institute. State policies in brief: An overview of abortion laws. Guttmacher Institute, July 2014. Available at: http://bit.ly/1iAuL5u. Accessed July 21, 2014.
34) Dennis A, Manski R, Blanchard K. Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women. *Journal of Health Care for Poor and Underserved*. In press.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 18, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing in support of S. 1696, the Women's Health Protection Act.

I am an obstetrician-gynecologist practicing in Utah. I recently completed a family planning fellowship at the University of Utah in Salt Lake City and will be staying in Utah to provide much-needed health care services in under-served areas. I have made patient advocacy a professional focus in addition to publishing clinical research and providing high-quality medical care. I received my medical degree from the University of Illinois at Chicago and completed a residency in obstetrics and gynecology at Albert Einstein Medical Center in Philadelphia.

As a physician who performs abortions as part of comprehensive medical care, the Women's Health Protection Act allows doctors to practice the safest kind of medicine: evidence-based medicine. Many of the state laws that are passed are directed at abortion providers under the guise of safety. If that were true, other doctors in other specialties should have to conform to the same laws for the procedures they perform that carry the same, if not higher, risks. This is not the case. The testimony given by Dr. Chireau was inaccurate on many counts, including providing research data that is outdated and poorly done. (That is to say, research that was either not peer-reviewed or has not held up to academic scrutiny.) Below are some examples of state-level laws that are passed and how they actually harm, not help, people and their families. I practice medicine in a conservative state and know first-hand the damage that having my hands tied by the law can do to people.

1. The Mandated Use of Ultrasound

Legislators have decided that they know better than doctors when and how ultrasounds should be used in abortion care. Some laws require a woman to receive written information regarding her right to see the ultrasound, some obligate her to see the ultrasound, and some not only force her to see the image but also obligate the physician to describe the image to her in detail. Research shows that ultrasound mandates don't change a woman's mind, because a woman has usually thought long and hard about her

decision to terminate her pregnancy.[1] I am currently required by law to ask my patients if they would like to see the ultrasound. In my own experience, many say yes; however, none of my patients have changed their minds after seeing the image. The mandate only serves to increase health care costs by subjecting women to unnecessary tests in these instances. There are many versions of these laws, depending on the state in which the physician practices. How and when a doctor performs an ultrasound prior to an abortion depends on these laws, not what is medically relevant to provide the best health care to the patient.

Ultrasounds are used by women's health professionals for valid medical reasons, including ruling out ectopic pregnancies and determining how far along a pregnancy is. This test is performed prior to the abortion, but there is no medical reason for it to be performed on the same day as the abortion. Ultrasounds should not be used for political or other purposes that fall outside of a standard of medical necessity.

We routinely show the patient an ultrasound image if she asks or if she agrees to view images for educational purposes. Laws that require women to view or hear her ultrasound against her will violate her rights and presume that she is uneducated about what pregnancy means. In no other area of medicine are doctors required to show patients images of their bodies or organs.

2. Bans on the Use of Telemedicine

Many areas of the country have few or no physicians, and health care resources are scarce. In these areas, the ability to counsel patients using modern technology such as video conference calls can actually mean the difference between receiving health care and not. Restrictions on the use of telemedicine means a woman may not have the opportunity to speak to a doctor regarding her pregnancy options: continuing the pregnancy and becoming a parent, continuing the pregnancy to ultimately place the child up for adoption, or terminating the pregnancy. Women deserve to be informed of all of their options in a timely manner, especially when a pregnancy is in question, and this may be safely done via phone or web interface. I see women who have traveled upwards of 500 miles to have an abortion, which is not easy for most women when you consider travel expenses, child care, and time off work. Similar to mandated waiting periods, having women make more than one trip when a tele-consult would suffice is a considerable burden in many areas of the country. *It does nothing to promote patient safety or quality of care.*

Physicians often counsel patients — their own patients and patients of other physicians if on-call — over the phone regarding symptoms, medications, and therapy options. Doctors also deliver the babies of their colleagues' patients as a standard practice, despite childbirth being 14 times riskier than a first trimester abortion. Abortion care is

[1] Kimport K, Preskill F, Cockrill K, Weitz T. Women's perspectives on ultrasound viewing in the abortion care context, Womens Health Issues. 2012 Nov-Dec;22(6):e513-7. doi: 10.1016/j.whi.2012.09.001. Epub 2012 Oct 5, available at http://www.ncbi.nlm.nih.gov/pubmed/23040800.

no different than other health care in this way. Legislative requirements for same-provider counseling or in-person counseling don't advance patient safety or quality of care and only create roadblocks to getting needed care.

In some innovative telemedicine programs, nurses dispense medical abortion medication after an initial, earlier visit with a physician to establish the pregnancy and discuss options. There is no safety reason why women should not be able to receive these medications in a separate office from a nurse after tele-approval by a physician.[2]

3. Regulation of Outpatient Clinics as Ambulatory Surgical Centers

A variety of states have imposed requirements that outpatient clinics conform to the same or similar regulations as an operating room in a hospital. These requirements can include anything from having wider doorways to having equipment in the room for general anesthesia (even though it is not used). These laws force the conversion of a perfectly safe outpatient clinic into a surgical suite that has features above and beyond the needs of the procedures being performed. In many areas of the country, such as mine, requiring abortion clinics that are already up to code and medical standards to meet additional ambulatory surgical center standards will leave those clinics destitute, resulting in women with fewer options for safe care (including many procedures unrelated to abortion care, such as cancer screenings).

Abortion is a procedure that is generally safely done in an outpatient setting. Its potential complication risks are no different than many other outpatient medical procedures performed in a provider's office. State laws should not require abortion care to be performed in settings that meet ambulatory surgical center standards as other medical procedures with similar risk profiles do not face the same requirements. None of the practices in which these other medical procedures are performed (colonoscopy, for example) are required to adhere to more complex surgical center standards.

Hysteroscopy and many assisted reproductive technology procedures such as taking a look inside the uterine cavity with a camera are performed in outpatient clinics that are not surgical centers. The procedures use instruments inside the uterus with the same risks of perforation, hemorrhage, and infection as an abortion procedure. Truth be told, the surgical management of a miscarriage is exactly the same as a first trimester surgical abortion. Exactly the same. I am permitted to perform a dilation and curettage in my clinic as long as it is in the context of a miscarriage, however this is not so in the case of the termination of an otherwise normal pregnancy. The only difference is discrimination against the pregnant person's fertility desires.

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[2] Grindlay K, Lake K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. Womens Health Issues. 2013 Mar-Apr;23(2):e117-22. doi: 10.1016/j.whi.2012.12.002. Epub 2013 Feb 12, available at http://www.ncbi.nlm.nih.gov/pubmed/23410620.

4. Waiting Periods and Gestational Age Limit Bans

Despite federal law upholding legal access to an abortion until fetal viability, many states are passing their own laws that reduce the gestational age limit for legal abortion procedures. Depending on the state in which she lives, a woman may have an abortion only before 20 or 22 weeks, effectively reducing the time she has to make her life-altering decision. A variety of states have also imposed waiting periods: the length of time between receiving informed consent for an abortion and the time of receiving the actual procedure which may range anywhere from 24 to 72 hours. These may seem like conflicting concepts, and that's because they are. One law effectively requires a more expedited decision process so as not to exceed the reduced gestational age limit, while the other requires a woman to wait longer under the guise of allowing her to make a more thoughtful decision. I take care of many women whose pregnancies have been diagnosed with horrible diseases and conditions incompatible with life, and these women must endure the knowledge of their very desired baby's diagnosis. Often these traumatic diagnoses are made after 20 weeks. She may have the diagnosis near (or past) that state's gestational age limit, which would require her to go to another state to terminate or to carry a pregnancy full-term, undergoing the risks of pregnancy and childbirth, only to watch her newborn suffer and die. Pregnancy, like other conditions such as cancer or heart disease, is time-sensitive and requires expedited treatment, not arbitrary delays imposed by the state.

My state, like many others, requires a waiting period before a woman can have an abortion. These laws are especially intrusive for women seeking pregnancy terminations. They presume women haven't considered their pregnancy options carefully and need "extra time" to be sure. If this is the case, much more dangerous procedures such as organ transplants, brain surgery, plastic surgery, etc. should also require waiting periods. Additionally, these unnecessary regulations and their exceptions are often confusing and may result in requiring a victim of rape or incest to suffer longer because she is waiting for the procedure to be allowed. Being forced to delay the provision of abortion care can also increase the cost and risk of the procedure and thus further delay it, sometimes pushing the pregnancy into the next trimester and bumping up against gestational age bans.

5. Requirements for Admitting Privileges to Local Hospitals

Legislation recently enacted in Texas requires abortion providers to have admitting privileges to a hospital located within 30 miles of their clinic. To understand why this is problematic, it is necessary to understand that, in order to practice medicine at a given hospital, a physician must have admitting privileges to that hospital. This allows the patients a doctor takes care of to be admitted to and cared for as an inpatient of that hospital. Admitting privileges, however, are not required to practice medicine at an outpatient clinic as an outpatient clinic — by its definition — does not have the capacity to provide inpatient care. Many other states have placed similar regulations on abortion providers, resulting in shortages of legal abortion providers when hospitals decide not to

or, in many cases, are disallowed from granting "those" physicians admitting privileges. There is no medical justification for this policy and it is a danger to women's ability to access care.

Once again, in no other specialty are physicians required to have admitting privileges to a hospital in order to perform outpatient procedures. For decades, abortion has been provided safely in an outpatient setting and, if complications arose, the physician would call for an ambulance to take the patient to the hospital. Patients taken to a hospital emergency room are treated whether their provider has admitting privileges or not. With these laws, hospitals wind up under tremendous pressure to deny privileges to abortion providers. In the case of Mississippi, the last clinic may close because the only abortion provider in the state is being denied admitting privileges, leaving women in that state with no in-state provider. Recent legislative efforts in Texas would close several rural clinics in already under-served areas, leaving many women hundreds of miles from care.

The Women's Health Protection Act is a critical response to this ever-increasing onslaught of politically motivated restrictions on abortion care masquerading as health and safety regulations. Thank you for holding this important hearing to shine a spotlight on this alarming trend.

Sincerely,

Leah Torres, MD, MS
Salt Lake City, UT

The Women's Health Protection Act: Beginning to Reclaim a Woman's Right to Choose

Testimony presented by

Ilyse Hogue
President
NARAL Pro-Choice America

On behalf of:
Illinois Choice Action Team
NARAL Pro-Choice Arizona
NARAL Pro-Choice California
NARAL Pro-Choice Colorado
NARAL Pro-Choice Connecticut
NARAL Pro-Choice Maryland
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice Minnesota
NARAL Pro-Choice Missouri
NARAL Pro-Choice Montana
NARAL Pro-Choice New Hampshire
NARAL Pro-Choice New Mexico
NARAL Pro-Choice New York
NARAL Pro-Choice North Carolina
NARAL Pro-Choice Ohio
NARAL Pro-Choice Oregon
NARAL Pro-Choice South Dakota
NARAL Pro-Choice Texas
NARAL Pro-Choice Virginia
NARAL Pro-Choice Washington
NARAL Pro-Choice Wisconsin
NARAL Pro-Choice Wyoming

U.S. Senate
Committee on the Judiciary

July 15, 2014

Members of the Judiciary Committee: I am pleased that you are holding today's hearing and am honored to submit this testimony for the record.

Today the panel will discuss the Women's Health Protection Act (S.1696), a bill that takes a modest but important first step in reclaiming a woman's constitutionally protected right to choose. NARAL Pro-Choice America works not just to support and protect, as a fundamental right and value, a woman's reproductive freedom, but to expand her ability to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion. The Women's Health Protection Act is a modest first step toward ensuring that *all* women have access to reproductive-health care, regardless of their zip code.

Choice Under Attack

In 1973, the Supreme Court held in *Roe v. Wade* that the Constitution's right to privacy encompasses the right to choose whether to end a pregnancy.[1] Well into its fourth decade, *Roe*'s protections remain an essential guarantor of freedom for American women, but in the years since this landmark decision, *Roe*'s protections have been eroded significantly; now, reproductive freedom is in great peril.

After the *Roe* decision, opponents of reproductive freedom, both inside and outside government, organized and undertook a concerted effort to chip away strategically at the right to choose through a series of legislative attacks. At the same time, they succeeded in nominating and confirming anti-choice jurists to the federal bench, all but guaranteeing that, over time, anti-choice state and federal laws would be upheld.

As a result of this strategy, the composition of the nation's highest court shifted dramatically by the time anti-choice legal advocates mounted their next major attack on *Roe* itself. In 1992 in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the newly more conservative court barely reaffirmed the decision in *Roe*, and at the same time sharply curtailed its protections. The *Casey* court abandoned the strict-scrutiny standard of review and adopted a less protective standard that allows states to impose restrictions as long as they do not "unduly burden" a woman's right to choose.[2] Under this new standard, the court cleared the way for state restrictions that it had previously found to violate the right to privacy and effectively invited states to impose new barriers on women's access to abortion.[3] Indeed, under *Casey*'s looser standard, courts have allowed a multitude of state restrictions to be imposed upon reproductive freedom and choice.[4] Abortion bans, mandatory waiting periods, biased-counseling requirements, and medically unnecessary regulations on doctors have unfortunately achieved their intended result: it is more difficult for women to obtain safe, legal abortion care today than it was in 1973, just after the *Roe* decision was handed down.

Now, anti-choice advocates are taking the next step: having already severely restricted women's access to legal abortion nationwide, now they are looking to put the procedure totally out of reach for many American women. Since 1995, state legislatures have enacted 807 anti-choice laws, and the pace accelerated steeply in the past three years. In 2011, after a wave of conservative lawmakers swept into office, state legislatures enacted nearly twice as many anti-choice measures as the previous year, a trend that shows no sign of slowing.

Many of the current restrictions were enacted under the guise of protecting women's health. In reality, however, anti-choice strategists' real goal is to shrink the number of abortion providers and to place so many barriers between women and legal abortion that the procedure is, for all practical purposes, out of reach. The following is a sample of the most prominent recent anti-choice state restrictions sweeping the nation:

- **Abortion Bans**: Since 2011, abortion bans have spread across the states, from those that outlaw abortion before a woman may even know she is pregnant to those that target later abortion. Indeed, 13 states ban abortion after 20 weeks without an adequate health exception.[5] Sponsors admit that abortion bans are part of an alarming, coordinated effort to lure the Supreme Court into dismantling the protections established by *Roe.*

- **Targeted Regulations of Abortion Providers (TRAP)**: Forty-five states and the District of Columbia have laws subjecting abortion providers to burdensome restrictions not imposed on other medical professionals.[6] These measures are an obvious attempt to drive doctors out of practice and make abortion care more expensive and difficult to obtain. Common TRAP regulations include those that limit the provision of care only to doctors, require doctors to convert their practices needlessly into mini-hospitals at great expense, limit abortion care to hospitals, rather than physicians' offices, and/or require doctors to have admitting privileges at a local hospital with nothing requiring facilities to grant such privileges.

- **Mandatory Ultrasound**: Twenty-four states have some type of ultrasound provision on the books with varying degrees of severity; several other states are considering such measures.[7] The most egregious of these laws mandate the performance and review of an ultrasound prior to abortion, regardless of whether the doctor recommends this procedure, and even against a woman's will.

- **Biased Counseling and Mandatory Delays**: Thirty-three states have laws that subject women seeking abortion services to biased-counseling requirements and/or mandatory delays. These laws subject women to a state-mandated lecture and/or materials, typically followed by a delay of at least 24 hours, and in some cases as long as 72 hours. In states with very few providers, a forced delay may result in a woman having to wait as long as another full week for her medical care – which makes it more expensive, increases the risks of the procedure, and in some cases, puts it out of reach altogether.

- **Restrictions on Medication Abortion**: Seventeen states have signed measures into law that restrict the use of medication abortion (also known as RU 486), which provides women with a safe and effective nonsurgical option for early pregnancy termination.[8] Anti-choice politicians fought FDA approval of this abortion option for decades, at every step. Having lost that fight, now they are doing all they can to restrict access to the medication, including restricting how it is delivered, restricting off-label use of the medication,[9] and banning its prescription through telemedicine networks.[10]

The Consequences for Women are Real

These restrictions represent more than just an abstract threat to our constitutional rights. Indeed, the hundreds and hundreds of anti-choice laws imposed on women have had very real and dire consequences:

- Several states only have one abortion provider.[11] In some of those, the doctor flies in from another state and provides services only one day a week.[12] As a result, women seeking abortion care in those states are severely limited in their options.

- In Texas, after the legislature imposed sweeping anti-choice restrictions on women last year, all abortion providers in the lower Rio Grande Valley stopped providing the procedure. Now that vast region has no abortion provider at all.[13] And new research shows that seven percent of all women in Texas who ultimately reached a provider tried first to self-abort.

- Anti-choice legislators have systematically enacted laws across the country banning abortion after 20 weeks. In some cases, such as the American Southeast, they have succeeded in creating entire regions across multiple states where there is no provider who can legally offer later abortion care. Although women need access to later abortion for a variety of reasons, many women who end pregnancies after 20 weeks are doing so because they are facing severe health threats or have recently received a diagnosis of a devastating fetal anomaly.

- NARAL Pro-Choice America's *Who Decides?* publication rates 25 states—half the country—with an F grade for reproductive rights, based on their state laws.[14] According to the Guttmacher Institute, more than half of all women in the country of reproductive age live in the states most hostile to abortion rights.[15]

Pre-*Roe* Hazards Could Reemerge

Effects like those described above could, if the trend is not reversed, signal the reemergence of a grim reality America once knew. When *Roe v. Wade* was decided in January 1973, abortion except to save a woman's life was banned in nearly two-thirds of states.[16] Laws in most of the remaining states allowed only a few additional exceptions.[17] An estimated 1.2 million women

each year resorted to illegal abortion,[18] causing as many as 5,000 annual deaths,[19] despite the known hazards of frightening trips to dangerous locations in strange parts of town, of whiskey as an anesthetic, doctors who were often marginal or unlicensed practitioners, unsanitary conditions, incompetent treatment, infection, hemorrhage, disfiguration, and death.[20]

Doctors who worked in emergency rooms before 1973 saw first-hand the consequences of illegal abortion. Dr. Louise Thomas, a New York City hospital resident during the late 1960s, summed up the dangers of illegal abortion, remembering the "Monday morning abortion lineup" of the pre-*Roe* period:

> What would happen is that the women would get their paychecks on Friday, Friday night they would go to their abortionist and spend their money on the abortion. Saturday they would start being sick and they would drift in on Sunday or Sunday evening, either hemorrhaging or septic, and they would be lined up outside the operating room to be cleaned out Monday morning. There was a lineup of women on stretchers outside the operating room, so you knew if you were an intern or resident, when you came in Monday morning, that was the first thing you were going to do.[21]

Today, because it is legal, abortion is one of the safest medical procedures available. Between 1973 and 1997, the mortality rate associated with legal abortion procedures declined from 4.1 to 0.6 per 100,000 abortions.[22] The American Medical Association's Council on Scientific Affairs credits the shift from illegal to legal abortion services as an important factor in the decline of the abortion-related death rate after *Roe v. Wade.* [23]

In the years since *Roe v. Wade*, hundreds of thousands of American women's lives have been saved. But as new restrictions put safe, legal abortion care out of reach again, the dangers women faced in the years before *Roe* already have begun to reappear.

All Women Should Have Access to Reproductive-Health Care

In the face of these legislative assaults on women's reproductive rights, the Women's Health Protection Act erects a protective barrier. This legislation would establish federal protections against anti-choice measures that purport to protect women's health but are really about taking away their right to choose. In so doing, the Women's Health Protection Act stands for the belief that women can and should be trusted to make these personal, private medical decisions without interference from politicians. Women across the nation welcome this effort to repel the cascade of medically unnecessary and politically motivated restrictions on access to abortion care.

If anti-choice forces prevail in their efforts, Dr. Thomas' experience in the New York hospital wards during the 1960s is likely to be repeated. Studies show that the more restrictions are placed on abortion care, the less accessible the medical procedure becomes. And history

demonstrates that restricted access does not eliminate abortion; rather, in an anti-choice climate, women are forced to seek control over their reproductive lives in any way possible, often risking serious injury or death. Lifting abortion restrictions reduces the number of clandestine, unsafe abortions. Removing unnecessary and inappropriate barriers to abortion care would improve women's health, and spurious claims that abortion services are dangerous should never be used to justify more restrictions on a woman's right to choose.[24] The Women's Health Protection Act stands as a much-needed and long-overdue response to the cascade of state restrictions on abortion care that *endanger*, not protect, women's health.

On behalf of NARAL Pro-Choice America and its more than one million member activists around the country, we urge the committee to ensure that all women, regardless of where they live, are able to realize their constitutionally protected right to choose. Passing the Women's Health Protection Act would be a modest but welcome step in the right direction.

[1] *Roe v. Wade*, 410 U.S. 113, 153 (1973).

[2] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), at 876.

[3] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), at 881-87.

[4] Between 1995 and 2006, states enacted 512 anti-choice legislative measures—including 45 in 2006 alone. *See generally* NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women's Reproductive Rights in the United States* (19th ed. 2010), *at* http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/.

[5] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? A State-by-State Report on the Status of Women's Reproductive Rights*, at 11 (23rd ed. 2013), at www.prochoiceamerica.org/whodecides.

[6] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? A State-by-State Report on the Status of Women's Reproductive Rights*, at 19 (23rd ed. 2013), at www.prochoiceamerica.org/whodecides.

[7] NARAL Pro-Choice America, *Forced Ultrasound Legislation is an Egregious Intrusion into Medical Care* (2014).

[8] In addition to internal analysis, data from this section is complemented with data from: Guttmacher institute, *State Policies in Brief: Medication Abortion* (May 1, 2014) at http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (last visited May 23, 2014).

[9] OHIO R.C. § 2919.123.

[10] W.S.A. § 253.105. In response to the vague and unnecessary restrictions imposed by the new law, Planned Parenthood of Wisconsin and Affiliated Medical Services stopped providing medical-abortion care. Pro-choice allies pursued a legal challenge—which is still ongoing—but the law has been temporarily enjoined and providers resumed providing non-surgical abortion care. Press Release, NARAL Pro-Choice Wisconsin, *Another Wisconsin Health Provider Ceases Medication Abortion in Face of Vague New Regulations* (May 22, 2012) at http://www.wispolitics.com/1006/052212NARAL.pdf (last visited Dec. 11, 2013).

[11] There is only one abortion provider in North Dakota, South Dakota, Arkansas, Mississippi and Missouri. National Abortion Federation, *How Can I Find a Provider Near Me?* at https://www.prochoice.org/Pregnant/find/ (last visited July 10, 2014).

[12] NARAL Pro-Choice America, *Targeted Regulation of Abortion Providers (TRAP) Laws: Decreasing Access, Driving Providers Away* (Jan. 2014) at http://www.prochoiceamerica.org/media/fact-sheets/abortion-access-trap.pdf (last visited July 10, 2014).

[13] Statement of Daniel Grossman, researcher, co-author Texas Policy Evaluation Project, at Ibis Reproductive Health (Mar. 2014) at http://www.ibisreproductivehealth.org/news/documents/Grossmanstatement03_06FINAL.pdf (last visited July 10, 2014).

[14] NARAL Pro-Choice America, *Who Decides?* (Jan. 2014) at http://www.prochoiceamerica.org/assets/download-files/2014-wd-report-card.pdf (last visited July 10, 2014).

[15] Guttmacher Institute, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Sere—in the Crosshairs* (Winter 2014) at http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html (last visited July 10, 2014).

[16] *Roe*, 410 U.S. at 118-119 n.2.

[17] *See, e.g.*, DEL. CODE ANN., tit. 24, §§ 1790-1793.

[18] Willard Cates, Jr. et al, *Comment: The Public Health Impact of Legal Abortion: 30 Years Later*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 25 (2003); Willard Cates Jr., *Legal Abortion: The Public Health Record*, 215 SCIENCE 1586 (1982); Richard Schwarz, SEPTIC ABORTION 7 (1968).

[19] The estimated number of deaths from illegal abortion services (e.g. 5,000) has been derived from the findings of several studies. The following is a summary of these studies: "Difficulty as it is to accumulate statistics in this area, a surprising similarity has been noted in various studies independently made within the last thirty years. If general trend observed is accepted, without becoming sidetracked in disputes over exact numbers of methodology, we must consider the probability that more than one million criminal abortions will have been performed in the United States in 1962, and more than five thousand women may have died as a direct result." Zad Leavey & Jerome M. Krummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 S. CAL. L. REV. 124 (1962) (citing to Gebhard, et al, PREGNANCY, BIRTH AND ABORTION 136-137 (1958); Frederick Taussig, ABORTION SPONTANEOUS AND INDUCED: MEDICAL AND SOCIAL ASPECTS 25 (1936); Marie Kopp, BIRTH CONTROL IN PRACTICE 222 (1934); Stix, *A Study of Pregnancy Wastage*, 13 MILBANK MEMORIAL FUND QUARTERLY 347, 355 (1935); MODEL PENAL CODE § 207.11, comment, p. 147 (Tent. Draft No. 9, 1959.). "It has been estimated that as many as 5,000 American women die each year as a direct result of criminal abortion. The figure of 5,000 may be a minimum estimate." Richard Schwarz, SEPTIC ABORTION 7 (1968) (citing to Taussig, 23-28, which discusses the original mathematical formula used for determining that somewhere between 8,000 and 10,000 women died each year from illegal abortion.).; "One recent study at the University of California's School of Public Health estimated 5,000 to 10,000 abortion deaths annually." Lawrence Lader, ABORTION 3 (1966) (also citing to Edwin M. Gold et al, *Therapeutic Abortions in New York City: A Twenty-Year Review*, in New York Dept. of Health, Bureau of Records and Statistics (1963), which discussed Dr. Christopher Tietze's estimate of nearly 8,000 deaths from illegal abortion annually in the United States. The estimate was based on the number of illegal abortions in New York City, the only major municipality keeping abortion statistics.); "[M]ore than five thousand women may have died as a direct result [of criminal abortion in the United States in 1962]." Zad Leavy & Jerome M. Kummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 S. CAL. L. REV. 123, 124 (1962); "Taussig and others have concluded that the abortion death rate during the late 1920s was about 1.2% and amounted to over 8,000 deaths per year." Russell S. Fisher, *Criminal Abortion, in* Harold Rosen, THERAPEUTIC ABORTION, MEDICAL PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL, AND RELIGIOUS CONSIDERATIONS 8 (1954).

[20] Walter Dellinger & Gene B. Sperling, *Abortion and the Supreme Court: The Retreat from* Roe v. Wade, 138 U. PA. L. REV. 83, 117 (Nov. 1989).

[21] Carole Joffe, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER *ROE V. WADE* 60 (1995).

[22] Laurie D. Elam-Evans et al., Centers for Disease Control & Prevention, *Abortion Surveillance – United States, 1999*, 51 MORBIDITY & MORTALITY WEEKLY REP. 1, 28, tbl. 19 (2002).

[23] Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After* Roe v Wade: *Trends in the Mortality and Morbidity of Women*, 268 JAMA 3231, 3232 (1992).

[24] Anne Tinker & Marjorie A. Koblinsky, *World Bank Discussion Papers: Making Motherhood Safe*, at 40-41 (1993).

NCJW®

National Council of Jewish Women

New York Office
475 Riverside Drive, Suite 1901
New York, NY 10115
Tel 212 645 4048
Fax 212 645 7466
Email action@ncjw.org

Washington Office
1707 L Street, NW Suite 950
Washington, DC 20036-4206
Tel 202 296 2588
Fax 202 331 7792
Email action@ncjwdc.org

Israel Office
NCJW Research Institute for Innovation in Education, Room 267
Hebrew University, Mt. Scopus
Jerusalem, Israel 91905
Tel 972 2 5882 208
Fax 972 2 5813 264
Email ncjwisrael@gmail.com

Web www.ncjw.org

July 15, 2014

The Honorable Patrick Leahy, Chairman
The Honorable Chuck Grassley, Ranking Member
US Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

RE: Full committee hearing, "S 1696: The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"

Written testimony in support of S 1696, submitted electronically.

Dear Chairman Leahy and Ranking Member Grassley:

The National Council of Jewish Women (NCJW) is a grassroots organization of volunteers and advocates who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children and families, and by safeguarding individual rights and freedoms.

Founded in1893, NCJW has a long history of strong support for the protection of every female's right to reproductive choices, including safe and legal abortion; access to contraception; and the elimination of obstacles that limit reproductive freedom. The ninety-thousand members, volunteers, and supporters of NCJW affirm abortion as an essential component in the spectrum of comprehensive, confidential, affordable reproductive health services that must be accessible to women, regardless of age, ability to pay, or other factors. Ensuring that all women have access to comprehensive reproductive health services, particularly including abortion, is essential to a woman's health, economic opportunity, and to her full equality.

We believe that each woman must have the right to exercise her own moral judgment when making personal decisions, including those that affect her reproductive life. Reproductive freedom is integral to a woman's religious liberty. A woman must be able to make decisions about her reproductive health according to her own religious beliefs, moral values, or faith tradition. For a woman to be able to make her own decisions, she must have access to the care and services she needs.

A FAITH IN THE FUTURE.

A BELIEF IN ACTION.®

Statement of National Council of Jewish Women
In Support of S 1696/HR 3471, the Women's Health Protection Act

NCJW is deeply troubled that, despite each woman's *de jure* constitutional right to end a pregnancy, the ability of a woman in the United States to access abortion has become dependent upon where she lives as well as her income. This landscape obstructs reproductive justice, the ability of a woman to fully exercise her reproductive rights regardless of her age, income, race, or other factors. State legislators have advanced restrictions that make abortion more difficult for women to access, and for health professionals to provide. These restrictions harm women's health, economic security, and religious liberty; and fall hardest on women and families who are marginalized in our communities, particularly those who are poor or low income and people of color.

Given this reality, the Women's Health Protection Act is urgently needed to restore a woman's ability to access abortion no matter where she lives, and restore her ability to truly make moral decisions about her health and well-being without political interference.

The Women's Health Protection Act would make unlawful any policy or regulation which singles out abortion services for limits that are more burdensome than those imposed on medically comparable procedures; those which do not significantly advance women's health or the safety of abortion care; and which make abortion services more difficult to access. Over the past several years, conservative state lawmakers have intensified their attacks on access to abortion, reaching unprecedented levels. More state restrictions have been enacted in the past four years than in the prior decade[1]. Recent trends include targeted regulation of abortion providers (or TRAP laws), placing medically unnecessary, onerous restrictions on clinics and providers; banning the use of telemedicine to provide abortion or forcing providers to adhere to outmoded regimens in the provision of medication abortion; and pre-viability or "later abortion" limits that ban abortion at an arbitrary gestational limit, among others. Taken together, more than half — or 56-percent[2] — of all women of reproductive age in the US currently live in states "hostile to abortion," where care is difficult or nearly impossible to access.

Such restrictions do not reduce the need for this abortion, but they erode women's rights and risk harming women and their families with far-reaching consequences. For many women, barriers to abortion only serve to make complex decisions even more difficult. This could have been the case for Dr. Julie Bindeman, a clinical psychologist who practices in Rockville, Maryland, who needed abortion later in pregnancy. In March 2014, Julie spoke to NCJW's 46th national convention about her experience, when our organization honored her with a "Women Who Dared" award for her courage in reproductive justice advocacy.

Julie and her husband had one son and wanted another child. Her first pregnancy in this effort resulted in miscarriage, a devastating outcome for her and her family. She was happy when she became pregnant after a second try, but the experience did not begin as she anticipated. She experienced blood clots and was put on "pelvic rest" for a week. Eventually, additional tests showed her developing fetus was

[1] Heather Boonstra and Elizabeth Nash, "A surge of state abortion restrictions puts providers – and the women they serve – in the crosshairs," *Guttmacher Policy Review*, Winter 2014 (http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html)
[2] Ibid.

Statement of National Council of Jewish Women
In Support of S 1696/HR 3471, the Women's Health Protection Act

healthy, so she went to her doctor for a 20-week ultrasound eager to learn its gender. The ultrasound showed she was having a boy, but the additional information gained from the scan showed complications. As Julie explains:

> *Our OB…told us that the ultrosound showed our child's brain ventricles were nearly twice the size they should be. My husband and I sat in stunned silence, and we slowly began to cry deep sobs of pain.*
>
> *…We then met with several specialists to get second and third opinions [from experts at Children's Hospital], including a radiologist, pediatric neurosurgeon, and genetic counselor. Each specialist confirmed the horrible news: our best case scenario, if the baby even survived to term, was that our son would have the developmental ability of a two-month-old.*
>
> *The diagnosis was ventriculamegaly and hydrocephalus, with likelihood of ancephaly [severe brain malformations]. We were told our two options: we could terminate the pregnancy, or carry to term and see what happened. I asked point blank about the chances of a miracle. The doctors at [Children's Hospital] tend to be 'hope-givers,' but for my question they had no optimistic outcome to share.*
>
> *We decided to end the pregnancy, [making a decision the day before Thanksgiving.] I somehow made it through the holiday completely in a fog, trying to ignore the kicks that were getting stronger. These kicks had no conscious thought behind them, nor would ony of my son's actions. [While Maryland allows surgical abortion at this stage of pregnancy, there were no providers in the state.] I wanted to be around family, so we decided to deliver locally. My husband and I went to the hospital and worked with the medical team to induce labor. My son died soon after delivery and I was discharged the next day. I was 21 weeks gestation.*

For Julie, ending her pregnancy was an emotionally fraught and painful decision. Thankfully, because she lived in Maryland, this decision remained hers to make. Had Julie lived in one of the 10 states that now ban abortion at about 20 weeks postfertilization[3], she might have been forced to carry her pregnancy to term. The Women's Health Protection Act would help women and families facing similar situations by making unlawful bans on abortion based on arbitrary gestational limits.

Julie's story further illustrates that every pregnancy is different. Not every pregnancy ends the way a family hopes it will; some end in miscarriage, sometimes a woman develops health complications, and in some cases, women hear difficult news from their doctors that something is wrong with their pregnancy. Just as each pregnancy is different, so is every woman's personal circumstances. According to the Guttmacher Institute, one in three women will have an abortion in her lifetime; each of their stories are as different as the lives they live. A woman may be facing an unintended pregnancy and knows she is not ready to become a parent; seeking to build her family, but facing difficult news about a severe fetal anomaly; or, already a mother who knows she cannot afford to raise another child. No matter her

[3] Guttmacher Institute, "States continue to enact abortion restrictions in first half of 2014, but at a lower level than in the previous three years," News in Context, July 8, 2014 (http://www.guttmacher.org/media/inthenews/2014/07/08/index.html)

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circumstance, a women must be free to make personal decisions about her health and reproductive life without political interference.

Current state interference in these decisions harms some women more than others, and can jeopardize their economic security. For example, women and families struggling to make ends meet, who today are disproportionately people of color, face steeper challenges to overcome restrictions on access to care than their neighbors with greater resources. Access barriers can impose great financial burdens on women and families, with far-reaching consequences: a woman may be forced to delay needed care, unnecessarily increasing the risk of an otherwise safe procedure, or shut off her phone or utilities just to pay for the care she needs. Indeed, recent studies show that a woman who seeks abortion services but is denied is three times more likely to fall into poverty than a woman who can access this care[4]. This threat to women's financial security and independence is another critical reason why we support the Women's Health Protection Act.

Safe, timely, accessible care is another reason why women need this legislation. Julie was able to obtain the quality care she needed near her home and family, but many women are seeing abortion services in their communities shrink dramatically or disappear altogether. A survey of clinics, state health departments and local abortion rights advocacy organizations conducted by The Huffington Post found that "at least 54 abortion providers across 27 states have shut down or ended their abortion services in the past three years" (from 2010-2013) primarily as a result of TRAP laws' onerous requirements[5]. Additionally, the Guttmacher Institute reports that nearly 60-percent of women of reproductive age now live in one of the 26 states with one or more TRAP restrictions[6]. Such statistics are appalling. When a woman decides to obtain an abortion, it is critical that she have access to safe, timely medical care, the availability of which should not depend on where she lives. The Women's Health Protection Act would help reverse this dangerous trend, ensuring that women across the country can access needed care.

Another critical reason why women need this legislation is the protection of women's religious liberty and moral agency. Julie was able to make a decision that was best for her and her family, in the context of her own religious, moral, and ethical beliefs and values. Despite it being their constitutional right, women in other states may not have that choice in reality, given restrictions on access to care. As a result, women who seek abortion, but are denied, see their religious liberty eroded along with their reproductive freedom.

As a faith-based women's organization, NCJW understands that those who would restrict women's access to abortion and other reproductive health services are often motivated by their religious beliefs. However, it is essential to recognize that there is no single religious teaching on these issues. The Jewish tradition teaches that, during a pregnancy, the life of the mother takes precedence over the potential life

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[4] Joshua Lang, "What Happens to Women Who are Denied Abortions?" *New York Times*, June 12, 2013 (http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=all&_r=1&)
[5] Laura Bassett, "Anti-abortion laws take dramatic toll on clinics nationwide," The Huffington Post, August 8, 2013 (http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html)
[6] Guttmacher Institute, "States continue to enact abortion restrictions in first half of 2014, but at a lower level than in the previous three years," News in Context, July 8, 2014 (http://www.guttmacher.org/media/inthenews/2014/07/08/index.html)

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of a fetus, particularly as "Judaism does not believe that personhood and human rights begin with conception, but with birth."[7] Different religions have differing views on when life begins, on attitudes towards abortion, and other reproductive health issues. Even within religions, there can be varying opinions.

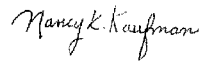
Our nation has answered the questions of this pluralism by upholding the key, founding principle and constitutional right of religious freedom. NCJW is committed ensuring that every person be given due respect for holding their own religious beliefs with regard to abortion and other healthcare. But we firmly believe it is unjust to privilege one view over another by enacting laws that restrict access to legal healthcare, in order to deny a woman from making her own faith-informed decisions about her health and family. Each person of faith, and those who do not follow a religious tradition, must be allowed to make their own faith or conscience-informed decision. For the legislature to mandate one religion's views on this very personal issue is to restrict religious liberty for all.

The decision to choose adoption, end a pregnancy, or become a parent are deeply personal. They may be complicated and challenging, as for NCJW honoree, Dr. Julie Bindeman. But no matter a woman's circumstances or where she lives, our lawmakers have a duty to protect her constitutional right to make this decision, based on her own religious beliefs and moral values and in the context of her life.

State legislators are eroding women's rights and freedoms. They are placing women's health, well-being, and economic security at risk as they aggressively enact unprecedented levels of restrictions on abortion. It is time for Congress to step in to provide women and their families with the federal protection they urgently need.

NCJW urges Congress to swiftly pass the Women's Health Protection Act and see it enacted into law. Thank you for your consideration of this testimony.

Sincerely,



Nancy K. Kaufman, CEO
National Council of Jewish Women

[7] The Rabbinical Assembly, "Resolution on reproductive freedom," February 2007, (http://www.rabbinicalassembly.org/resolution-reproductive-freedom)

July 22, 2014

The Honorable Patrick Leahy, Chair
The Honorable Charles Grassley, Ranking Member
Senate Judiciary Committee
Washington, DC 20510

Dear Chairman Leahy and Ranking Member Grassley:

Thank you for the opportunity to submit this statement on behalf of the National Network of Abortion Funds in support of S. 1696, the Women's Health Protection Act, on which a hearing was held before the Senate Judiciary Committee on July 15, 2014.

The National Network of Abortion Funds was founded in 1993 and includes more than 80 abortion funds in the United States, Mexico, Canada and the United Kingdom. Every day, our funds serve women who need abortion care and are struggling financially. Each year we help over 24,000 women obtain abortion care they otherwise would not be able to obtain. We know first-hand the impact of restrictions that make abortion more unavailable and unaffordable.

Restrictions on abortion create significant obstacles for women seeking care. This impact falls most on women who are struggling financially to make ends meet. Because of the connection between racial discrimination and economic disadvantages, they are disproportionately more likely to be women of color and immigrant women, and are often younger as well. Women with lower socioeconomic status – specifically those who are least able to afford out-of-pocket medical expenses – already experience disproportionately high rates of adverse health conditions. Denying access to abortion care only exacerbates existing health disparities.[1]

Studies show that most Americans do not have enough savings to cover a financial emergency, which means they have to borrow, sell or pawn personal items, or divert money from another financial obligation to cover emergencies such as an unexpected health care need.[2] This,

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[1] Foster DG, Roberts SCM and Mauldon J, Socioeconomic consequences of abortion compared to unwanted birth, abstract presented at the annual meeting of the American Public Health Association, San Francisco, Oct. 27–31, 2012. Available at https://apha.confex.com/apha/140am/webprogram/Paper263858.html.

[2] National Foundation for Credit Counseling, Majority of Americans do not have money available to meet an unplanned expense, news release, Aug. 15, 2011. Available at http://www.nfcc.org/NewsRoom/newsreleases/FLOI_July2011Results_FINAL.cfm, accessed Aug. 20, 2013. Cited in Boonstra, HD, "Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest." *Guttmacher Policy Review*, Vol. 16, No. 3, 2013.

P.O. Box 170280 • Boston, MA 02117 • Tel. 617-267-7161 • Fax 617-267-7160
info@fundabortionnow.org • www.fundabortionnow.org

combined with the growing challenges in finding affordable abortion care, make it increasingly difficult for women to safely and legally end their pregnancies.

Abortion restrictions that increase the delays or cost of an abortion force many women to delay their procedure for as long as two to three weeks. The cost and potential health risks of the procedure increase the longer they wait.[3]

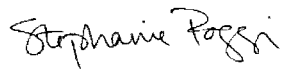
Not only do these laws create more burdens for low-income women, but they contribute to poverty. Studies show that a woman who seeks an abortion but is denied is three times more likely to fall into poverty than one who is able to get an abortion.[4]

The Women's Health Protection Act, which dismantles many of the barriers for women seeking abortion services, will contribute to a healthier country in which every woman can get affordable and available pregnancy related care, including birth control, maternal care, and abortion services. While it addresses some of the important barriers to care, it does not address one of the most formidable, which is insurance coverage, especially through Medicaid.

The Hyde Amendment has banned the federal government from covering abortion for women enrolled in Medicaid, or Indian Health Services, women in the military, Peace Corps or in federal prisons, except in cases of rape, incest, or endangerment to the life of the woman. These policies unjustly interfere with a woman's ability to make the decision best for her and her family.

We applaud the important and necessary progress the Women's Health Protection Act will make for the health, rights, and dignity of women and families. And we urge you to work to repeal harmful insurance coverage restrictions that also interfere with the self-determination of so many in our nation. We urge you to pass the Women's Health Protection Act because every woman deserves the ability to make her own important life decisions about pregnancy, wherever she lives and however much she makes.

Sincerely,



Stephanie Poggi
Executive Director

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[3] National Foundation for Credit Counseling, Majority of Americans do not have money available to meet an unplanned expense, news release, Aug. 15, 2011. Available at http://www.nfcc.org/NewsRoom/newsreleases/FLOI_July2011Results_FINAL.cfm, accessed Aug. 20, 2013. Cited in Boonstra, HD, "Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest." *Guttmacher Policy Review*, Vol. 16, No. 3, 2013.

[4] Foster DG, Roberts SCM and Mauldon J, Socioeconomic consequences of abortion compared to unwanted birth, abstract presented at the annual meeting of the American Public Health Association, San Francisco, Oct. 27–31, 2012. Available at https://apha.confex.com/apha/140am/webprogram/Paper263858.html.

"S. 1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"

Testimony submitted by

Debra Ness, President
Sarah Lipton-Lubet, Director of Reproductive Health Programs
Melissa Safford, Policy Advocate

U.S. Senate Judiciary Committee
Chairman Patrick Leahy and Ranking Member Charles Grassley

July 15, 2014

1875 connecticut avenue, nw ~ suite 650 ~ washington, dc 20009 ~ phone: 202.986.2600 ~ fax: 202.986.2539
email: info@nationalpartnership.org ~ web: www.nationalpartnership.org

The National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)(3) organization located in Washington, D.C. We have worked tirelessly for over forty years to expand access to quality, affordable health care for all Americans that includes comprehensive reproductive health services; to eliminate discrimination in the workplace; and to enable women and men to meet the dual demands of work and family. The National Partnership strongly supports S. 1696, the Women's Health Protection Act, and we urge the Senate to pass this important legislation.

The Women's Health Protection Act Would Begin to Reverse the Devastating Impact of Years of Callous Attacks on Women's Access to Abortion Care.

Women's access to abortion care is under attack in states across the country. According to the Guttmacher Institute, from 2011 to 2013, states enacted more abortion restrictions than in the entire previous decade. In 2013 alone, 22 states passed 70 abortion restrictions, making it increasingly difficult for health care providers to offer abortion care and for women to access this vital health care service. While states have an important role to play in regulating the medical profession, when those regulations do not comport with medical standards or when they directly interfere in the relationship between women and their health care providers, lawmakers have abused their authority. Legislatures pass these laws under the guise of protecting women's health, but in reality, they jeopardize it. The bottom line is that these laws make abortion care more difficult to access, and women's health and safety is threatened when they are unable to get the health care they need.

All women deserve access to affordable, high-quality care and the treatment options that best meet their needs. Yet laws that place onerous restrictions on abortion care make abortion more difficult to access, especially for low-income women. They can also force health care providers to choose between adhering to their ethical and professional obligations to provide the highest standard of care and following restrictions enacted in pursuit of a political agenda. The Women's Health Protection Act would reverse this distributing trend by ensuring that women can make personal health care decisions for themselves regardless of where they live.

The Women's Health Protection Act Would Protect the Patient-Provider Relationship by Ensuring that Medical Professionals are Able to Make Decisions Based on Their Best Medical Judgment.

There is a strong national consensus that quality care should be evidence-based and patient-centered, and should improve health outcomes. Health care providers, the federal government, state and local governments and patient advocates across the country are all investing significant resources in promoting high-quality care. According to the Institute of Medicine – an independent, nonprofit organization that serves as the health arm of the National Academy of Sciences – *quality care is care that*

meets the patient's needs and is based on the best scientific knowledge. It is the right care at the right time in the right setting for the individual patient. However, when it comes to regulation of abortion care, things are moving in the opposite and wrong direction. States are enacting restrictions that undermine the high-quality, patient-centered care that health care providers and advocates strive to achieve.

For example, thirteen states have passed laws mandating an ultrasound before an abortion. While ultrasound is frequently used as a standard part of abortion care, best practices and medical ethics indicate that it should be administered only when the health care provider believes it is necessary for medical purposes or when the patient requests it. Laws requiring a provider to administer an ultrasound regardless of the patient's individual circumstances, along with other state-directed mandates such as forcing a provider to display the image and describe it – even when a woman objects – undermine quality care. It is a violation of medical standards to use a procedure to influence, shame or demean a patient. These laws usurp the medical judgment of health care providers and ignore the needs and best interests of women.

Another example of these harmful laws include those that prohibit a provider from using evidence-based standards to administer medication abortion or ban the use of telemedicine to provide this care. Eighteen states have passed such restrictions, which have no basis in, or are contrary to, medical evidence. These laws restrict a woman's ability to access appropriate, evidence-based care in a timely manner and in the most appropriate setting, undermining quality care.

Medication abortion is a safe, nonsurgical abortion method in which medications are used to end a pregnancy. This method is medically indicated for certain women, and others may choose it because it provides them more control and it is more private. This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure. Yet several states have prohibited the use of evidence-based prescribing when it comes to medication abortion. These states require providers to adhere to an outdated protocol that is found on the label for the medication abortion drug, as initially approve by the FDA in 2000, rather than allowing providers to administer it according to the most up-to-date research.

It is common practice – and often representative of the best quality care – for providers to follow the medical community's evidence-based regimen in lieu of the protocol found on a medication's label. The American Medical Association has voiced its "strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion." Yet some laws restricting medication abortion make it a crime for a health care provider to follow the most up-to-date standard of care.

Years of use in the field, as well as additional research and clinical studies, allow doctors to learn much more about a drug and adjust the standard of practice based on

the most current scientific evidence. The best practices for care consistently evolve as new evidence is collected, while an FDA label will typically not be updated unless the manufacturer was to advertise the drug for a new purpose and, even then, only when the manufacturer has gone through a complicated and expensive updating process.

Major medical organizations across the United States and the world have endorsed the more recently developed, evidence-based regimen for medication and abortion. As the American College of Obstetricians and Gynecologists and the American Medical Association have jointly stated, "evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA over 13 years ago," adding that the evidence-based regimen is "superior" to the FDA protocol.

The other way states are restricting access to medication abortion is by prohibiting it from being provided using telemedicine. Telemedicine is a safe way to make health care more accessible, especially to women in underserved areas. Consultation through video conferencing, where a patient interacts with a remote provider is a common and growing method of providing care. When medication abortion is administered via telemedicine, a woman first has a face-to-face meeting with a trained medical professional at a health care clinic where she receives information about the medication and the process. The woman then meets with a physician via a video conference system to review her medical records and ask questions. Once the medical visit is completed, the physician authorizes the clinic to administer the medication.

The American College of Obstetricians and Gynecologists has determined that medication abortion "can be provided safely and effectively via telemedicine with a high level of patient satisfaction," and that laws banning telemedicine are contrary to medical evidence. Studies comparing face-to-face medication abortion provision with medication abortion via telemedicine show equivalent effectiveness and rates of positive patient experience. Telemedicine patients particularly valued being able to receive abortion care at clinics closer to their homes.

The Women's Health Protection Act would prohibit these onerous restrictions that interfere in the patient-provider relationship, as well as others that target abortion care and serve only to restrict access to this important health care service for women.

Lawmakers Should Acknowledge and Support Health Care Providers' Ethical and Professional Obligation to Put Their Patients First, and Should Strive to Improve the Quality of Care – Not Undermine it.

The National Partnership recognizes that states have an appropriate role to play in regulating the medical profession, but stepping into the exam room with an ideological agenda, overriding providers' medical judgment, ignoring patients' needs, and erecting barriers to constitutionally protected reproductive rights is an unacceptable overreach.

The National Partnership urges all lawmakers to reject regulations or actions that inappropriately infringe on the relationship between patients and their health care providers, or that require providers to violate accepted, evidence-based medical practices and ethical standards. Laws that are based on ideology and not sound medical evidence, and that single out abortion care for restrictions that are more burdensome than those imposed on medically comparable care or make abortion care more difficult to access, must be taken off the books.

Conclusion

All women deserve access to high-quality abortion care and the treatment options that best meet their needs without unnecessary, ideological, and political barriers. The National Partnership for Women & Families urges the Senate to pass S. 1696, the Women's Health Protection Act, to protect women's health and to ensure that health care decisions are made by women and their health care providers – not by politicians.

Source: *Bad Medicine: How a Political Agenda is Undermining Women's Health Care*, National Partnership for Women & Families, July 2014.

Testimony Submitted for the Record

Judy Waxman
Vice President for Health and Reproductive Rights
National Women's Law Center

Hearing on S. 1696, The Women's Health Protection Act of 2013
U.S. Senate Committee on the Judiciary

July 15, 2014

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The Center utilizes a wide range of tools – including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education – to achieve gains for women and their families, including protecting and advancing women's reproductive health and rights.

The National Women's Law Center is writing in strong support of S. 1696, the Women's Health Protection Act. We urge the Senate to pass this legislation.

Women Have a Constitutional Right to Decide Whether to Have an Abortion

Over forty years ago, the Supreme Court held that the constitutional right to privacy includes a woman's right to decide whether to have an abortion.[1] The Supreme Court's recognition of that right has made a significant difference in women's lives, and women and their families have come to rely upon it. As the Supreme Court said when it reaffirmed *Roe* in its 1992 decision *Planned Parenthood v. Casey*, "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[2]

State Politicians are Increasingly Encroaching upon that Right, Leaving a Woman's Constitutional Right Dependent upon the State in which She Lives

Despite *Roe*'s promise to women, anti-abortion politicians in the states have continued their push to further challenge the core constitutional protections for a woman's decision to have an abortion. In the last three years alone, states have passed a record number of abortion restrictions – more than in the entire previous decade.[3] These laws are a dangerous overreach into a woman's personal medical decisions, and are creating a country where a woman's constitutional right to abortion depends upon her zip code.

Some of these laws are blatant attempts to override *Roe v. Wade* and the constitutional parameters established by the Supreme Court. For example, the Court made it clear in *Roe v. Wade*, and reaffirmed in *Planned Parenthood v. Casey*, that states cannot ban abortion prior to viability. Yet, in 2013, North Dakota passed a law banning abortion as early as six weeks of pregnancy, which is before most women even know they are pregnant, and Arkansas passed a law banning abortion at 12 weeks of pregnancy.[4] The Women's Health Protection Act reaffirms that under federal law, as under the U.S. Constitution, these blatant attempts to take away abortion prior to viability are unlawful.

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[1] Roe v. Wade, 410 U.S. 113 (1973).

[2] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

[3] *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*, GUTTMACHER INSTITUTE, http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html.

[4] H.B. 1456, 63d Leg. Assemb., Reg. Sess. (N.D. 2013) (codified as N.D. CENT. CODE § 14-02.1-05.1 to -.2 (2013)), *invalidated by* MKB Mgmt. Corp. v. Burdick, No. 1:13-CV-071, 2014 WL 1653201 (D.N.D. Apr. 16, 2014), *appeal filed*, No. 14-2128 (8th Cir. May 14, 2014); S.B. 134, 89th Gen. Assemb., Reg. Sess. (Ark. 2013) (codified as ARK. CODE ANN. § 20-16-1301 to -1307 (2013)), *invalidated in part by* Edwards v. Beck, No. 4:13CV00224SWW, 2014 WL 1245267, at *4 (E.D. Ark. Mar. 14, 2014) (holding twelve-week ban on abortion unconstitutional and permanently enjoining enforcement of § 20-16-1304), *appeal filed*, No. 14-1891 (8th Cir. Apr. 16, 2014).

Many of the state laws being passed restrict access to abortion not by banning it outright but by singling out the provision of abortion services for restrictions that are more burdensome than those imposed on other medical procedures and making it more difficult or expensive to obtain. In fact, 26 states regulate abortion providers beyond what is necessary to ensure patient safety.[5]

For example, laws requiring abortion providers to obtain medically unnecessary hospital admitting privileges. There is no medical reason for these laws, and plans are already in place in the rare case of an emergency. That is why groups like the American Medical Association and the American Congress of Obstetricians and Gynecologists oppose these laws, which are written with the goal of making access to safe and legal abortion hard or even impossible.

In Mississippi, where the state passed an admitting privileges law in 2012, doctors who provide abortions at the sole abortion clinic in the state were denied privileges at every hospital to which they applied.[6] Making it clear that this law was not about protecting women, the author of the legislation said, "The intent of the legislation is to cause fewer abortions. So if the [one clinic left in Mississippi] had to shut down, then I think it is a positive day for the unborn."[7] Fortunately, a federal district judge blocked the law while the lawsuit moves forward, so that Mississippi women who need abortion care are not forced to leave the state.[8] However, women living in the Texas Rio Grande Valley are not so lucky. The Fifth Circuit Court of Appeals upheld Texas's admitting privileges requirement, despite the fact that it is causing clinics to close and forcing these women to travel 150 miles to access an abortion provider.[9]

The Women's Health Protection Act will make it clear that such restrictions – and others that unfairly target only abortion providers, make abortion more difficult for women to access, or have no medical or clinical justification – are unlawful.[10] This will establish a clear standard across states, and help protect the constitutional right to privacy of each woman, no matter where she lives.

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[5] *State Policies in Brief: Targeted Regulation af Abortion Providers*, GUTTMACHER INST. (July 1, 2014), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

[6] Associated Press, *Legal Woes for Mississippi's Only Abortion Clinic*, USA TODAY, Jan. 11, 2013, http://www.usatoday.com/story/news/nation/2013/01/11/abortion-mississippi-women-clinic/1828289.

[7] M.J. Lee, *Bill Dooms Only Miss. Abortion Clinic*, POLITICO (Apr. 5, 2012), http://www.politico.com/news/stories/0412/74871.html#ixzz37fV2gAwW.

[8] A federal judge prevented the law from going into effect while the lawsuit, *Jackson Women's Health Organization v. Currier*, proceeds. *See* Press Release, Center for Reproductive Rights, Federal Judge Blocks All Enforcement of Mississippi Admitting Privileges Requirement (Apr. 15, 2013), http://reproductiverights.org/en/press-room/federal-judge-blocks-all-enforcement-of-mississippi-admitting-privileges-requirement. The state appealed the temporary injunction, and the Fifth Circuit heard arguments in the case in April 2014. Press Release, Center for Reproductive Rights, Fifth Circuit Considers Mississippi Law Designed to Shutter Last Clinic in the State (Apr. 28, 2014), http://reproductiverights.org/en/press-room/Fifth-Circuit-Considers-Mississippi-Law-Designed-to-Shutter-Last-Clinic-in-the-State.

[9] Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 597 (5th Cir. 2014).

[10] Restrictions such as requiring women to undergo a mandatory ultrasound or visit anti-abortion crisis pregnancy centers and those that put medically unnecessary restrictions on the use of medication abortion would also be unlawful under Sec. 4(a) of the Women's Health Protection Act.

Conclusion

In the four decades since Roe v. Wade was decided, women and their families have come to rely upon the fundamental constitutional protection of a woman's decision to have an abortion. Although *Roe* – and the right to privacy and liberty upon which it relies – has been repeatedly reaffirmed by the Supreme Court, attacks upon the right continue. As these attacks on women's access to reproductive health care continue unabated, the ability of women to obtain the health care they need has never been at greater risk. That is why the National Women's Law Center supports the Women's Health Protection Act, which is necessary to enshrine in federal law the principle that each woman, no matter in which state she lives, has access to safe, legal abortion services as guaranteed under the U.S. Constitution. The National Women's Law Center strongly urges the Committee and Congress to pass S. 1696.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 22, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

The New York Abortion Access Fund writes in support of the Women's Health Protection Act, which protects the ability to obtain abortion services by dismantling many of the barriers that currently exist for people seeking this important healthcare. Every individual faces their own unique circumstances, challenges, and potential complications, and must be able to make her own decisions based on their doctor's advice, their personal values, and what's best for the individual and her family. Everyone needs affordable and accessible pregnancy-related care, including abortion, regardless of where they live and notwithstanding their economic, political, or personal situation. We urge Congress to pass the Women's Health Protection Act, and uphold our nation's promise of equal rights under the Constitution, so that everyone can make personal reproductive health decisions with dignity.

Despite the clear constitutional rights established in *Roe v. Wade*, a growing number of individuals are finding it increasingly challenging to access abortion care. In our communities throughout the country, it has become extremely difficult for people to safely and legally end a pregnancy because states have enacted laws singling out reproductive health care for onerous regulations that are not imposed on other areas of medicine. Low income people, people of color, and young people are more likely to experience unintended pregnancy and therefore more likely to need abortion services than affluent white individuals: these outcomes are caused by socioeconomic disadvantage, lack of access to family planning, persistent forms of racism and other structural barriers to care, and mistrust in a medical system that has a history of discrimination and disparate treatment.[1] As a result, restrictions on abortion care amplify existing health disparities, disproportionately harming people who already face barriers to accessing quality health care, due to their socioeconomic status, gender, and race.

We can protect a person's health and well-being by ensuring that everyone has access to the reproductive health care they need. Restrictions imposed on health care providers and abortion services impede meaningful access to essential services to the detriment of public health — particularly for individuals who are already disadvantaged by systems of economic and racial oppression. According to a recent survey of state health departments, more than fifty abortion clinics have closed or stopped providing abortion since the 2010 onslaught of legislative attacks

New York Abortion Access Fund · FDR Station, Box 7569, New York, NY 10150 · 212-252-4757 · nyaaf.org

on reproductive health services began around the country.[ii] In Mississippi, for example, a medically unnecessary admitting privileges law creates a significant obstacle to receiving care. Mississippi is the poorest state in the country and is one of five states that have only one remaining clinic.[iii] Many patients of the sole Mississippi clinic already take on the burden of cost and two to three hours of travel to receive care.[iv] The 2012 law would close the last remaining clinic in the state and would force patients to venture out of state to access care.[v] For now, the clinic remains open while the case is pending in federal court.

The distance patients must travel to reach an abortion provider negatively impacts their ability to access reproductive health services. Eighty-two percent of U.S. counties do not have abortion services and 74 percent of patients living in rural areas must travel more than 50 miles to get to the nearest abortion clinic.[vi] Rural individuals are doubly burdened by lack of access to care: not only due to a lack of providers, but also because 95 percent of U.S. counties that exhibit persistent patterns of poverty are in rural areas.[vii] In 2008, one-third of U.S. women reported travelling more than 25 miles to reach a clinic and women in states with mandatory counseling and waiting period requirements were more likely than their peers to travel even further.[viii] Despite strong evidence that medication abortion can be safely prescribed via telemedicine and dispensed by trained nurses, state legislatures have specifically targeted the way that individuals in rural areas access abortion by restricting the mode by which they receive the medicine and the medical professional who dispenses it.[ix]

Everyone deserves to make informed decisions about their health care based on scientifically accurate information from a doctor they trust, free from discrimination. Race and sex-selective abortion bans encourage medical professionals to scrutinize patients based on racial or ethnic background, based only on stereotypes.[x] Such bans do nothing to address the true causes of racism and sexism; rather, they open up the floodgates to anti-immigrant and racist sentiments based in stereotypes about the Asian American community and about a black woman's ability to determine the best course to take in her reproductive healthcare.

Furthermore, no one should not be mandated to receive or listen to false information prior to receiving care – not only because it is medically inaccurate, but also because restrictions requiring multiple visits unnecessarily increase the expense of the procedure. State-mandated biased counseling serves no purpose other than to intimidate and stigmatize patients seeking medical treatment. Such laws have been proven to drive up the cost to individuals, thereby preventing services to some patients and delaying care into the second trimester when the procedure is less safe.[xi] African American patients have been a particular target of biased counseling, based on false claims that they are targeted by abortion providers in order to commit "black genocide."[xii] Finally, our nation's youth are in special need of medically accurate information about reproductive and sexual health: for example, research shows that Asian Pacific American teens are less likely to communicate with their medical provider about sexuality and risk prevention than any other ethnic group.[xiii]

A person cannot make a meaningful decision about whether to become a parent if safe, legal, available, and affordable abortion services are out of reach. Approximately 69 percent of women

obtaining abortions live close to or below the federal poverty level and 27 percent of those women live in deep poverty, meaning that they have income at 100-199 percent of the federal poverty line.[xiv] Poor individuals who decide to have an abortion often have to wait many weeks to have the procedure while they raise the necessary funds and this wait drives up the cost and increases the risk of the procedure.[xv] Furthermore, a person working to raise the necessary funds must often divert money from paying for food, rent, or utilities, and harmful restrictions such as mandatory counseling and waiting periods compound the cost for patients due to lost wages and added childcare and transportation expenses.[xvi] Moreover, young and low-income individuals are most likely to experience such delays and thus mounting costs due to procedures performed later in pregnancy.[xvii] If a patient is ultimately unable to afford an abortion, they may be forced to carry an unwanted pregnancy to term; individuals who carry unwanted pregnancies to term are three times more likely to fall below the federal poverty line within two years.[xviii]

Our government has a particular responsibility to ensure that individuals who have limited access to affordable health care can receive the same quality of care as those with means. Due to the link between institutional racism and socioeconomic disadvantage, people of color are at higher risk of living in poverty and are more likely to lack access to regular, high-quality family planning and other health care services.[xix] People of color are disproportionately affected by restrictions that increase the cost of an abortion because they are more likely than white individuals to experience unintended pregnancy,[xx] to seek abortion care,[xxi] and to qualify for public insurance.[xxii] Sixty-six percent of women who have an abortion have some form of health insurance, but 57 percent report paying out of pocket, largely because many forms of state and federal Medicaid do not cover abortion.[xxiii] Restrictions also unduly affect immigrants, who are more likely to live in poverty than individuals born in the United States, and are routinely denied access to health care coverage, including abortion coverage.[xxiv] In fact, low-income immigrants who qualify for Medicaid are excluded from coverage for their initial five years of residence.[xxv] Undocumented individuals are unjustly excluded from federal Medicaid benefits and cannot even purchase health plans at full price in state insurance marketplaces.[xxvi] Such barriers to care are not only unfair, but are also flawed public health policy, preventing immigrants from maintaining their health and that of their families.

It should be noted that the reproductive health disparities affecting our communities are broader than high unintended pregnancy rates. More consistent exposure to medical care could improve health outcomes that significantly impact our communities, especially with regards to maternal mortality and earlier detection of cancers. Maternal mortality is highly pronounced for African American individuals, as they are three to four times more likely to die from pregnancy related causes than white patients, a risk that is compounded by lack of access to contraception.[xxvii] Lower income patients and people of color are also less likely to receive routine exams such as mammograms and pap smears that improve early detection of life-threatening conditions. Most likely due to late detection and the prohibitive cost of care, African American women are more likely than any other group of women to die from breast cancer and Latinas are more likely to be diagnosed in a later stage of cancer when it is harder to treat than are white women.[xxviii] Moreover, the racial disparity of HIV infection is stark: African American women are twenty

times more likely than white women to be infected with HIV.[xxix] One in thirty-two African American women will be diagnosed with HIV in their lifetimes.[xxx]

Taken together, the barriers to accessing safe, legal, affordable abortion care, free from medically unnecessary restriction, are formidable and seriously undermine a person's health, human rights, dignity, and self-determination. The Women's Health Protection Act would begin to address some, though not all, of these barriers, focusing on dismantling the restrictions aimed at closing clinic doors and making it more difficult and less dignified for patients to access this care. We believe that this legislation, in combination with separate, but parallel efforts to restore insurance coverage for abortion, protect abortion access for young people, and eliminate violence against providers, will return us to a landscape where everyone is able to get the health care they needs, regardless of their circumstance.

Everyone has the right to good health and well-being for themselves and their family. But for too long, the reproductive health care needs of our communities have been undermined by inaccessibility of care, prohibitive costs, discrimination, and medically unnecessary and restrictive legislation. Study after study by national and international experts show that restrictions on abortion don't reduce its frequency, but rather delay or prevent patient's access to the procedure. Everyone needs affordable and accessible pregnancy-related care, including abortion, regardless of where they lives and notwithstanding their economic or racial status or personal situation. We urge Congress to act now and pass the Women's Health Protection Act.

Sincerely,
New York Abortion Access Fund Board of Directors

Endnotes

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[i] Christine Dehlendorf, et al. *Disparities in Abortion Rates: A Public Health Approach.* 103:10 American Journal of Public Health (2013).
[ii] Laura Bassett, *Anti-Abortion Laws Take Dramatic Toll on Clinics Nationwide*, Huffington Post (Aug. 26, 2013), http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html.
[iii] Tony Pierce, *America's Ten Poorest States*, CN8C.com (Sept. 27, 2013), http://www.cnbc.com/id/101068491/page/11; Amanda Ness, *Household Income: 2012*. United States Census Bureau (2013); Bassett, *supra*.
[iv] Kate Sheppard, *Inside Mississippi's Last Abortion Clinic*, Mother Jones (Jan. 22, 2013), http://www.motherjones.com/politics/2013/01/inside-mississippis-lastabortion-clinic;
[v] *Id.*
[vi] Erin McKelle, *Learning Intersectionality: A Process*, RH Reality Check (Jul. 2, 2014), http://rhrealitycheck.org/article/2014/07/02/learning-intersectionality-process.
[vii] *Id.*
[viii] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?* 22:8 Journal of Women's Health, 706-713 (2013).
[ix] Heather D. Boonstra. *Medication Abortion Restrictions Burden Women and Providers—and Threaten US Trend Toward Very Early Abortion*. 16:1 Guttmacher Policy Review (2013); Dan A. Grossman, et al. *Changes in service delivery patterns after introduction of telemedicine provision of*

medical abortion in Iowa. 103:1 American Journal of Public Health, 73-78 (2013); Kate Grindlay, et al. *Women's and Providers' Experiences with Medical Abortion Provided through Telemedicine: A Qualitative Study*. 23:2 Women's Health Issues, e117-e122 (2013); Dan A. Grossman, et al. *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*. 118: 2 Obstetrics & Gynecology, 296-303 (2011).

[x] Sital Kalantry & Miriam Yeung, University of Chicago. Replacing Myths with Facts: Sex Selective Abortion Laws in the United States (2014).

[xi] Theodore J. Joyce, et al., Guttmacher Institute. The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review (2009).

[xii] Guttmacher Institute, *Claim that Most Abortion Clinics are Located in Black or Hispanic Neighborhoods is False* (Jul. 14, 2014, 11:23 AM), http://www.guttmacher.org/media/evidencecheck/provider-location.html; Akiba Solomon, *Another Day, Another Race-Baiting Abortion Billboard*, Colorlines, Mar. 29,201, 1http://colorlines.com/archives/2011/03/another_day_another_racist_billboard.html; Kai Wright, Georgia Anti-Abortion Billboards Turn Up in Los Angeles, Too, Colorlines, Feb. 25, 2011, http://colorlines.com/archives/2011/02/georgia_anti-abortion_billboards_turn_up_in_los_angeles_too.html; Miriam Zoila Pérez, Past and Present Collide as the Black Anti-Abortion Movement Grows, Colorlines, Mar. 3, 2011, http://colorlines.com/archives/2011/03/past_and_present_collide_as_the_black_anti-abortion_movement_grows.html.

[xiii] Courtney Chappell, National Asian Pacific American Women's Forum, Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women (2005).

[xiv] Rachel K. Jones, et. al, Guttmacher Institute, Characteristics of U.S. Abortion Patients, 2008 8 (2010).

[xv] Heather D. Boonstra, Guttmacher Institute, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States (2007); Joyce, *supra*.

[xvi] Boonstra, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States *supra*; Sarah Jane Glynn & Jane Farrell, Center for American Progress. Latinos Least Likely to Have Paid Leave or Workplace Flexibility (2012); Tara Culp-Ressler, *By the Numbers: Why Most U.S. Women Struggle to Afford Abortion*, Think Progress (May 8, 2013) http://thinkprogress.org/health/2013/05/08/1979831/women-struggle-afford-abortion.

[xvii] Diana G. Foster & Katrina Kimport. *Who Seeks Abortions at or After 20 Weeks?* 45:4 Perspectives on Sexual and Reproductive Health, 210-218 (2013); Susan Yanow, National Women's Health Network. *Why Restrictions on Later Abortion Care Impact Us All* (Jul. 14, 2014, 11:19 AM), https://nwhn.org/newsletter/node/1420.

[xviii] Joshua Lang, *Unintentional Motherhood*, New York Times Sunday Magazine, Jun. 16, 2013, http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=all.

[xix] Alexandra Cawthorne. *The Straight Facts on Women in Poverty*, Center for American Progress, October 8, 2008, http://www.americanprogress.org/issues/women/report/2008/10/08/5103/the-straight-facts-on-women-in-poverty; Katherine Gallagher Robbins & Lauren Frohlich, National Women's Law Center. National Snapshot: Poverty Among Women & Families, 2012 (2013).

[xx] Mia Zolna & Laura Lindberg, Guttmacher Institute. Unintended Pregnancy: Incidence and Outcomes Among Young Adult Unmarried Women in the United States, 2001 and 2008 (2012).

[xxi] Jones, et. al, Characteristics of U.S. Abortion Patients, *supra*.

[xxii] January Angeles. *Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children*, Center on Budget and Policy Priorities, May 3, 2011, http://www.cbpp.org/cms/index.cfm?-fa=view&id=3483.

[xxiii] Jones, et. al, Characteristics of U.S. Abortion Patients, *supra*.

[xxiv] 20% of the uninsured in America are legally-present and undocumented immigrants and 22% of women of reproductive age in the United States are uninsured. Center For Reproductive Rights and National Latina Institute for Reproductive Health, Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley (2013); Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Jul. 14, 2014, 10:49 AM), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

[xxv] National Immigration Law Center, *Immigrants and the Affordable Care Act* (Jul. 14, 2014, 10:52 AM) http://www.nilc.org/immigrantshcr.html; Kaiser Family Foundation, *supra*.

[xxvi] Samantha Artiga, Kaiser Family Foundation Commission on Medicaid and the Uninsured, Medicaid and the Uninsured (2013).

[xxvii] Office of Women's Health, *Minority Women's Health: Pregnancy-related Death*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:55 AM) http://womenshealth.gov/minority-health/african-americans/pregnancy.html; Guttmacher Institute, *Fact Sheet: Induced Abortion in the United States* (Jul 14. 2014, 10:57 AM), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[xxviii] Office of Women's Health, *Minority Women's Health: African-Americans: Breast Cancer*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:55 AM), http://womenshealth.gov/minority-health/african-americans/breast-cancer.html; Office of Women's Health, *Minority Women's Health: Latinas: Breast Cancer*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:59 AM), http://womenshealth.gov/minority-health/latinas/breast-cancer.html.

[xxix] Division of HIV/AIDS Prevention, *HIV among African Americans*, Centers for Disease Control and Prevention (Jul. 14, 2014, 10:16 AM), http://www.cdc.gov/hiv/risk/racialethnic/aa/facts/index.html.

[xxx] *Id.*

Senate Judiciary Committee Hearing Testimony
Congressional Hearing on S. 1696, the Women's Health Protection Act

July 15, 2014

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in strong support of Senator Blumenthal's S. 1696, the "Women's Health Protection Act," which is under consideration in today's hearing before the U.S. Senate Committee on the Judiciary.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the U.S. Every year, Planned Parenthood health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted infections (STIs), and other essential care to nearly three million patients. As the largest sex educator in the country, Planned Parenthood provides reliable reproductive health information to a million young people and parents each year. Nearly 80 percent of Planned Parenthood patients have incomes at our below 150 percent of the poverty level and are among the most vulnerable, facing limited access to reliable and affordable health care.

Planned Parenthood Federation of America strongly supports the Women's Health Protection Act, which would create federal protections against state restrictions on abortion that do not advance women's health and safety and instead create barriers to accessing this safe and legal medical procedure. This critical legislation would protect a woman's constitutional right to access safe and legal abortion by making it unlawful for states to pass restrictions that endanger women's health and safety; interfere with women's personal medical decisions; and make it harder, and in some cases even impossible, to access safe and legal abortion. This legislation is needed to ensure that a woman's rights do not depend on her zip code.

In 2011, 36 states around the country adopted 135 new restrictions on abortion[1], making it the most harmful legislative session to women's health and safety on record. Only second to 2011's massive assault on women's reproductive rights was the legislative session in 2013, which resulted in more than 70 harmful abortion restrictions becoming law in 24 states across the country.[2] For example, South Dakota not only passed an unprecedented 72-hour mandatory waiting period in 2012, but in 2013 exempted weekends and holidays from this calculation. In 2013, Wisconsin and Alabama enacted targeted restrictions designed specifically to shut down those states' providers of safe and legal abortion. And in Texas, a plethora of new medically unnecessary abortion restrictions have already dramatically reduced women's access to abortion, especially in those parts of the state where women have the least access to health care. By September, the second largest state in the country could be left with as few as six abortion providers.

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[1] Guttmacher Institute, States Enact Record Number of Abortion Restrictions in 2011 (January 2012) Available at http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html.
[2] Guttmacher Institute, State Legislation and Policies Enacted in 2013 Related to Reproductive Health (October 2013), Available at http://www.guttmacher.org/statecenter/updates/2013Newlaws.pdf.

The state laws that would be addressed by the Women's Health Protection Act are passed under the false guise of helping women. In reality, these cruel laws do nothing to advance women's health and safety but instead cut off women's access to safe and legal abortion and to the wide range of preventive services that women's health centers provide, including birth control, breast and cervical cancer screenings, and STI testing and treatment.

At Planned Parenthood, we work every day to make sure women receive the high-quality health care they need in a safe, respectful environment, including abortion. Ensuring the health and safety of Planned Parenthood patients is central to our mission, and fundamental to every person who works at Planned Parenthood. Our health centers have rigorous standards and training for staff as well as emergency plans in place because women's health is our first priority.

At the federal and state levels, there are multiple agencies that oversee and regulate Planned Parenthood and other health care providers. But we don't stop there; Planned Parenthood health centers go through an accreditation process with rigorous standards, regular review and inspections, and ongoing training. We constantly evaluate new research in the field, new recommendations from medical associations, new technologies, and feedback from patients, experts, and regulators to continue improving our practices.

We welcome oversight of all health centers and regulations that protect patient safety. But the harmful restrictions we see at the state level – such as requiring admitting privileges or that abortions be performed in ambulatory surgical centers – have no medical basis. These bills were not being advanced by or supported by medical experts but by politicians – with the end goal of making safe, legal abortion difficult or even impossible to access. Those behind these politically motivated proposals ultimately hope to shut down our health centers, which would leave thousands without care.

For example, there is no medical basis for laws requiring doctors who provide abortion to have admitting privileges. Data, including from the CDC, shows that abortion has over a 99% safety record.[3] The American College of Obstetricians and Gynecologists and the American Medical Association both oppose these restrictions.[4] For patients' safety, providers already have plans in place in the exceedingly rare case of emergency. The state of Alabama's own Department of Health said an admitting privileges law was not necessary and urged the state not to pass it.[5] An independent, court-appointed medical expert in the Wisconsin admitting privileges trial said to the judge, "I think it is an unacceptable experiment to see if you decrease access (to abortion) and see if more women die. It is not acceptable. It is not ethical. People will resort to illegal abortions."[6] And the Oklahoma State Medical Association (OSMA) spoke out against admitting privileges legislation there, writing that it: "would result in the Legislature and unelected bureaucrats at the

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[3] Pazol, Karen, et al. (2013). "Abortion Surveillance — United States, 2010." *MMWR*, 62(ss08);1-44. Available athttp://www.cdc.gov/mmwr/preview/mmwrhtml/ss6208a1.htm?s_cid=ss6208a1_w

[4] American Congress of Obsetricians and Gynecologists (2013). ACOG and AMA File Amicus Brief in Planned Parenthood v. Abbott. Available at http://www.acog.org/About_ACOG/News_Room/News_Releases/2013/ACOG_and_AMA_File_Amicus_BriefACOG

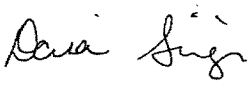
[5] Memorandum in Support of Plaintiffs' Motion for Summary Judgment at [page number], *Planned Parenthood Se., Inc. v. Strange*, ___F. Supp. 2d ___, 2014 WL 1320158 (M.D. Ala 2014) (No. 2:13-cv-405–MHT), ECF No. 109

[6] Van Egeren, Jessica. "Court's impartial doctor: Decreasing access to abortion clinics an 'unacceptable experiment." The Cap Times, 29 May 2014. Available at http://host.madison.com/news/local/writers/jessica_vanegeren/court-s-impartial-doctor-decreasing-access-to-abortion-clinics-an/article_9d1da286-e768-11e3-973e-001a4bcf887a.html

Department of Health interfering in the physician/patient relationship and crafting more burdensome regulations that... may not reflect medical science or the best interest of the patient."[7]

The United States continues to have some of the highest rates of teen pregnancy and maternal and infant mortality rates in the developed world. There are significant gains to be made in protecting women's access to comprehensive health care. We need federal policy - like the Women's Health Protection Act - that will put women's rights, health, and lives first by stopping harmful state restrictions from interfering with women's personal decision-making and constitutionally protected rights, and ultimately their ability to access comprehensive preventive health care services.

Sincerely,



Dana Singiser
Vice President of Public Policy and Government Relations
Planned Parenthood Action Fund
Planned Parenthood Federation of America
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005

[7] OSMA Opposition to SB 1848." Letter to Oklahoma State Senate. 14 Feb. 2014

PHYSICIANS FOR REPRODUCTIVE HEALTH

Headquarters:
55 West 39th Street
Suite 1001
New York, NY 10018-3889
Tel: 646-366-1890
Fax: 646-366-1897

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July 15, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley:

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. A large number of the doctors Physicians represents practice in the field of obstetrics and gynecology, but many are pediatricians, family physicians, cardiologists, neurologists, radiologists, and others. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

Physicians welcomes the opportunity to submit testimony on the Women's Health Protection Act of 2014 (S. 1696). This critical bill would ensure that all women are able to make personal decisions about reproductive health care, regardless of where they live.

I. Introduction

As physicians, patient safety is our top priority. Which is why we are dismayed by the actions of politicians across the country who have passed harmful restrictions on abortion in the name of patient safety. In many states, the effect has been catastrophic, as politicians have increasingly sought new ways to interfere with the patient-provider relationship and undermine women's access to safe abortion care.

Abortion is one of the safest medical procedures in the United States. Rates of infection and serious complications following a medication or surgical abortion are extremely low. In fact, data from the Centers for Disease Control and Prevention (CDC) found that abortion has over a 99% safety record.[1] State lawmakers are actually harming women by decreasing access to safe and legal abortion care.

[1] Karen Pazol et al., Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2009*, Morbidity and Mortality Weekly Report 61:1-44, Table 25 (Nov. 23, 2012), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6108a1.htm (last visited July 10, 2014).

As physicians, we provide the highest quality, most compassionate, safest medical care, and in some states now, we are unable to because of unnecessary laws. Allow me to give you some examples from our members of restrictive state laws that are hurting our ability to practice medicine and jeopardizing our patients' health and lives.

I. Laws mandating unnecessary visits to a clinic

Several states require unnecessary in person visits for women seeking abortion care. Missouri has a mandated 24-hour waiting period for women having abortions. Dr. Elizabeth Schmidt practices in Missouri and recently had a patient, Sonia[2], who was pregnant with a fourth child. She and her husband were initially ecstatic about the pregnancy until she was diagnosed with an aggressive form of breast cancer. She needed to terminate the pregnancy immediately to start chemotherapy. Due to a mandatory waiting period, she was forced to wait 24 hours before Dr. Schmidt could perform her abortion. It is cruel that Missouri state law forced Sonia to wait to start life-saving treatment.

Dr. Colleen McNicholas also practices in Missouri and cared for a patient named Julie. She and her husband were told early in her pregnancy that the much desired baby they were expecting was affected with multiple abnormalities, the sum of which would not allow their baby to survive outside the womb. Sadly, Julie and her husband were given no assistance when they requested information on pregnancy termination. They were heartbroken, both by the diagnosis and what they perceived was a lack of compassion by their physician. Without the help of their primary obstetrician, they attempted to navigate the complicated environment around pregnancy termination in Missouri. It took them 3 weeks to locate an abortion provider, only to be told that there would be additional delays. Under Missouri's restrictive laws, Julie would be required to travel two hours to a facility on two separate occasions to comply with the state required 24 hour waiting period. When they were able to finally access the care they deserved, Julie's pregnancy was a little over 20 weeks pregnant. Julie's story of unnecessary delays and onerous requirements is unfortunately not uncommon, especially in places where access to providers is so limited.

Just this year, the Missouri legislature voted to extend the waiting period to three days. While the governor vetoed this harmful legislation the legislature will likely try to enact it again, increasing the burdens on Missouri women like Sonia and Julie.

II. Hospital admitting privilege requirements

As physicians, we oppose legislative interference in the practice of medicine, including requiring admitting privileges, as they do nothing to protect the health of our patients and are contrary to modern medical practice. Surgical abortion is associated with similar or fewer risks compared to other outpatient surgical procedures, yet states with such restrictions only require providers of abortion care to have admitting privileges. For example, the mortality rate of colonoscopy is more than 40 times greater than that of abortion, and yet, no state has imposed admitting privilege requirements for gastroenterologists who

[2] All patient names have been changed to protect confidentiality.

perform these procedures.[3] There is simply no medical reason to treat abortion providers differently from other providers of procedures with similar or greater risks of complications. That abortion is singled out shows that the true motivation of these laws it to limit access.

Requiring abortion providers to have hospital admitting privileges jeopardizes women's access to safe and legal abortion care by preventing qualified health centers and providers from offering abortion care, forcing many to shut down. After a Texas law requiring hospital admitting went into effect in November of 2013, 19 of 33 abortion clinics closed, including clinics in McAllen and Beaumont. The closure of the McAllen clinic, located in the Rio Grande Valley (one of the poorest regions in the nation), has forced women to make an estimated two-and-a-half hour (150 mile) drive to Corpus Christi, four hour (240 mile) trip to San Antonio, or five hour (310 mile) drive to Austin.[4] These distances can prove to be insurmountable obstacles for low-income women, leading some to seek more accessible but illegal abortion pills from Mexico or forcing them to have and raise a baby they feel unprepared for.[5] Neither of these scenarios is good for women's health or dignity.

III. Unnecessary regulations that single out abortion

Many states have laws and regulations in place that are not related to improving patient outcomes. Regulations governing abortion practice should be rooted in evidence-based medicine, serve legitimate health interests, and not impede access to abortion care. Numerous states single out abortion providers for regulation not required of other outpatient facilities providing similarly complex medical services. These measures serve only to impair access to abortion which is not beneficial to women's health. On September 1, 2014, when a Texas provision requiring clinics to conform to ambulatory surgical center standards goes into effect, it is estimated that many additional clinics will close, leaving only six clinics in the state of Texas, the second most populous state in the country.

Lack of access to abortion care has a great impact on patients. Dr. Leah Torres practices in Utah and cared for a patient, Jenny, who drove several hours from home in order to get her abortion. She had four children and was struggling to get by. Once she saved the money for the procedure, she realized there were no local doctors who could take care of her. Her own physician told her that if it were not for unnecessary regulations requiring his clinic to conform to ambulatory surgical center requirements, he could have provided the care. However, only one clinic in the state met these requirements and that was five hours away. But under Utah state law, Jenny still had to wait 72 hours and then find child care and take time off of work to make the long trip. When she finally saw Dr. Torres, Jenny was exasperated and distraught, especially because of the barriers she faced to receive care. She was confident in her decision to have her

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[3] Brief of *Amici Curiae* American College of Obstetricians & Gynecologists and the American Medical Association in support of Plaintiffs-Appellees at 4, fn. 10, Planned Parenthood of Greater Texas Surgical Health Services v. Attorney General Gregory Abbott, No. 13-51008 (5th Cir. Dec. 19, 2013).

[4] Manny Fernandez, *Abortion Law Pushes Texas Clinics to Close Doors*, THE NEW YORK TIMES, (March 6, 2014), http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html?_r=0.

[5] Rick Jervis, *Texas abortion law creates abstacles for Valley women*, USA TODAY, (May 17, 2014), http://www.usatoday.com/story/news/nation/2014/05/17/texas-abortion-law-women-valley/8804871/.

abortion. She only regretted living in a place where she could not obtain this safe and legal procedure sooner. While abortion is very safe, risks increase when women are forced to delay obtaining care.

IV. Measures limiting the provision of medication abortion

There are two ways to end a pregnancy in the first trimester – a brief surgical procedure or a regimen of two medications. Each year, roughly 200,000 U.S. women use medications to end a pregnancy. The most widely used medication is mifepristone (available in the United States as Mifeprex and also known as RU-486) along with misoprostol. Mifepristone was approved for use by the U.S. Food and Drug Administration (FDA) in 2000.

Numerous studies confirm that mifepristone is equally effective at lower dosages than the regimen in the 2000 FDA label, meaning that a woman can take one pill as opposed to three pills, which causes fewer side effects and decreases costs. Studies also show that a woman can follow directions and take the second medication at home instead of returning to the clinic or doctor's office to be handed a pill. Lastly, researchers have found that mifepristone is safe and effective in the first ten weeks of pregnancy, expanding safe access to this method past the original 7 weeks in the FDA label.

Study after study has established that these regimens are safe, more effective, and carry fewer side effects. These evidence-based regimens have become standard medical practice in the U.S. and abroad.[6] But that has not stopped state legislatures from trying to limit clinicians to the outdated FDA regimen and thus limit women's access to this early, safe option.

Dr. Lin-Fan Wang, who works in New York City, cared for Mary, a 35-year-old elementary school teacher with a 10-year-old son, who she sees every year for her physical. At her recent physical, Mary told Dr. Wang that she thought she was pregnant, which her pregnancy test confirmed. She immediately became tearful and said that she could not continue the pregnancy – she was already having a hard time juggling a full time job and raising her son as a single mom. They discussed her options, and she decided to have a medication abortion. Because Mary lives in New York, that same day, Dr. Wang gave her the first pill, and Mary was able to take the second set of pills and complete the abortion in the privacy and safety of her own home. At Mary's follow-up visit, she said that she was so grateful that her doctor was able to provide her abortion on the same day as her clinic visit. The care that Mary received is the high quality, evidence-based care we strive to deliver as health care professionals.

In contrast, Ohio, where Dr. Lisa Perriera practices, is one such state that mandates the use of outdated protocols. A woman in Ohio must make four visits to the clinic and take the second medication in the clinic or doctor's office rather than in the comfort of her home. For women able to access medication abortion,

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[6] ACOG practice bulletin on medical abortion, "Medical Management of First-Trimester Abortion," #143, March 2014, http://www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb143.pdf?dmc=1&ts=20140703T1932230602).

this protocol subjects them to higher risk of side effects, and for patients that travel to Ohio from Kentucky or West Virginia, some of these women can begin to pass the pregnancy in the car on the drive home. This Ohio law does nothing to make abortion safer—all it does is limit access to safe medication abortion. These restrictive laws effectively remove medication abortion as an option for many women by making it more expensive and requiring four trips to the clinic. This is detrimental to women's health. For some women, using medications to end a pregnancy is preferable. For example, medication abortion may be medically indicated for women who have certain uterine anomalies, have large uterine fibroids, or are extremely obese. In what other area of medicine, is a safe alternative treatment effectively banned?

V. Bans on second-trimester abortion care

Although most abortions in the United States are provided early in pregnancy, some women will need abortion care later in pregnancy. Many serious health conditions materialize or worsen in the second trimester and compromise the health of a pregnant woman. State lawmakers have been relentless in passing abortion bans that are clearly unconstitutional, often contain only narrow and inadequate health exceptions, and deny our patients crucial medical care.

Physicians for Reproductive Health's consulting medical director, Dr. Anne Davis of New York, cared for Brenda, a mother of two who was 22 weeks pregnant. She had been bleeding throughout her pregnancy, but since this was a very desired pregnancy, she was waiting and hoping for the best. Her condition developed into placental abruption; the placenta had separated from the uterine wall, causing potentially life-threatening bleeding. Her bleeding worsened and she was reaching the point where she would have suffered massive hemorrhage, shock, and death. Her pregnancy was dangerous to her and had to end. Because she lived in New York, Dr. Davis was able to provide the abortion care she needed quickly and safely. Brenda survived and hopes to have more children.

One of my patients, Jane, and her husband were expecting their first child. But her ultrasound at 20 weeks revealed that fetus had a significant cardiac abnormally. After consulting with specialists and having additional tests, they found out that the diagnosis was a lethal genetic anomaly, Trisomy 18. The majority of pregnancies diagnosed with Trisomy 18 result in stillbirths and most babies born with this genetic condition do not live more than a few days. Jane and her husband decided to terminate the pregnancy. Fortunately, in my state Jane and her husband had time for the necessary testing, consultation, counseling and reflection.

Bans on abortion care in the second trimester jeopardize the lives and health of our patients. Lethal fetal abnormalities are often not diagnosed until after 20 weeks and medical complications in pregnancy that endanger women's health can present during this time as well. These bills force women to travel greater distances for abortion care or deny them safe care altogether. Women and families need compassion and the ability to make decisions with dignity, not arbitrary barrier that limit their access to safe care.

VI. Conclusion

As physicians, we are obligated by professional ethics to provide the best care possible to our patients. Why would we give more medication than necessary? Or require a woman to make an unnecessary trip to see a doctor when she does not need to? Why should a state single out abortion for needless regulations not imposed on other health care providers? These medically unjustified laws replace medical judgment with

political agendas. These intrusions into the practice of medicine are offensive to doctors and the women for whom they care, and ominously threaten medical and scientific integrity.

The care Mary received in New York from Dr. Wang was based on the best available medical evidence. The care that the women in Missouri, Ohio, and Utah received was based on legislators dictating medical practice, harming their female constituents. It is unjust that accessible abortion care is dependent on a woman's zip code.

Every woman has her own unique circumstances and must be able to make personal medical decisions, including the decision to have an abortion, without political interference. For these real women and their families, the decision to have an abortion was made after consultation with their health care providers and consideration of all the issues involved. Abortion was a critical medical procedure that protected their health as well as the well-being of their families.

As physicians, we work every day to make sure our patients receive the high-quality health care they need in a safe, respectful environment. We need the Women's Health Protection Act to ensure that all women have access to comprehensive reproductive health care, including abortion, regardless of where they live. It is critical to the lives and health of our patients that this bill passes. For these reasons, I ask you to please support S. 1696.

Sincerely,

Dr. Nancy Stanwood, MD, MPH
Board Chair, Physicians for Reproductive Health

United States Senate

Committee on the Judiciary

Hearing on S.1696

Women's Health Protection Act

Tammi Kromenaker

Clinic Director, Red River Women's Clinic

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

Red River Women's Clinic respectfully submits the following testimony in support of S.1696 (the Women's Health Protection Act) to the United States Senate Committee on the Judiciary.

I. Red River Women's Clinic and Its Patients

My name is Tammi Kromenaker and I am the Director of Red River Women's Clinic. I have been working in the field of reproductive health care for more than 20 years, and have dedicated my career to providing safe, effective, and compassionate reproductive health care to the women of North Dakota and the surrounding states. Red River Women's Clinic is the only abortion provider in the state of North Dakota and has provided safe abortion care and other reproductive health care services to women in North Dakota for 15 years. We maintain the highest quality standards for our practice. Red River Women's Clinic mission is to not only provide safe reproductive health services, but to also provide those services in an emotionally supportive environment.

Red River Women's Clinic provides abortion and other reproductive health care services to women from a broad range of backgrounds. Approximately 60% of our patients are already mothers, with at least one child at home. These women rely on their own personal experiences and understanding of pregnancy and parenting to make careful, considered decisions about what is best for themselves and their families. Some patients seek abortion because they are pregnant as a result of rape, are victims of domestic violence, or because the pregnancy poses a risk their health. In addition, most of our patients get abortions very early in pregnancy – 92% of all abortions performed at our clinic are in the first trimester. Many women from all different backgrounds have sought services at the clinic at some point in their lives.

For my patients who are already parents, who are low-income, or who just cannot raise a child at this point in their lives, accessing safe, legal abortion care is essential for them to be able shape their destiny and the future of their families. When women choose for themselves when they are ready to provide for a child, the entire family and society benefit. Having control over whether and when to become a parent means more opportunities for education, employment, and adequate health care for women and families. It means their children will get the love and attention that is essential for healthy development. Choosing abortion care can be one of the most empowering life choices a woman makes. It may mean that she can leave an abusive relationship, continue to care for the children she already has, take back control after a sexual assault, or continue treatment for a chronic illness.

The clinic serves women who reside in the state as well as women who travel from South Dakota and Minnesota, and on occasion, from as far away as Canada. Currently, approximately two-thirds of the clinic's patients travel to the clinic from at least an hour away, and almost half of all patients travel for more than two hours. On average, our patients drive approximately 120

miles (240 miles round-trip) in order to reach Red River Women's Clinic. Some patients have told me that making the trip to our clinic was difficult for them because of the distance, or because of their financial situation. In addition, some of our patients have confided in me that they were in abusive relationships and that this situation made it very difficult to get away from home in order to be seen at the clinic. As the last remaining option for women in North Dakota and the surrounding area seeking a safe and legal abortion, it is difficult for me to see my patients struggle financially and logistically to access care that is critical to their health and well-being, and protected by the Constitution.

II. Legislative Attacks on Abortion Care in Recent Years

I support reasonable, evidence-based regulations for all forms health care—including abortion care—that truly promote patient health. All three of the physicians who work at Red River Women's Clinic are board-certified and licensed to practice medicine in North Dakota, and we comply with myriad laws and rules that apply to the provision of health care, just like any other medical profession. However, North Dakota currently has numerous laws restricting abortion on the books that have no bearing on patients' health and safety. And in recent years the North Dakota legislature doubled down on their hostility to abortion access, passing six new bills restricting access to abortion *in the last two legislative sessions alone*,[1] including the most extreme, and blatantly unconstitutional, abortion ban in the nation—at 6 weeks of pregnancy.[2] These bills also included a restriction on medication abortion that would have effectively banned

[1] H.B. 1297, 62d Leg. (N.D. 2011); codified at N.D. CENT. CODE § 14-02.1-03.5; H.B. 1305, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-04.1; H.B. 1456, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-05.2; S.B. 2368, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-05.3; S.B. 2305, 63rd Leg (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-04(1); S.R. 4009, 63rd Leg. (N.D. 2013).
[2] N.D. CENT. CODE § 14-02.1-05.2 (2013).

it entirely[3] and requiring physicians who perform abortions to have admitting privileges at a local hospital,[4] which is completely unnecessary to ensure women's health or safety. These requirements shamelessly single out Red River Women's Clinic, the last remaining option for women in North Dakota to access safe and legal abortion services, and treat us differently than other medical providers that perform similar services.

We have gone to court to fight nearly every one of these harmful measures enacted since 2011, and we have won injunctions against several of them.[5] But North Dakota women—and the health care providers who serve them—should not have to file lawsuits year after year, fighting restriction after restriction, to protect their basic constitutional rights. This laser-focus on eviscerating the right to abortion has created a situation in which North Dakota women have different constitutional rights than women in other parts of the country: Women in California or New York do not have to go into court year after year to keep their reproductive health centers' doors open. It's time for Congress to step in.

III. A National Response is Needed: The Women's Health Protection Act

In signing the nation's most extreme abortion ban last year, North Dakota Governor Jack Dalrymple said: "Although the likelihood of this measure surviving a court challenge remains in question, this bill is nevertheless a legitimate attempt by a state legislature to discover the boundaries of Roe v. Wade," calling the "constitutionality of [the] measure" an "open question."[6]

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[3] N.D. CENT. CODE § 14-02.1-03.5 (2011).

[4] N.D. CENT. CODE § 14-02.1-04(1) (2013).

[5] *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205 (N.D. Dist. Ct., Cass Cnty. July 15, 2013) (order granting permanent injunction); *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205 (N.D. Dist. Ct., Cass Cnty. July 31, 2013) (order granting preliminary injunction), *dismissed without prejudice*, No. 09-2011-CV-02205 (N.D. Dist. Ct. Mar. 14, 2014); *MKB Management Corp. v. Burdick*, --- F. Supp. 2d ---, 2014 WL 1653201 (D.N.D. Apr. 16, 2014) (order granting permanent injunction).

[6] Governor Provides Statement on Signed Bills, North Dakota Office of the Governor (Mar. 26, 2013), *available at* http://governor.nd.gov/media-center/news/governor-provides-statement-signed-bills.

But women's fundamental constitutional rights aren't subject to experimentation, state by state. This outrageous statement underscores the fact that the women I serve simply cannot rely on their state elected officials to respect and protect their constitutional rights. They need federal protection—they need the Women's Health Protection Act.

The Women's Health Protection Act would create federal protections against exactly the relentless attacks on women's health enacted by the North Dakota legislature in recent years—laws that single out health care providers like Red River Women's Clinic and do not apply to other, similar health care providers, with the goal of blocking access to safe and legal abortion care. The Women's Health Protection Act would prohibit states from passing the extremely dangerous types of measures Red River Women's Clinic is currently fighting in court, like the near-total abortion ban and the admitting privileges law that was designed to close our clinic. The Women's Health Protection Act would also protect North Dakota women against harmful abortion restrictions that do nothing to advance women's health and safety, which our state legislature seems bent on passing, year after year.

Our constitutional system was not set up so that a woman's fundamental constitutional rights depend entirely on where she lives. North Dakota women need and deserve access to safe and legal abortion care, without political interference, and without running to court each and every time the legislature threatens to choke off that access. Passing the Women's Health Protection Act would take the critical step of ensuring that the individual constitutional rights of every woman would be protected as a matter of federal law, whether she lives in Bismarck or Boston.

Women's Health Protection Act (S 1696)
Testimony Presented by Jessica Arons, President & CEO
U.S. Senate Committee on the Judiciary
July 15, 2014

To Chairman Leahy, Ranking Member Grassley and members of the Committee: I am honored to submit this testimony. Today you are considering the Women's Health Protection Act (S.1696), introduced by Sen. Richard Blumenthal (D-CT).

The mission of the Reproductive Health Technologies Project (RHTP) is to advance the ability of every woman of any age to achieve full reproductive freedom with access to the safest, most effective, appropriate, and acceptable technologies for ensuring her own health and controlling her fertility. To fulfill this mission, RHTP seeks to build consensus in support of an education, research and advocacy agenda for reproductive health and reproductive freedom.

RHTP was founded in order to bring mifepristone to the U.S. market as a non-surgical abortion option. We feel that it is our unique mission and responsibility to ensure that medication abortion remains a meaningful and viable option for women seeking to end a pregnancy, especially as the availability of surgical abortion continues to decline across the country. Moreover, it is one of our highest priorities to eliminate the cost barriers to abortion care in this country.

Medication Abortion Restrictions

Mifeprex (the brand name of mifepristone) was approved by the U.S. Food and Drug Administration (FDA) in September 2000 as a pharmaceutical method for early abortion. Over the last 13 years, women have welcomed the abortion pill as a less clinical, more private, non-invasive option for early-term abortion.

Abortion opponents have pursued a number of strategies in various states to limit women's access to this safe and effective way to end a pregnancy in the first trimester. On the surface, the restrictions may seem reasonable. But upon further examination, it becomes clear that these laws single out abortion care and treat it differently than other types of health care in ways that could be detrimental to women's health.

When a woman needs to end her pregnancy, it is important that she have access to safe medical care from a range of qualified medical professionals who are able to practice medicine in compliance with the most up-to-date standards of care. Unfortunately, many state legislatures, driven by anti-abortion ideology instead of informed by science, have imposed restrictions on medication abortion that do not improve health or safety outcomes for women.

Physician-Only Requirements:
Thirty-eight states require that medication abortion must be administered by a licensed physician.[1]

[1] Guttmacher Institute, *State Policies in Brief: Medication Abortion* (July 1, 2014), available at http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf.

- There is no medical necessity for mifepristone to be provided solely by a doctor rather than other types of licensed medical personnel, such as physicians' assistants or nurse practitioners.[2]
- As with most restrictions on abortion, this limitation is not about patient safety and does not improve patient care.
- The result of physician-only restrictions is to make it more difficult, and often more expensive, to provide medication abortion to a woman who seeks this option.

Telemedicine Restrictions:

- Fifteen states currently require the clinician providing a medication abortion to be physically present during the procedure, which effectively prohibits the use of telemedicine (such as video conferencing) to prescribe medication remotely.[3]
- In places where mifepristone is administered remotely by a physician after consultation via video, patients report a high level of satisfaction and studies have shown it to be a safe and effective practice for the provision of abortion care.[4]
- Mifepristone is the only drug that has been explicitly limited in its telemedicine use, while access to a range of other healthcare options via such methods is rapidly expanding.[5]
- Given continued technological advances and the potential to meet the healthcare needs of underserved populations, telemedicine should be encouraged as a way to meet women's reproductive health needs into the future rather than added to the list of ways women are denied abortion care.

Prohibitions on Off-Label Use:

Ohio and Texas currently require mifepristone to be administered in compliance with the FDA protocols stated on the drug's label, rather than based on the current evidence-based standard that has been developed in clinical practice (considered "off-label" use). Oklahoma also passed a law prohibiting off-label use of mifepristone that will become effective later in 2014.[6]

- Strict compliance with FDA labeling protocol for mifepristone requires: administering a higher dose than is necessary (600 vs. 200 mg), which also makes the procedure more expensive; using the drug only during the first seven weeks of pregnancy, as opposed to nine weeks in the off-label regimen; and having a woman complete her abortion procedure in a clinic instead of at home.

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[2] J. Yarnall et al., "Non-Physician Clinicians Can Safely Provide First Trimester Medical Abortion," *Reproductive Health Matters* 17(33): 61-9 (May 2009); American Public Health Association, *Policy Statement: Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (November 2011).

[3] Guttmacher Institute, *Medication Abortion.* States with current bans are AL, AZ, IN, KS, LA, MI, MO, MS, NC, NE, OK, SD, TN, and TX. In addition, the IA Board of Medicine passed an administrative rule in 2013 to ban the use of telemedicine for abortion, which has been temporarily enjoined by court order.

[4] D. Grossman et al., "Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine," *Obstetrics & Gynecology* 118 (2 Pt. 1): 296-303 (August 2011).

[5] Reproductive Health Technologies Project, "Telemedicine and the Potential for Expanded Access to Reproductive Health Care" (June 2014), available at http://www.rhtp.org/contraception/documents/TelemedicineandReproductiveHealthJune2014FINAL.pdf; American Telemedicine Association, "Telemedicine Case Studies," available at http://www.americantelemed.org/about-telemedicine/telemedicine-case-studies.

[6] Guttmacher Institute, *Medication Abortion.* AZ and ND also enacted similar statutes, which have been enjoined by court order. TX allows a lower dose of mifepristone to be used, in line with the evidence-based protocol, but providers must adhere to the rest of the outdated FDA labeling requirements.

- It is common medical practice to rely on "off-label" use of medication. According to the American Medical Association, approximately 20% of all prescriptions are written off-label; the range is 50-75% for pediatric uses, as children are rarely included in clinical drug trials.[7]
- Most physicians prefer the "off-label" regimen for Mifeprex because it is safe and effective and has improved patient care. The American College of Obstetricians and Gynecologists (ACOG) recommends the lower-dose mifepristone regimen in its guidelines for physicians, citing fewer side effects and lower cost for patients.[8] Today, 96% of all medication abortions in the U.S. depart from the original FDA protocol.[9]

Barriers to Abortion Access

Current state restrictions on abortion access burden women seeking both surgical and non-surgical abortion care. The average cost of a medication abortion in a clinic is $504 and a first-trimester surgical abortion is $480.[10] While this amount may seem nominal to a U.S. Senator, it can mean the difference between getting necessary medical care to end a pregnancy and paying for rent, food, or utilities to a woman living on the brink of poverty. And due to draconian laws like the Hyde Amendment, which denies Medicaid coverage for abortion care in most circumstances, poor women typically must find a way to pay for an abortion procedure entirely out of pocket.

There have been 205 restrictions related to abortion services passed by state legislatures from 2011 through 2013.[11] Most popular among this recent spate of legislative activity are Targeted Regulations of Abortion Providers (TRAP) laws. Passed under the pretense of making abortion safer for women, these measures involve the imposition of unnecessary, arbitrary, and burdensome standards that have led to a number of clinics shutting down because they cannot afford to make the required costly renovations. Despite the lip service given to women's health and safety by these bills' proponents, the real purpose of these measures is to put abortion clinics out of business.[12]

The most marginalized people – poor women, rural women, young women, women of color, and immigrant women – bear the greatest burden of such restrictions. For instance, women in the Rio Grande Valley in Texas have seen the only two abortion clinics in the region close their doors as a result of the state's TRAP laws, leaving them without access to a provider within 240 miles.[13] This area, where

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[7] American Medical Association, National Task Force on CME Provider/Industry Collaboration, "On-Label and Off-label Usage of Prescription Medicines and Devices, and the Relationship to CME" (2010), available at http://www.ama-assn.org/ama1/pub/upload/mm/455/fact-sheet-4.pdf.

[8] ACOG Practice Bulletin no. 67, "Medical Management of Abortion" (2009).

[9] Brief in opposition for Oklahoma Coalition for Reproductive Justice, *Cline v. Oklahoma Coalition for Reproductive Justice,* U.S. Supreme Court, no. 12-1094, May 2013.

[10] J. Jerman and R. Jones, "Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment," *Women's Health Issues* 24-4: e419-24(May 2014).

[11] H. Boonstra and E. Nash, "A Surge of State Abortion Restrictions Puts Providers – and the Women They Serve – in the Crosshairs," *Guttmacher Policy Review* 17(1) (Winter 2014), available at http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html.

[12] For example, see comments by Mississippi Governor Phil Bryant on a 2012 state law requiring hospital admitting privileges for providers at the state's only abortion clinic: "My goal of course is to shut it down." Ross Adams, "Deadline Day for Jackson Abortion Clinic," WJTV.com, January 10, 2013, available at http://www.wjtv.com/story/21270984/deadline-day-for-jackson-abortion-clinic.

[13] Manny Fernandez, "Abortion Law Pushes Texas Clinics to Close Doors," *New York Times,* March 6, 2014, available at http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html.

more than 30 percent of people live under the federal poverty level, is home to the largest concentration of low-wage farmworkers in the country.[14] Already cut off from health care generally (in part because of Texas's concomitant defunding of family planning clinics[15]) and already experiencing some of the largest health disparities in the country, these women are now facing a public health crisis of monumental proportions.[16]

With fewer clinics, the additional costs involved in obtaining an abortion increase as well – in transportation, lodging, time off work (often unpaid), and child care.[17] TRAP laws, especially in combination with abortion funding and coverage bans like the Hyde Amendment, are making abortion care unaffordable for the women who need it. Just as poll taxes made voting unaffordable for African Americans, so too is this toxic combination of abortion restrictions putting abortion care out of reach for the women in this country who are already struggling to get by.

How the Women's Health Protection Act Would Address These Restrictions

RHTP has worked for over twenty years to ensure that a full range of effective reproductive health care options are available to all women. We vociferously oppose the onerous and unnecessarily restrictive state laws detailed above that have absolutely no medical basis and may even threaten women's health and safety. The Women's Health Protection Act (WHPA) would establish a national baseline of protections for women's access to reproductive health care around the country, rather than allowing them to be subjected to a patchwork quilt of increasing restrictions in various states.

WHPA's provision to bar states from imposing medically unnecessary regulations solely on reproductive health care providers would reduce restrictions on both surgical and non-surgical abortion procedures. In the provision of medication abortion, for example, states would not be allowed to dictate that abortion providers adhere to the outdated FDA protocol in prescribing Mifeprex, a type of regulation that does not apply to any other area of medical practice. Indeed, it would be unheard of to disallow a safe and widely used evidence-based "off label" approach in any other medical setting.

We applaud Sen. Blumenthal for introducing WHPA and its congressional intent to expand access to clinical abortion care. We would also welcome legislative efforts to remove abortion restrictions that target low-income women, young women, and those who need later abortion care. In sum, we urge your support for WHPA so that women can access safe, quality, affordable abortion care no matter where in the U.S. they live.

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[14] Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* (November 2013).
[15] K. White et al., "Cutting Family Planning in Texas," *New England Journal of Medicine* 367: 1179-81 (September 2012).
[16] Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestro Texas*.
[17] L. Finer et al., "Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States, *Contraception* 74(4):334–344 (April 2006).

Dana Weinstein
1521 W. Kersey Lane
Rockville, MD 20854
(301) 340-6556
danaw@owdesign.com
July 14, 2014

Senator Richard Blumenthal
U.S. Senate
724 Hart Senate Office Building
Washington, DC 20S10

Dear Senator Richard Blumenthal:

I am writing to lend my unwavering support for your legislation, the Women's Health Protection Act, S.1696. Thank you for having the courage to introduce S. 1969 – and for attempting to roll back the onslaught of laws now sweeping the nation that claim to protect women's health but in actuality make it harder to get safe, legal abortion care.

Five years ago today, I terminated my much wanted and loved pregnancy. It was the most gut-wrenching, impossibly difficult act. It is also one that I am profoundly grateful I could choose, and have performed safely.

Despite being legal, my experience was filled with undue hardship. And my abortion took place **before** many of the laws (active and proposed) sweeping across our country took hold.

My diagnosis:

In July 2009, at nearly 31 weeks into my pregnancy, my husband and I received shocking and devastating news about the health of our unborn daughter. After nearly 8 months of prenatal care that indicated the pregnancy was progressing along perfectly normal, we learned our baby was missing a main piece of her brain...the part that connects the right and left hemispheres. This is known as agenesis of the corpus callosum. Additionally, the surface of the brain was malformed and severely underdeveloped, a condition called polymicrogyria. Where brain mass and tissue should have grown and been plentiful, only large pockets of empty space and gaping holes existed.

Because of the severe brain anomalies, our baby would have had on-going seizures -- 70% of the time. And that was best case scenario. Our daughter would lack the physical coordination to suck, swallow, feed, walk, talk or know her environment -- if she survived birth at all.

If we had carried our baby to term, we would have needed a resuscitation order in place prior to giving birth as she was incapable of living without significant medical assistance.

And no amount of surgery, medicine or physical therapy could reverse, improve, or fix this horrendous diagnosis.

We did not want our daughter to exist solely because of machines where she would never run, laugh, play or interact with me, her mommy or her daddy or her big brother Nate or her dog Misty. We did not want to bring a child into this world that would only be here in a vegetated state, if at all.

As much as we loved and wanted our daughter, we didn't want her existence to be one of constant suffering.

Forced to travel out of state for care:

Because I was so far along in my pregnancy, and it was 6 weeks after Dr. Tiller had been murdered, the only option available at the time of our diagnosis was for me to travel across the country from Maryland to Colorado to one of a handful of facilities in the U.S. that provides later abortion care.

I was completely unprepared for this logistical obstacle because I knew abortion care was legal in Maryland. But with no practicing physician to help in the summer of 2009, my only option was to travel out of state.

It was awful to go through the hell of ending my very much wanted and loved pregnancy and to have to do it across the country, so far from my home and loved ones.

Implications of proposed nation-wide 20 week ban:

It never occurred to me that a fetal anomaly would exist in our baby – and that it would go undetected despite the prenatal care I received until so late in my pregnancy. There was nothing in our family history that put us at an elevated risk for a genetic abnormality and all the testing due to my "advanced maternal age" of 38 returned normal.

I quickly learned that a diagnosis like mine couldn't have occurred and was impossible to confirm until much, much later than 20 weeks because brain development happens well into the third trimester.

Although my termination came later in pregnancy than most, if nothing is done to stop 20-week ban legislation, had I been subjected to the legislation, I would have been forced either to seek an illegal procedure, to leave the country, or to carry a doomed pregnancy to term, risking my health and enduring warm "congratulations" from everyone on the street, which is a fate that is beyond cruel for women caring a fetus that is incompatible with life.

The period of time I had to endure between learning our diagnosis and ending her suffering was agonizing. Each movement of my baby – movement that for months had brought me such joy – now brought only unbearable heartache.

Looking down at my full pregnant belly knowing how sick my daughter was, and knowing that she would not live was horrendous.

I am extremely fortunate to have given birth to two healthy children since our loss. During both of those pregnancies, it wasn't possible to begin to test for what was wrong with our first daughter until the 20 week mark at the earliest. And had either pregnancies shown signs of brain malformation at that time, only the agenesis of the corpus callosum would have appeared – not the other, more severe abnormalities as it would have been too early based on brain development and gestational age.

If we do nothing to stop the 20-week bans from passing in states across the country, not only would the anomalies we experience not be identifiable in time, but even if we could spot something immediately prior to or just at the 20 week mark, there wouldn't be time to monitor and confirm the severity of the problems. No mother or her family should be forced to rush testing, consultation and decision-making about something as serious as the viability of their baby because of an abortion time limit.

Forced ultrasound technology:

Ultrasound technology could not detect what my baby had. Any description of her anatomy would have been a false picture of her health. My baby had all 10 fingers, 10 toes, a beautiful face, picture perfect spine, lungs, heart and even a long femur bone – she would have been a tall child according to the technician reviewing the last sonogram I had at the time of receiving our diagnosis. All outwardly signs were perfect. But her neurological system and her brain were the complete opposite of normal. And yes, I am forever haunted by the words of that technician informing me that my child would have been tall.

It is demeaning and unconscionable that women in many states across the country are forced to undergo an ultrasound against their will. I am grateful I was not forced to hear a description of the pregnancy. But unfortunately, many women are - and I am heartened that Sen. Blumenthal's legislation would block those cruel forcible laws that cause so much anguish to other women.

These assaults on a women's right to choose are deplorable. Abortion access should not be a hardship, no matter what the circumstances are for women seeking this service. Women must be allowed to choose what is best for their family and for their unborn child – including abortion as a viable, affordable option.

Thank you again, Senator Blumenthal, for your bravery in introducing this proactive legislation and for creating the Women's Health Protection Act.

With admiration and respect,

Dana Weinstein

Testimony of the National Abortion Federation

and Abortion Providers in Ohio, Pennsylvania, and Tennessee

Submitted to Chairman Leahy and Ranking Member Grassley

United States Senate Committee on the Judiciary

For the Hearing on S. 1696, the Women's Health Protection Act

July 15, 2014

National Abortion Federation
1660 L St NW Suite 450
Washington, D.C. 20036

The National Abortion Federation is the professional association of abortion providers in North America. NAF's mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women.

I. Women's Constitutional Rights are Threatened in the United States

Across the country, a woman's right to access safe, legal abortion care is in crisis. Over 200 restrictions on abortion care were enacted by states in the last 3 years[1] and 733 new restrictions have already been introduced in the 2014 legislative sessions in the states.[2] As part of a coordinated national anti-abortion political strategy, state and local legislative bodies across the United States have enacted more restrictions on abortion care between 2011 and 2014 than in the entire previous decade.[3] Collectively, these regulations form the most serious threat to abortion rights since *Roe v. Wade* affirmed a woman's constitutional right to choose. In many parts of the nation, a woman's ability to access her constitutionally protected right to abortion care depends on whether she is fortunate enough to live near a clinic or whether she has the financial means available to travel, often long distances, to reach the care that she needs. A woman's health options should not depend on her geographic location.

Since 1977, the National Abortion Federation has ensured the safety and high quality of abortion practice with standards of care, protocols, and accredited continuing medical education. As the professional association of abortion providers, our evidence-based *Clinical Policy Guidelines* (CPGs) establish the standards for quality abortion care in North America. Our members include private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals who together care for more than half the women who choose abortion in the United States and Canada each year.

Our providers are committed to protecting the health, safety, and well-being of women. And yet, these dedicated health care professionals have been severely affected by the onslaught of anti-choice legislation, enacted under the guise of increasing "women's health and safety." We cannot continue to allow politicians and anti-choice extremists to interfere with medical practice to the detriment of women's health. We submit this testimony in support of S. 1696, the Women's Health Protection Act. The Women's Health Protection Act is necessary to protect women's constitutional rights from these harmful state restrictions, which impose unnecessary and burdensome regulations on abortion providers and create barriers to women's access to abortion care.

II. Targeted Regulation of Abortion Providers (TRAP) Laws

NAF is opposed to regulations that are not based in evidence and standards of medical practice, and target abortion providers for provisions that do not apply to other facilities providing comparable care. Targeted Regulation of Abortion Providers (TRAP) legislation singles out abortion providers for medically unnecessary, politically motivated state regulations which are often completely at odds with evidence-

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[1] Guttmacher Institute. STATE LEGISLATION IN 2011/2012/2013 RELATED TO REPRODUCTIVE HEALTH, *available at* http://www.guttmacher.org/statecenter/updates/2011newlaws.pdf.

[2] *State Policy Trends: More Supportive Legislation, Even As Attacks on Abortion Rights Continue*, Guttmacher Inst., Apr. 9, 2014, http://www.guttmacher.org/media/inthenews/2014/04/09/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute).

[3] *More State Abortion Restrictions Were Enacted in 2011–2013 Thon in the Entire Previous Decade*, GUTTMACHER INST., Jan. 2, 2014, http://www.guttmacher.org/media/inthenews/2014/01/02/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute).

based standards of care. These laws are proffered by their anti-choice supporters as health and safety regulations. However, these laws jeopardize the safety of women, unfairly target abortion providers, and make it more difficult for women to access abortion care. Sponsors of TRAP laws imply, contrary to medical evidence, that abortion clinics are unsafe and need further regulation. This is clearly untrue. Abortion care is one of the safest and most commonly provided medical procedures in the United States, and serious complications are extremely rare.[4] The following measures are examples of the harmful regulations that would be prohibited by the Women's Health Protection Act.

A. Hospital Admitting Privileges

The Women's Health Protection Act would create federal protections against state regulations that set medically unnecessary professional requirements for physicians and other health care providers. These include laws that, as a prerequisite to providing abortion care, require medical professionals to have admitting privileges or a similar formal arrangement at a nearby hospital. Admitting privileges govern how a doctor admits patients – often via a contractual relationship between the doctor and hospital. Many states have recently passed these laws, including Alabama, Louisiana, Mississippi, North Dakota, Oklahoma, Tennessee, Utah, and Wisconsin.

NAF's *Clinical Policy Guidelines* have never required physicians to have admitting privileges at a hospital, because there is no evidence that this requirement would improve patient outcomes. Furthermore, regulations requiring physicians to have hospital admitting privileges are not supported by the medical community. Medical organizations such as the American Medical Association and the American College of Obstetricians and Gynecologists oppose admitting privileges requirements, as they do not reflect current medical practice and provide no real benefit to patients. In the rare instance that a woman would need emergency care in a hospital, the emergency room staff and on-call physicians are available to provide that care, just as they would for any other type of complication.

There are many reasons why a physician providing abortion care would not routinely have hospital admitting privileges, none of which are related to the quality of care they provide. Requirements for admitting privileges vary substantially from hospital to hospital – depending on the hospital affiliation, number of hospitalists, and administration. As such, hospitals may refuse to grant physicians privileges because of outside pressure or religious affiliation, or require physicians to live within a certain distance of the hospital, perform a minimum number of on-call days, or admit a certain minimum number of patients each year. These requirements are often insurmountable for physicians in many practice areas, including abortion care.

B. Medically Irrelevant Physical Facility Requirements

In addition to hospital admitting privilege requirements, 27 states have restrictions in place that single out abortion facilities for onerous physical plant requirements or politically motivated,

[4] *Facts on Induced Abortion in the United States*, GUTTMACHER INSTITUTE, http://www.guttmacher.org/pubs/fb_induced_abortion.html (last updated Feb. 2014).

medically unnecessary policies and equipment standards. For example, 13 states have regulations that set forth size requirements for procedure rooms and corridors. Other states have placed onerous regulations on lighting fixtures, temperature requirements, ventilation systems, and items such as landscaping or the number of parking spaces. Abortion care is a simple surgical or pill-based procedure that is typically provided in outpatient settings. These types of regulations are not evidence-based and vary substantially from what is medically necessary for the health and safety of patients, as well as what is required of facilities providing comparable medical care. Any physical plant requirements for health care facilities that provide abortion care should be based on the services provided, not on politics.

Imposing medically unnecessary physical facility requirements places a substantial burden on abortion facilities, often forcing health care providers to undertake extensive renovations that serve no medical purpose, or close their doors entirely, negatively impacting women's access to safe abortion care.

III. Legislative Interference with Evidence-Based Provision of Medication Abortion

The Women's Health Protection Act would create protections against state regulations that limit a physician's ability to prescribe or dispense drugs based on established standards of care and good faith medical judgment. Seventeen states have passed regulations that interfere with current medical practice for the provision of medication abortion.

Medication abortion is abortion induced with FDA-approved drugs mifepristone (RU-486) and misoprostol, and is most effective up to ten weeks into a pregnancy. Medication abortion allows a woman to have a safe, effective abortion without a surgical procedure. More than 2 million women in the US have chosen to have a mifepristone medication abortion since it was approved by the FDA in 2000.

As a result of numerous studies and considerations, it is now the international standard of care for medical professionals to follow an evidence-based regimen when prescribing medication abortion that differs from the FDA label. There is nothing unusual about this. The FDA does not regulate the practice of medicine – its regulatory process is a threshold for approving drugs for use. It is standard medical practice in the U.S. for medical professionals to prescribe FDA-approved drugs in dosages and for medical indications that were not specifically approved – or even contemplated – in the FDA labeling process. The FDA does not automatically update a drug label when a new standard of care is adopted by the medical community. The drug manufacturer must pay for an FDA label change. Thus, off-label or evidence-based use of medication is very common.[5] If a state were to bar all off-label drug uses, the effect would be widespread with broadly negative consequences on patient care and treatment options. Once again, anti-choice politicians have singled out abortion care for a different standard than is applied to other comparable procedures.

[5] David C. Radley et al., *Off-label Prescribing Among Office-Based Physicians*, 166 ARCHIVES INTERNAL MED. 1021, 1021-1026 (2006).

NAF's *Clinical Policy Guidelines* allow evidence-based regimens because they are safe, supported by peer-reviewed research, and use a lower dose of medication that is equally effective. Domestic and international organizations have done the same, including Planned Parenthood Federation of America, the American College of Obstetricians and Gynecologists, the World Health Organization, and the Royal College of Obstetricians and Gynecologists. Regulations of medication abortion that limit use to the FDA protocol are out of step with the medical standard of care and do nothing to improve the health and safety of women. These regulations were designed to limit access to a safe, effective abortion option by requiring an outdated medical practice.

IV. TRAP Laws Will Continue to Erode Women's Constitutionally-Protected Rights

In states like Tennessee, Mississippi, Alabama, Arkansas, Texas, Oklahoma, Louisiana, North Dakota, and Ohio, abortion restrictions have eroded the availability of abortion care to critically low levels. Enactment of TRAP laws discourages health care providers from offering abortion care by making provision overly burdensome and expensive. In 2011, 89% of counties in the United States were already without an abortion care provider.[6] Further decreasing access to abortion care with politically motivated restrictions jeopardizes women's health. Unfortunately, low-income women and women of color disproportionately bear the burden of these restrictions.

We urge you to support every woman's right to access safe, legal abortion care, and pass the Women's Health Protection Act.

V. Testimony of National Abortion Federation Members from Ohio, Pennsylvania, and Tennessee on the Impact of Anti-Abortion TRAP Laws

Testimony of Chrisse France, Med, Executive Director,
Preterm, Cleveland, Ohio
In support of the Women's Health Protection Act, July 15, 2014

My name is Chrisse France, and I am the Executive Director of Preterm, an independent, nonprofit abortion care clinic in Cleveland, Ohio. Preterm is an Ohio state-licensed ambulatory surgery center (ASC) that provides abortion care and reproductive health services for 5,000 women annually. We have served the women of Cuyahoga County, Northeast Ohio, Western Pennsylvania, and beyond since 1974. We provide compassionate, high-quality abortion care and related services in a safe and comfortable environment.

Since 2011, Ohio has enacted some of the most challenging restrictions to abortion access in the country. That year, we were required to begin using only the FDA-approved regimen for medication abortion with mifepristone and misoprostol. Clinics and physicians in every state, including Ohio, have used the more effective and better-tolerated evidence-based regimen since FDA-approval in 2001. Using evidence-based regimens that vary from the FDA label is very common in all fields of medicine.

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[6] RACHEL K. JONES & JENNA JERMAN, GUTTMACHER INST., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2011, 1 (2014), *available at* http://www.guttmacher.org/pubs/journals/psrh.46e0414.pdf.

Now, however, Ohio doctors are forced to use the less effective and more expensive FDA-approved regimen. As a result, women have to make a total of four clinic visits, instead of two. And rather than taking the second medication – misoprostol – at home, women are now required to take the medication at the clinic. Prior to this requirement, women took misoprostol at home, which is preferable so that they can complete the abortion in the privacy and comfort of their own home and not have to travel during this time when they may be experiencing cramping and bleeding. Also, the FDA-approved regimen requires three times the dose of mifepristone than what is effective under the evidence-based regimen.

By preventing a physician from using a safe and effective alternative to the FDA-approved regimen, this law takes away their medical decision-making capabilities and legislates how physicians can practice medicine. Likewise, the law takes away the decision-making capacity of their patients.

In 2010, 624 women chose to have a medication abortion at Preterm. In 2011, that number dropped to 345, and then to 90 the following year. There was a corresponding increase in surgical abortions, indicating that women do not change their minds about their abortion decision, regardless of the restrictions and attempts to limit their access.

Consider a woman who makes the decision to have an abortion in Ohio, which more than 24,000 women did in 2012. These are the legislative and regulatory barriers she faces:

- If she is low-income she must gather enough cash because Medicaid and most insurance companies will not pay for her abortion. The cost is around $400 for a first trimester abortion and more than $1,000 if she is in her second trimester.
- She then makes her first of at least two appointments. She has to walk through a gauntlet of mostly older male protesters who scream at her "not to kill her baby."
- She has to be offered Ohio state government-mandated resources about birth and adoption. She may accept or refuse the materials. Almost everyone declines.
- She must be informed of the gestational age of her pregnancy and whether or not a heartbeat is heard, offered the opportunity to view or hear the heartbeat on an ultrasound, and be informed as to the probability, based on her gestational age, of carrying the pregnancy to term. This often makes women cry, but it does not change their minds; it just makes them feel shamed and stigmatized.
- She must wait more than 24 hours before having her abortion.
- If she chooses medication abortion she must make a total of four visits to the clinic. If she is beyond 16 weeks, her abortion will take place over three days. All other women must make at least two visits.

Ohio also has a requirement that every ASC must maintain a written transfer agreement with a local hospital. Due to another state requirement, public hospitals are forbidden from entering into transfer agreements with abortion clinics. That poses a nearly impossible hurdle for providers in communities where the only hospital is a public hospital or part of a Catholic hospital system. This requirement is unnecessary and burdensome, and does absolutely nothing to improve the quality of care. The risk of

complications requiring hospitalization for a first trimester abortion are 0.71 per 1,000 women, far safer than most surgical procedures.[7] While transfers are extremely rare, hospitals are required to accept patients, regardless of from where the patient is transferred. Hospital transfer agreements should not be susceptible to political pressure from groups with an agenda other than absolute patient safety. However, this is exactly what is happening in Ohio as the only ASCs that have been unable to obtain a transfer agreement are abortion clinics. Because of the politicized process, the requirement to obtain and update a transfer agreement annually is onerous and unnecessary, for both the hospital and the ASC.

Although I believe that all health care facilities should be expected to maintain the highest quality of care and that inspections help ensure high quality care, the requirements that I have discussed in my testimony are both burdensome and medically unnecessary. My clinic already abides by a number of federal and state laws, and has been licensed in the state of Ohio as an ASC since 1997. Additionally we are accredited by a number of professional associations, including the Accreditation Association for Ambulatory Health Care (AAAHC). Accreditation is a voluntary process through which an ambulatory health care organization is able to measure the quality of its services and performance against nationally recognized standards. The accreditation process involves self-assessment by the organization, followed by thorough on-site review by the AAAHC's expert surveyors, who are themselves, health care professionals. Likewise, Preterm is a member of the National Abortion Federation and the Abortion Care Network.

In the past year, four Ohio clinics have closed and three more are appealing mandates to close because of the transfer agreement requirement. Cincinnati may soon be the largest metropolitan area in the country without an abortion provider. Women, especially low-income women and those with health conditions, already have to travel considerable distance to receive abortion care. Ohio women deserve better, and the Women's Health Protection Act is necessary to protect women – including Preterm's patients – from additional harmful state restrictions, which impose unnecessary and burdensome regulations on abortion providers and create barriers to women's access to abortion care.

Testimony of Kim F. Chiz, RN, BSN, Director of Nursing,
Allentown Women's Center, Allentown, Pennsylvania
In support of the Women's Health Protection Act, July 15, 2014

Since 1978, the Allentown Women's Center, now located in Bethlehem, Pennsylvania, has provided reproductive health care services, including abortion care, to a large geographic region extending well beyond our home in the Lehigh Valley. Most of the counties in Pennsylvania have no abortion care provider and many of our patients spend long hours in cars and buses to obtain the care they need.

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[7] *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Edited by Maureen Paul, MD et al. Wiley and Sons, 2009

Some of them come from Pike, Luzerne, Bradford, Lackawanna Counties, and the coal regions of Central Pennsylvania. Some travel from as far as Western New Jersey, Southern New York, the state of Delaware, and the Pennsylvania cities of Williamsport and State College.

Even without anti-choice legislation, our patients face many obstacles in obtaining abortion care. Hurdles can include: child care; lack of funds, which often forces patients to borrow money or spend their savings; severe weather; juggling work and school; and transportation, which often includes finding someone to drive them home and/or often travel three or more hours to reach us. When they arrive at our clinic, they must drive or walk past the aggressive, shouting bullies who often make them feel scared, threatened, and shamed. If they have insurance, it often does not pay for their abortion care. Many must take unpaid time off from work or school to get here. Even though *Roe vs. Wade* legalized abortion care in 1973, these are some of the obstacles Pennsylvania women have always had to surmount in order to maintain their reproductive autonomy. Before 1973, Pennsylvania women had abortions. The lucky ones traveled to states where it was legal or found competent medical practitioners to help them illegally, closer to home. The unlucky ones died by their own hands or by those of an unsafe, untrained person. Women have always needed access to abortion care and they always will.

In 1982, Pennsylvania increased the number of unnecessary, burdensome provisions that a woman must overcome to obtain abortion care with the passage of the Abortion Control Act, which the Supreme Court of the United States upheld in *Planned Parenthood v. Casey* in 1992. As a result, our patients have unnecessarily tolerated waiting periods and a parental consent requirement, and have listened to Pennsylvania state-mandated information which often has nothing to do with their circumstances. They have been belittled by their government's assumption that they do not know what happens inside their own bodies during pregnancy. Women under 18 years of age, who were unable to obtain parental consent because of domestic violence, have sat before judges to request permission to access basic health care services. Yet they continue to need us.

While the burdens imposed by the Abortion Control Act will not be alleviated by the passage of the Women's Health Protection Act, its passage would provide some very real protections for Pennsylvania women, particularly against the targeted regulation of abortion providers (TRAP) that reduces access to abortion care. For example, it would block the passage of an unnecessary and dangerous Hospital Clinical Privileges Bill which is currently pending in Pennsylvania's State Legislature. This bill would require physicians who provide abortion care to establish a business contract with a hospital, which can be nearly impossible to get due to the politicized process, and is unnecessary and does not improve patient safety. Our physicians are already board certified, our nurses have professional licensure, and our staff already provides safe and compassionate care.

These requirements are unnecessary as, in the highly unlikely event a complication does occur, Pennsylvania abortion clinics already have transfer agreements with local hospitals in place to handle these complications. Also, the bill targets only physicians who are providing abortion care, which has an incredible safety record, unparalleled to surgical procedures that would not be covered in this bill. This privileges bill would not apply to gastroenterologists providing colonoscopies, orthopedic surgeons

performing complex out-patient surgical repairs or any other physician operating outside of a hospital. Instead, the true intent of the bill is to close Pennsylvania abortion clinics, as we have seen in other states.

Not only would WHPA provide protection against admitting/clinical privileges laws, but also against medically irrelevant physical facility requirements. In 2011, the Pennsylvania State Legislature passed a law that requires abortion care providers to meet the requirements of Ambulatory Surgical Centers (ASC). ASCs provide a wide variety of surgical procedures that are more complicated than abortion care, including sterile orthopedic, ophthalmologic, gastroenterological, and cosmetic surgeries. Abortion care is a simple procedure that does not necessitate large sterile fields or high-tech air flow systems. Despite the clear differences between a true ASC and our abortion clinic, we have been required to meet these regulations.

Finally, this ASC TRAP law resulted in the closure of many Pennsylvania abortion clinics. Additional clinics were required to cut back the services they offer and can no longer provide later care. This has made a long trip even longer for many women and increased their already burdensome expenses. We have already heard reports of women self-inducing abortion through herbal medications and ordering black market medications from dubious internet sources. The passage of additional TRAP laws has not – and will not – make women safer, it will do the very opposite. When women cannot access safe and legal abortion, they will turn to other means.

Passage of the Women's Health Protection Act will protect our patients from additional state laws which do not improve their safety, but instead close clinics and add to the burdens women already face. This would not be the first time federal legislation could help to protect women. In 1994, the federal government acted to protect our patients from clinic violence and harassment through the Freedom of Access to Clinic Entrances (FACE) Act. We are in need of a federal protection again. Due to the onslaught of state legislation nationwide that imposes medically unnecessary and burdensome regulations on abortion providers and creates barriers to women's access to abortion care, it is time for a federal law that will protect women's constitutional rights, and the Women's Health Protection Act would do just that.

Testimony of Katy Leopard, Director of Community Partnerships,
Choices: Memphis Center for Reproductive Health, Memphis, Tennessee
In support of the Women's Health Protection Act, July 15, 2014

My name is Katy Leopard and I work at Choices: Memphis Center for Reproductive Health in Memphis, Tennessee, as the Director of Community Partnerships. For 11 years I was a stay at home mother of three children, PTA President, and active volunteer in my church. Memphis, Tennessee, is a city of exceptional beauty and a unique, gritty, southern charm. Memphis is also a city of desperate poverty and racial disparity and it was those issues I wanted to address when I went back to work. Choices is an independent, non-profit, community health center founded in 1974 following the Roe v. Wade Supreme Court ruling. The agency's mission is to empower individuals in the Mid-South community to make

informed choices for and about their reproductive health. Choices is working to build a comprehensive reproductive medical practice that provides a range of sexual and reproductive health services for more than 3,000 women, men, and teens each year.

Women do not come to Choices because they want to have an abortion. They come because they do not want to be pregnant. Or because a pregnancy is not sustainable, or because it would endanger their health. Some of them see that having a baby right now will cause them to have to quit the job they just got, or withdraw from the college they just entered, or further aggravate an already dangerous family situation at home. They come to us from Mississippi, Arkansas, and beyond not because they want to spend some time visiting Memphis, or because they have a caring primary care physician who could meet their needs at home but referred them to us instead, or because a family friend knows our doctor. They come because they are desperately trying to stay in control of their lives. The Women's Health Protection Act can help these women.

The women who come to Choices often cannot pay for their care without assistance. They often have to provide written excuses to bosses who want to know why they have to miss a day, and often have to scrape together gas or hotel money in order to pay to travel long distances to have a procedure which is legal but highly stigmatized. They have to park next to and pass by people who yell at them through megaphones, call them murderers, and reach into their car windows. Every day there are men and women who come to Choices for regular wellness exams, STI testing and treatment, pregnancy planning help or pregnancy prevention counseling. The Women's Health Protection Act can help these people.

But not if Choices does not exist.

Recently in Tennessee the state legislature passed a law requiring that doctors who perform abortions have hospital admitting privileges. This medically unnecessary law has had disastrous consequences for abortion access in communities in which religiously affiliated hospitals refuse to offer privileges to physicians who provide abortions. Private hospitals have no accountability to the community and should not have this power over women's access to abortion. Luckily, Choices' physician has admitting privileges but another clinic providing abortions in Memphis was forced to close as a result of this law, severely straining current capacity. In Tennessee, a woman has a short window in which to determine if she is pregnant and then to make a decision to continue the pregnancy or not. Because of the more limited capacity now in the Mid-South area, many women are not able to schedule an appointment before they are too far in their pregnancy. This forces a woman to carry an unwanted pregnancy to term or to travel even greater distances at greater expense to obtain an abortion.

Under another law specifically targeted at abortion providers in Tennessee, Choices is required to be licensed as an ambulatory surgical center. This requirement insists that Choices be outfitted with medically unnecessary but expensive building requirements. Forcing clinics to meet ambulatory surgical center standards, even if they only do first-trimester abortions, which can be done in a short procedure or with a pill, is yet another attempt by the Tennessee Legislature to prohibit women from accessing safe and legal abortion care.

Many other laws already passed by the Tennessee state legislature would have closed the doors of Choices. Thankfully, the Tennessee Supreme Court has ruled these laws in violation of the state constitution. In November, voters in Tennessee will decide on a change to that constitution, which would open the door for increasingly restrictive laws designed to shut clinics like Choices down. Under the guise of "protecting women's health" these new laws would legislate Choices and a women's constitutional right to safe and legal abortion out of existence in Tennessee.

The Women's Health Protection Act can help the women of Tennessee. We urge you to pass it.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 21, 2014

Dear Chairman Leahy and Ranking Member Grassley and Members of the Senate Judiciary Committee:

We thank the Committee for holding a Congressional hearing on S.1696, "The Women's Health Protection Act of 2013" and for providing advocates the opportunity to provide written testimony on this important piece of legislation. We believe the Women's Health Protection Act is critical in ensuring access to the full range of reproductive healthcare, including abortion care, for all women, particularly Latinas, regardless of where they live. We are honored to submit the enclosed testimony.

We hope to draw the Committee's attention to the negative impact that restrictions on abortion care have on Latinas and how these restrictions compound the health inequities that Latinas, their families, and their communities currently experience. For instance, in states such as Texas, Latinas disproportionately experience a wide range of health problems and treatable diseases, such as cervical cancer. Restrictions on reproductive healthcare, including abortion care, contribute to the negative health outcomes of these women by delaying access to needed care and limiting access to providers and other sources of care.

Finally, restrictions on abortion care are out of step for what most Latinos/as think regarding political interference in Latina decision-making. Seventy-four percent of registered Latino/a voters agree that a woman should be able to make her own personal, private decisions about abortion care without political interference.[1]

[1] Lake Research Partners, Reproductive Health Technologies Project & National Latina Institute for Reproductive Health. Poll: Latino Voters Hold Compassionate Views on Abortion; 2011: 1. Available at: http://latinainstitute.org/Latinopoll. [Last accessed on July 9, 2014].

Again, thank you for this opportunity to submit written testimony. We believe the Women's Health Protection Act can provide Latinas and other women of color one more tool in achieving health equity. A woman's zip code should not determine the healthcare she receives.

Sincerely,

Jessica González-Rojas
Executive Director

Enclosure: NLIRH S. 1696, "The Women's Health Protection Act of 2013" Testimony

CC: Laurel Sakai and Rose Goldberg
Office of United States Senator Richard Blumenthal

CC: Kristine Kippins
Federal Policy Counsel
Center for Reproductive Rights

Stories of Those Who Have Suffered when Politicians Interfere in Women's Personal Health Decisions

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Danielle Deaver
Nebraska

"I want my daughter's life — and the tragic circumstances surrounding her death — to stand for something."

At 22 weeks, Danielle Deaver's water broke prematurely. She and her husband Robb learned she'd experienced a spontaneous rupture of her membranes, resulting in the loss of most of the amniotic fluid surrounding the fetus. From that point, her body was unable to retain any fluid, which a doctor told her would result in little or no further lung development, inability for limbs to develop properly, and less than a 10 percent chance the fetus would survive after delivery. The doctor could not legally induce labor due to Nebraska law, and told Danielle to wait for the start of labor. Danielle went into early labor at 23 weeks, and post-delivery pathology showed that she had begun to develop an infection. Her baby was alive for 15 minutes.

Chantelle Kendall
Utah

"It was on a Friday, and it was at 3:00 a'clock, and by the time the radiologist read us the report it was 5:00. I had to wait a week, being pregnant, feeling this baby kick, it was such a nightmare.

Chantelle and her husband Richard were elated about her pregnancy. Everything was going fairly well until about the 17th week, when a radiologist told the couple that their baby had severe brain defects and that "if the baby survived through delivery he would almost certainly live a life of suffering, requiring a feeding tube and round-the-clock care." Chantelle and Richard made the devastating decision to terminate the pregnancy. Because of the timing of their initial report from the radiologist, and because Utah legislators had recently passed a provision mandating a 72-hour waiting period for a woman seeking an abortion, Chantelle was forced to continue her pregnancy for an additional agonizing week.

Liz Read-Katz
Missouri

"This was the hardest and saddest decision I have ever made but one that I made because it was in my best interest, my family's best interest and because I loved my baby so much that I couldn't stand the thought of her being born in pain and agony and only to ever see the walls of a hospital....An additional 72 hour wait, extra ultrasounds, mandatory videos would not have changed my mind, they would have just caused me more pain than I was already going through."

Liz and her husband were ecstatic about her pregnancy. But after genetic testing at about 16 weeks, Liz received a call from her doctor notifying her that her that chances of having a child with Trisomy 18 had gone from 1 in 3,000 to greater than 1 in 10. A high-resolution ultrasound at 17 weeks, 1 day found a heart defect, digestive issues, and markers for Trisomy 18. Amniocentesis confirmed that Liz's baby had Trisomy 18, which her genetic counselor told her is considered incompatible with life. She and her husband made the heartbreaking and difficult decision to terminate her pregnancy. After the procedure, her doctor informed her all of the baby's large joints had been formed incorrectly and "had he been born alive he would have been born in agony," and the day after, she learned from her genetic counselor that her baby's external sex organs had also not formed properly.

Christie Brooks
Central Virginia

"My husband and I were confronted with two equally horrible options — carry the pregnancy to term and watch our baby girl suffocate to death upon birth, or terminate the pregnancy early and say goodbye to our much-wanted and much-loved baby girl."

Christie was pregnant with her second child, a planned and wanted pregnancy. After a 20 week ultrasound, she found out her daughter would be born with a severe structural birth defect called congenital diaphragmatic hernia (CDH), and would suffocate at birth. She made the difficult decision of ending the pregnancy at 22 weeks.

Judy Shackelford
Wisconsin

"'I know what it is like to live without a mother,' Shackelford says. 'My mother died when I was only four years old, and it changed my life forever.'"

Four months into her pregnancy, Judy developed a pregnancy-induced blood clot in her arm. The only guarantee that she wouldn't die and leave behind her five-year-old son was for Judy to terminate the pregnancy. She and her husband made the very difficult decision to terminate the pregnancy.

Cecily Kellogg
Pennsylvania

Cecily was 23 weeks pregnant with her twin sons, Nicholas and Zachary. She was suffering from a number of health complications when she found out they were symptoms of preeclampsia. Cecily went in for an ultrasound with her husband, where they found out one of their sons had died. Her health worsened rapidly, and after doctors failed to stabilize her condition, Cecily and her husband were told they would have to terminate the remaining pregnancy to preserve her life.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 14, 2014

Dear Chairman Leahy and Ranking Member Grassley:

As national, state, and local organizations committed to women's reproductive health, rights, and justice, we write in support of the **Women's Health Protection Act of 2013**.

Despite the clear constitutional rights established more than four decades ago in the landmark Supreme Court decision *Roe v. Wade*, each year politicians across the country pass harmful restrictions in an effort to roll back a woman's right to make the best health care decisions for herself and her family. Any one of these restrictions imposed on health care providers and abortion services can have a devastating impact on the women affected by it. But when all of these various attempts to block access to abortion work together, the effect is often catastrophic—making a range of essential reproductive health care virtually impossible to obtain for far too many women.

Every pregnant woman faces her own unique circumstances and potential challenges, and she must be able to make her own decisions based on her personal values, the advice of the medical professionals she trusts, and what's right for her family. In recent years, however, politicians have increasingly sought new ways to interfere with personal decision-making and undermine women's access to abortion care. State legislatures have been more active than ever in passing burdensome requirements that single out abortion providers and services and do nothing to advance women's health or safety —and, in fact, ultimately jeopardize women's health. States enacted a record-breaking 92 restrictions on abortion in 2011, and over 100 additional dangerous and unnecessary measures have passed into law since then.

Examples of restrictions on abortion that have been enacted with increasing frequency in recent years that single out abortion services and impede access include:

- Requirements that health care providers perform tests and procedures even if they are not medically necessary;
- Measures that force health care providers to follow outdated medical guidelines rather than follow the current standard of care;
- Prohibitions on expanding access to women in rural areas through telemedicine;

- Requirements imposed on health care facilities that perform abortion that normally apply to hospitals or ambulatory surgical centers;
- Requirements that physicians at abortion clinics maintain admitting privileges at local hospitals, despite the safety of abortion and the fact that admitting privileges are not necessary in the event of a complication;
- Measures that require a woman seeking an abortion to make multiple unnecessary trips to the abortion provider; and
- Making a woman visit an anti-abortion "crisis pregnancy center."

A woman's constitutional rights should not depend on her zip code. But the legislative attacks on reproductive health care have made it so that women in some parts of the country have diminished access to essential reproductive health care. We need a federal law that would make these restrictions unlawful, thus allowing medical providers to do the important work of providing safe, legal, high-quality health care to all women across the country. We need the **Women's Health Protection Act**. We thank you for calling a hearing on this critical legislation and pledge our support in working toward its passage.

Sincerely,

Abortion Care Network
Alliance for Justice
American Association of University Women
American Civil Liberties Union
American Congress of Obstetricians and Gynecologists
Association of Reproductive Health Professionals
Atlanta Women's Center
Black Women's Health Imperative
Blue Mountain Clinic Family Practice
Catholics for Choice
Center for Reproductive Rights
Center on Reproductive Rights and Justice at UC Berkeley School of Law
Cherry Hill Women's Center
Civil Liberties and Public Policy
Delaware County Women's Center
Feminist Women's Health Center
Hadassah, The Women's Zionist Organization of America, Inc.
Hartford GYN Center
Ibis Reproductive Health
Jewish Women International
Law Students for Reproductive Justice
Medical Students for Choice
MergerWatch Project

NARAL Pro-Choice America
National Abortion Federation
National Asian Pacific American Women's Forum
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Health
National Network of Abortion Funds
National Partnership for Women & Families
National Women's Law Center
National Women's Health Network
Northland Family Planning Centers, Michigan
Nursing Students for Choice (NSFC)
Oklahoma Coalition for Reproductive Justice
People For the American Way
Philadelphia Women's Center
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Connection
Presidential Women's Center
Religious Coalition for Reproductive Choice
Reproductive Health Access Project
Reproductive Health Technologies Project
Sexuality Information and Education Council of the U.S. (SIECUS)
South Carolina Coalition for Healthy Families
Southwest Women's Law Center
Trust Women/Silver Ribbon Campaign
Tucson Women's Center
Whole Woman's Health
Wisconsin Alliance for Women's Health
Women's Medical Fund (Pennsylvania)

United States Senate
Committee on the Judiciary

Hearing
"S.1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights"

Testimony Submitted for the Record by the Undersigned Organizations

July 22, 2014
Washington, DC

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 22, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

We, the undersigned reproductive justice advocates,[1] write in support of the Women's Health Protection Act, which protects a woman's ability to obtain abortion services by dismantling many of the barriers that currently exist for women seeking this important health care. Every woman faces her own unique circumstances, challenges, and potential complications, and must be able to make her own decisions based on her doctor's advice, her personal values, and what is best for her and her family. Every woman needs affordable and accessible pregnancy-related care, including abortion, regardless of where she lives and notwithstanding her economic, political, or personal situation. We urge Congress to pass the Women's Health Protection Act, and uphold our nation's promise of equal rights under the Constitution, so that every woman can make personal reproductive health decisions with dignity.

Despite the clear constitutional rights established in *Roe v. Wade*, a growing number of women are finding it increasingly challenging to access abortion care. In our communities throughout the country, it has become extremely difficult for women to safely and legally end a pregnancy because states have enacted laws singling out reproductive health care for onerous regulations that are not imposed on other areas of medicine. Lower income women, women of color, and young women are more likely to experience unintended pregnancy and therefore more likely to need abortion services than affluent white women: these outcomes are caused by socioeconomic disadvantage, lack of access to family planning, persistent forms of racism and other structural barriers to care, and mistrust in a medical system that has a history of discrimination and disparate treatment.[2] As a result, restrictions on abortion care amplify existing health disparities, disproportionately harming women who already face barriers to accessing quality health care, due to their socioeconomic status, gender, and race.

We can protect women's health and well-being by ensuring that every woman has access to the reproductive health care she needs. Restrictions imposed on health care providers and abortion services impede meaningful access to essential services to the detriment of public health — particularly for women who are already disadvantaged by systems of economic and racial oppression. According to a recent survey of state health departments, more than 50 abortion clinics have closed or stopped providing abortion since the 2010 onslaught of legislative attacks on reproductive health services began around the country.[3] In Mississippi, for example, a medically unnecessary admitting privileges law creates a significant obstacle to receiving care.

Mississippi is the poorest state in the country and is one of the reportedly five states that have only one remaining clinic.[4] Many patients of the sole Mississippi clinic already take on the burden of cost and two to three hours of travel to receive care.[5] The 2012 law would close the last remaining clinic in the state and would force women to venture out of state to access care.[6] For now, the clinic remains open while the case is pending in federal court.

The distance women must travel to reach an abortion provider negatively impacts their ability to access reproductive health services. Eighty-two percent of U.S. counties do not have abortion services and 74 percent of women living in rural areas must travel more than 50 miles to get to the nearest abortion clinic.[7] Rural women are doubly burdened by lack of access to care: not only due to a lack of providers, but also because 95 percent of U.S. counties that exhibit persistent patterns of poverty are in rural areas.[8] In 2008, one-third of U.S. women reported travelling more than 25 miles to reach a clinic and women in states with mandatory counseling and waiting period requirements were more likely than their peers to travel even further.[9] Despite strong evidence that medication abortion can be safely prescribed via telemedicine and dispensed by trained nurses, state legislatures have specifically targeted the way that women in rural areas access abortion by restricting the mode by which they receive the medicine and the medical professional who dispenses it.[10]

Every woman deserves to make informed decisions about her health care based on scientifically accurate information from a doctor she trusts, free from discrimination. Race and sex-selective abortion bans encourage medical professionals to scrutinize women based on racial or ethnic background, based only on stereotypes.[11] Such bans do nothing to address the true causes of racism and sexism; rather, they open up the floodgates to anti-immigrant and racist sentiments based in stereotypes about the Asian American community and about a black woman's ability to determine the best course to take in her reproductive health care.

Furthermore, women should not be mandated to receive or listen to false information prior to receiving care – not only because it is medically inaccurate, but also because restrictions requiring multiple visits unnecessarily increase the expense of the procedure. State-mandated biased counseling serves no purpose other than to intimidate and stigmatize women seeking medical treatment. Such laws have been proven to drive up the cost to women, thereby preventing services to some women and delaying care into the second trimester when the procedure is less safe.[12] African American women are regularly the target of misleading and false information intended to dissuade them from choosing abortion: for example, anti-abortion organizations often claim that communities of color are being targeted by abortion providers in order to commit "black genocide."[13] Finally, our nation's youth are in special need of medically accurate information about reproductive and sexual health: for example, research shows that Asian Pacific American teens are less likely to communicate with their medical provider about sexuality and risk prevention than any other ethnic group.[14]

A woman cannot make a meaningful decision about whether to become a parent if safe, legal, available, and affordable abortion services are out of reach. Approximately 69 percent of women obtaining abortions live close to or below the federal poverty level and 42 percent of those women reported income qualifying them as poor, meaning that they have income below 100 percent of the federal poverty line.[15] Poor women who decide to have an abortion often have to

wait many weeks to have the procedure while they raise the necessary funds and this wait drives up the cost and increases the risk of the procedure.[16] Women commonly cite financial barriers as leading to a delay in getting an abortion and if a woman is ultimately unable to afford the procedure, she may be forced to carry her unwanted pregnancy to term.[17] Furthermore, a woman working to raise the necessary funds must often divert money from paying for food, rent, or utilities, and harmful restrictions such as mandatory counseling and waiting periods compound the cost for women due to lost wages and added childcare and transportation expenses.[18] Moreover, young and low-income women are most likely to experience such delays, and thus mounting costs, due to procedures performed later in pregnancy.[19] Furthermore, research shows that women who carry unwanted pregnancies to term because they are denied care due to gestational age are three times more likely to fall below the federal poverty line within two years.[20]

Our government has a particular responsibility to ensure that women who have limited access to affordable health care can receive the same quality of care as those with means. Due to the link between institutional racism and socioeconomic disadvantage, women of color are at higher risk of living in poverty and are more likely to lack access to regular, high-quality family planning and other health care services.[21] Women of color are disproportionately affected by restrictions that increase the cost of an abortion because they are more likely than white women to experience unintended pregnancy,[22] to seek abortion care,[23] and to qualify for public insurance.[24] Sixty-six percent of women who have an abortion have some form of health insurance, but 57 percent report paying out of pocket, largely because many forms of state and federal Medicaid do not cover abortion.[25] Restrictions also unduly affect immigrant women, who are more likely to live in poverty than women born in the United States, and are routinely denied access to health care coverage, including abortion coverage.[26] In fact, low-income immigrants who qualify for Medicaid are excluded from coverage for their initial five years of residence.[27] Undocumented women are unjustly excluded from federal Medicaid benefits and cannot even purchase health plans at full price in state insurance marketplaces.[28] Such barriers to care are not only unfair, but are also flawed public health policy, preventing immigrants from maintaining their health and that of their families.

It should be noted that the reproductive health disparities affecting our communities are broader than high unintended pregnancy rates. More consistent exposure to medical care could improve health outcomes that significantly impact our communities, especially with regards to maternal mortality, HIV prevention, and earlier detection of cancers. Maternal mortality is highly pronounced for African American women, as they are three to four times more likely to die from pregnancy related causes than white women, a risk that is compounded by lack of access to contraception.[29] Lower income women and women of color are also less likely to receive routine exams such as mammograms and pap smears that improve early detection of life-threatening conditions. Most likely due to late detection and the prohibitive cost of care, African American women are more likely than any other group of women to die from breast cancer and Latinas are more likely to be diagnosed in a later stage of cancer when it is harder to treat than are white women.[30] Moreover, the racial disparity of HIV infection is stark: African American women are twenty times more likely than white women to be infected with HIV.[31] One in thirty-two African American women will be diagnosed with HIV in their lifetimes.[32]

Taken together, the barriers to accessing safe, legal, affordable abortion care, free from medically unnecessary restriction, are formidable and seriously undermine women's health, human rights, dignity, and self-determination. The Women's Health Protection Act would begin to address some, though not all, of these barriers, focusing on dismantling the restrictions aimed at closing clinic doors and making it more difficult and less dignified for women to access this care. We believe that this legislation, in combination with separate, but parallel efforts to restore insurance coverage for abortion, protect abortion access for young people, and eliminate violence against providers, will bring us closer to a landscape where every woman is able to get the health care she needs, regardless of her circumstances.

Every woman has the right to good health and well-being for herself and her family. But for too long, the reproductive health care needs of our communities have been undermined by inaccessibility of care, prohibitive costs, discrimination, and medically unnecessary and restrictive legislation. Study after study by national and international experts show that restrictions on abortion don't reduce its frequency, but rather delay or prevent women's access to the procedure. Every woman needs affordable and accessible pregnancy-related care, including abortion, regardless of where she lives and notwithstanding her economic or racial status or her personal situation. We urge Congress to act now and pass the Women's Health Protection Act.

Sincerely,

Abortion Rights Fund of Western Mass
ACCESS Women's Health Justice
Bay Area Doula Project
Black Women's Health Imperative
California Latinas for Reproductive Justice
Center on Reproductive Rights and Justice at Berkeley Law at University of California
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Forward Together
The Lilith Fund
Ms. Foundation for Women
National Asian Pacific American Women's Forum
National Latina Institute for Reproductive Health
New Voices Pittsburgh: Women of Color for Reproductive Justice
New Voices Cleveland: Women of Color for Reproductive Justice
Oklahoma Coalition for Reproductive Justice
Political Research Associates
Provide
Raising Women's Voices for the Health Care We Need
Religious Coalition for Reproductive Choice
SisterReach
SisterSong Women of Color Reproductive Justice Collective
SPARK Reproductive Justice NOW
Surge Northwest
Women's Medical Fund

Endnotes

[1] Asian Communities for Reproductive Justice, *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice* (2005); SisterSong Women of Color Reproductive Justice Collective, *What Is RJ?* (Jul. 21, 2014, 12:18 PM), http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81; Elsa Rios & Angela Hooton, *A National Agenda for Reproductive Justice*, National Latina Institute for Reproductive Health (2005); Courtney Chappell, *Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women: A National Agenda for Action*, National Asian Pacific American Women's Forum (2005).

[2] Christine Dehlendorf, et al. *Disparities in Abortion Rates: A Public Health Approach*. 103:10 American Journal of Public Health (2013).

[3] Laura Bassett, *Anti-Abortion Laws Take Dramatic Toll on Clinics Nationwide*, Huffington Post (Aug. 26, 2013), http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html.

[4] Tony Pierce, *America's Ten Poorest States*, CNBC.com (Sept. 27, 2013), http://www.cnbc.com/id/101068491/page/11; Amanda Ness, *Household Income: 2012*. United States Census Bureau (2013); Bassett, *supra*.

[5] Kate Sheppard, *Inside Mississippi's Last Abortion Clinic*, Mother Jones (Jan. 22, 2013), http://www.motherjones.com/politics/2013/01/inside-mississippis-lastabortion-clinic.

[6] *Id.*

[7] Erin McKelle, *Learning Intersectionality: A Process*, RH Reality Check (Jul. 2, 2014), http://rhrealitycheck.org/article/2014/07/02/learning-intersectionality-process.

[8] *Id.*

[9] Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?* 22:8 Journal of Women's Health, 706-713 (2013).

[10] Heather D. Boonstra. *Medication Abortion Restrictions Burden Women and Providers—and Threaten US Trend toward Very Early Abortion*. 16:1 Guttmacher Policy Review (2013); Dan A. Grossman, et al. *Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa*. 103:1 American Journal of Public Health, 73-78 (2013); Kate Grindlay, et al. *Women's and Providers' Experiences with Medical Abortion Provided through Telemedicine: A Qualitative Study*. 23:2 Women's Health Issues, e117-e122 (2013); Dan A. Grossman, et al. *Effectiveness and Acceptability of Medical Abortion Provided through Telemedicine*. 118: 2 Obstetrics & Gynecology, 296-303 (2011).

[11] Sital Kalantry & Miriam Yeung, University of Chicago. Replacing Myths with Facts: Sex Selective Abortion Laws in the United States (2014).

[12] Theodore J. Joyce, et al., Guttmacher Institute. The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review (2009).

[13] National Women's Law Center, *Crisis Pregnancy Centers are Targeting Women of Color, Endangering Their Health* (Jul. 21, 2014, 5:04 PM); Family Planning & Contraceptive Research, *Understanding Crisis Pregnancy Centers (CPCs)*. University of Chicago: Medicine (2013); Guttmacher Institute, *Claim that Most Abortion Clinics are Located in Black or Hispanic Neighborhoods is False* (Jul. 14, 2014, 11:23 AM), http://www.guttmacher.org/media/evidencecheck/provider-location.html; Akiba Solomon, *Another Day, Another Race-Baiting Abortion Billboard*, Colorlines, Mar. 29,201, 1http://colorlines.com/archives/2011/03/another_day_another_racist_billboard.html; Kai Wright, Georgia Anti-Abortion Billboards Turn Up in Los Angeles, Too, Colorlines, Feb. 25, 2011, http://colorlines.com/archives/2011/02/georgia_anti-abortion_billboards_turn_up_in_los_angeles_too.html; Miriam Zoila Pérez, Past and Present Collide as the Black Anti-Abortion Movement Grows, Colorlines, Mar. 3, 2011, http://colorlines.com/archives/2011/03/past_and_present_collide_as_the_black_anti-abortion_movement_grows.html.

[14] Sumie Okazaki, *Influences of Culture on Asian Americans' Sexuality*, 39 Journal of Sex Research 34, 37 (2002); Courtney Chappell, National Asian Pacific American Women's Forum, Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women (2005).

[15] Rachel K. Jones, et al, Guttmacher Institute, Characteristics of U.S. Abortion Patients, 2008 8 (2010).

[16] Heather D. Boonstra, Guttmacher Institute, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States (2007); Joyce, *supra*.

[17] Foster, et al., *supra*; Kawchi E. Janiak, et al. *Abortion barriers and perceptions of gestational age among women seeking abortion care in the latter half of the second trimester*, 89:4 Contraception, 322-7 (2014); Diana G. Foster, et al. Denial of abortion care due to gestational age limits. 87:1 Contraception, 3-5 (2013).

[18] Boonstra, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States *supra*; Sarah Jane Glynn & Jane Farrell, Center for American Progress. Latinos Least Likely to Have Paid Leave or Workplace Flexibility (2012); Tara Culp-Ressler, *By the Numbers: Why Most U.S. Women Struggle to Afford Abortion*, Think Progress (May 8, 2013) http://thinkprogress.org/health/2013/05/08/1979831/women-struggle-afford-abortion.

[19] Diana G. Foster, et al. *Predictors of Delay in Each Step Leading to an Abortion*. 77:4 Contraception, 289-293 (2008); Diana G. Foster & Katrina Kimport. *Who Seeks Abortions at or After 20 Weeks?* 45:4 Perspectives on Sexual and Reproductive Health, 210-218 (2013); Joshua Lang, *Unintentional Motherhood*, New York Times Sunday Magazine, Jun. 16, 2013, http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=all; Susan Yanow, National Women's Health Network. *Why Restrictions on Later Abortion Care Impact Us All* (Jul. 14, 2014, 11:19 AM), https://nwhn.org/newsletter/node/1420.

[20] Foster, et al., *supra*; Foster & Kimport, *supra*; Lang, *supra*; Yanow, *supra*.

[21] Alexandra Cawthorne. *The Straight Facts on Women in Poverty*, Center for American Progress, October 8, 2008, http://www.americanprogress.org/issues/women/report/2008/10/08/5103/the-straight-facts-on-women-in-poverty; Katherine Gallagher Robbins & Lauren Frohlich, National Women's Law Center. National Snapshot: Poverty among Women & Families, 2012 (2013).

[22] Mia Zolna & Laura Lindberg, Guttmacher Institute. Unintended Pregnancy: Incidence and Outcomes among Young Adult Unmarried Women in the United States, 2001 and 2008 (2012).

[23] Jones, et al, Characteristics of U.S. Abortion Patients, *supra*.

[24] January Angeles. *Ryan Medicaid Block Grant Would Cause Severe Reductions in Health Care and Long-Term Care for Seniors, People with Disabilities, and Children*, Center on Budget and Policy Priorities, May 3, 2011, http://www.cbpp.org/cms/index.cfm?-fa=view&id=3483.

[25] Jones, et al, Characteristics of U.S. Abortion Patients, *supra*.

[26] 20% of the uninsured in America are legally-present and undocumented immigrants and 22% of women of reproductive age in the United States are uninsured. Center For Reproductive Rights and National Latina Institute for Reproductive Health, Nuestra Voz, Nuestra Salud, Nuestro

Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley (2013); Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Jul. 14, 2014, 10:49 AM), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

[27] National Immigration Law Center, *Immigrants and the Affordable Care Act* (Jul. 14, 2014, 10:52 AM) http://www.nilc.org/immigrantsher.html; Kaiser Family Foundation, *supra*.

[28] Samantha Artiga, Kaiser Family Foundation Commission on Medicaid and the Uninsured, Medicaid and the Uninsured (2013).

[29] Office of Women's Health, *Minority Women's Health: Pregnancy-related Death*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:55 AM) http://womenshealth.gov/minority-health/african-americans/pregnancy.html; Guttmacher Institute, *Fact Sheet: Induced Abortion in the United States* (Jul 14. 2014, 10:57 AM), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[30] Office of Women's Health, *Minority Women's Health: African-Americans: Breast Cancer*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:55 AM), http://womenshealth.gov/minority-health/african-americans/breast-cancer.html; Office of Women's Health, *Minority Women's Health: Latinas: Breast Cancer*, U.S. Department of Health & Human Services (Jul. 14, 2014, 10:59 AM), http://womenshealth.gov/minority-health/latinas/breast-cancer.html.

[31] Division of HIV/AIDS Prevention, *HIV among African Americans*, Centers for Disease Control and Prevention (Jul. 14, 2014, 10:16 AM), http://www.cdc.gov/hiv/risk/racialethnic/aa/facts/index.html.

[32] *Id.*

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH
Salud | Dignidad | Justicia

S.1696 "Women's Health Protection Act of 2013"
Testimony submitted by
Jessica González-Rojas
National Latina Institute for Reproductive Health

U.S. Senate
Senate Judiciary Committee
July 21, 2014

Dear Chairman Leahy and Ranking Member Grassley and other distinguished members of the Senate Judiciary Committee:

I am honored to submit this testimony on behalf of the National Latina Institute for Reproductive Health.

The National Latina Institute for Reproductive Health (NLIRH) strongly urges the committee to support S.1696, the "Women's Health Protection Act of 2013." S.1696 will help ensure that women of color, particularly Latinas, are able to receive safe, legal, and quality reproductive healthcare regardless of where they live. NLIRH is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 26 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications.

Over the years, state politicians have passed several laws that erode access to the full range of reproductive healthcare, including abortion care, for women when they need it. So far in 2014, 13 states have passed 21 restrictions on abortion care.[i] For instance, Florida recently amended its state laws to further diminish a woman's ability to access late-term abortion care only if a woman's life or physical health is threatened.[ii] This restriction may impact the over 4.3 million Latinos/as that live in Florida.[iii] Other restrictions that impact Latina health include: prohibitions on the use of telemedicine to expand access to healthcare for women in rural areas; requirements that effectively force a woman seeking abortion care to make multiple trips to a provider; requirements on reproductive healthcare facilities that provide abortion care that mainly apply to hospitals or ambulatory surgical centers; and several others. The Women's Health Protection Act is needed to reverse the harmful impact of these restrictions so that providers are able to give quality, reproductive healthcare to all Latinas.

State level restrictions on abortion services create additional barriers to quality, healthcare for women of color, including Latinas. These restrictions exacerbate current health inequities these communities face and contribute to

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH
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negative health outcomes.

As of now, more than 33 percent of Latinos/as do not have health insurance.[iv] Almost a quarter of Latinas live at or below the poverty level,[v] and over 40 percent of Latina headed family households live below the poverty level.[vi] Due to such high rates of poverty, for many women of color, they will need federal insurance coverage to meet their health care needs. As of now, 3 in 10 Latinas qualify and are enrolled in Medicaid.[vii]

Additionally, Latina communities suffer from disproportionately high rates of preventable and treatable reproductive health conditions. Nationally, Latinas are diagnosed with cervical cancer at nearly twice the rate of non-Latina white women.[viii] Latinas also experience disproportionately high rates of unintended pregnancy[ix] and sexually transmitted infections including HIV.[x] Access and cost of care, are among several attributing factors. In fact, 57% of young Latinas ages 18-34 have struggled with the cost of prescription contraception, making it highly likely that they will not be able to use contraception on a regular basis.[xi]

Geography also plays a role in determining the health outcomes of Latinas. In Texas, Latinas report a higher rate of health concerns, such as diabetes, cardiovascular disease, obesity, and cancer mortality, than Latinas nationally.[xii] Additionally, Texas women experience cervical cancer at a rate 19 percent higher than the national average, but Texan Latinas also have a higher incidence of cervical cancer than their white or Black peers in the state.[xiii] Immigrant Latinas in Texas are also more likely to experience cervical cancer.[xiv] Women living in counties bordering the Texas-Mexico border are 31 percent more likely to die of cervical cancer compared to women living in other counties.[xv] In Texas, where Latinos are three times as likely to live in poverty as whites,[xvi] racial health disparities are more severe in areas like the Lower Rio Grande Valley ("Valley").

Furthermore, Latinas have less access to affordable health insurance and healthcare if they live in a state that has not expanded Medicaid, severely impacting already medically underserved communities. In Texas, 50 percent of Latinas of reproductive age do not have health insurance[xvii] and many of these women will lose the opportunity to access reproductive healthcare because Texas has not expanded Medicaid.

Restrictions on abortion care have several, negative consequences for Latina health and well-being.

Measures that restrict access to abortion services further delay and increase the cost of abortion care for women. These policies create additional barriers to care for low-income, women of color, including Latinas, who rely on the federal government as their source of insurance coverage. This is especially true for women

who qualify and are enrolled in Medicaid because they are subject to the Hyde Amendment, which is a total ban on abortion coverage with limited exceptions for Medicaid enrollees. Because of this, many women who are making ends meet and who qualify for Medicaid are forced to continue with their pregnancies. Due to lack of Medicaid insurance coverage, between 18% and 35% of women who needed abortion care continued their pregnancies.[xviii] In states such as Texas, Latinas may pay an additional $146 dollars in seeking abortion care due to its 24 hour waiting period.[xix] Such restrictions on abortion care may put Latinas and their families in economic distress. In fact, studies show that women who need abortion services but are denied care are three times more likely to fall into poverty than those who are able to receive abortion care.[xx]

For immigrant Latinas, their immigration status dictates the healthcare they are able to receive. Restrictions on abortion care negatively impact their health and well-being by further limiting their options in accessing the full range of reproductive healthcare. Currently, undocumented Latinas and Deferred Action for Childhood Arrivals (DACA) recipients are barred from the tax credits and premium benefits of the Affordable Care Act, from using their own dollars to buy health insurance in the marketplaces, and are not eligible to apply for the Children's Health Insurance Program (CHIP) or Medicaid.[xxi] Additionally, Latinas who have been legal permanent residents for less than five years are also not eligible for Medicaid or CHIP.[xxii] Many immigrant Latinas may not have the necessary government identification to access affordable, healthcare services at clinics.[xxiii]

Also, immigrant Latinas face a lack of culturally and linguistically competent providers and lack of access to healthcare due to geography and lack of transportation. For many Latinas in the Valley in Texas who live in *colonias*, or unincorporated communities along the Texas-Mexico border, they may need to travel to a healthcare provider in cities, such as McAllen or Brownsville, which are several miles away. This is a real barrier given that these women face limited availability of public transportation or they must rely on private transportation to access the care they need. Making such arrangements has its own set of challenges, including taking time off of work, arranging and paying for childcare, saving money for gas, and waiting for friends and family to take them to their appointments.[xxiv] In our Nuestro Texas report, some Latinas underscored how transportation is a constant source of concern for them. A Latina from Mission, Texas, stated, "Sometimes it's a struggle, right, because [my husband] works and I don't drive. Most of the time we manage, but if he can't, then I just have to miss my appointment because we have no public transportation."[xxv] Because there are no local accessible clinics in Mission, this Latina and her family must travel to San Juan which is a half-hour drive away.[xxvi]

Sometimes, Latinas in the Valley are able to access preventive health tests, such as pap smears, at mobile clinics, but these clinics may only come to these women's

communities once a year.[xxvii] If these women cannot access affordable reproductive healthcare, they will often make the decision to travel to Mexico to access this care. For many, this is a difficult decision to make as they may not be able to return if they are undocumented.[xxviii]

Also, there are few sources of care for Latinas who need access to the full range of reproductive healthcare. Often, these restrictions impact providers who not only provide abortion care, but who also provide preventive healthcare, such as cervical cancer screenings, testing for sexually transmitted infections, and contraceptive care.[xxix] As one Latina commented in our Nuestro Texas report, "We have all the information we need on reproductive health but have no access and no money. What good is the information if we don't have help or access?"[xxx] Furthermore, for low-income Latinas who cannot access abortion care through Medicaid, they cannot seek this service at community health centers.[xxxi]

Finally, restrictions to the full range of pregnancy-related care may put Latinas at risk for unsafe abortion care, including care from unlicensed practitioners.

In addition, restrictions on abortion care are out of step for what most Latinos/as think regarding political interference in Latina decision-making. Seventy-four percent of registered Latino/a voters agree that a woman should be able to make her own personal, private decisions about abortion care without political interference.[xxxii]

Access to reproductive healthcare, including abortion care, is a pocketbook issue for many Latinas and their families. Restrictions on abortion care make it more likely that Latinas will have to decide between paying for the healthcare she needs or putting food on the table for her family.

Political and corporate interference in the personal, healthcare decisions of Latinas and their families contribute to poor health outcomes by denying them the ability to make the best decisions for their health with the consultation of their providers.

The Women's Health Protection Act can provide Latinas and other women of color one more tool in achieving positive, health outcomes and health equity. A woman's zip code should not determine the healthcare she receives or the health she wants to achieve.

NLIRH urges the committee to support the Women's Health Protection Act of 2013.

ENDNOTES

[i] Guttmacher Institute. States Continue to Enact Abortion Restrictions in First Half of 2014, but at a Lower Level Than in the Three Previous Years. http://www.guttmacher.org/media/inthenews/2014/07/08/index.html [Last accessed on July 9, 2014].

[ii] Gold RB., Nash E., Rathbun G., & Vierboom Y. Guttmacher Institute. Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2014. http://www.guttmacher.org/statecenter/updates/2014/statetrends22014.html [Last accessed on July 9, 2014].

[iii] PewResearch. Hispanic Trends Project. Demographic Profiles of Hispanics in Florida, 2011. http://www.pewhispanic.org/states/state/fl/ [Last accessed on July 9, 2014].

[iv] Cohn E. Obamacare Has Drastically Cut the Uninsured Rate for Blacks, Hispanics. The Huffington Post. June 5, 2014. Available at: http://www.huffingtonpost.com/2014/06/05/blacks-hispanics-uninsured_n_5451900.html?utm_hp_ref=tw. [Last accessed on July 9, 2014].

[v] Arons J. & Rosenthal L. How the Hyde Amendment Discriminates Against Poor Women and Women of Color. May 10, 2013. Available at: http://www.americanprogress.org/issues/women/news/2013/05/10/62875/how-the-hyde-amendment-discriminates-against-poor-women-and-women-of-color/. [Last accessed on July 9, 2014].

[vi] National Partnership for Women and Families. Latinas and the Wage Gap; 2014: 3. Available at: http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/latinas-wage-gap.pdf. [Last accessed on July 9, 2014].

[vii] Kaiser Commission on Key Facts. Health Coverage for the Hispanic Population Today and Under the Affordable Care Act. April 2013:3. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/04/84321.pdf. [Last accessed on July 9, 2014]; National Asian Pacific American Women's Forum. AP(eye) on the Hill-September 2013. October 2013. Available at: http://napawf.org/2013/10/apeye-on-the-hill-september-2013/ [Last accessed on July 9, 2014].

[viii] Latinas contract cervical cancer at 1.6 times the rate of white women. U.S. Department of Health and Human Services. The Affordable Care Act and Latinos. http://www.hhs.gov/healthcare/facts/factsheets/2012/04/aca-and-latinos04102012a.html [Last accessed on July 9, 2014].

[ix] Latinas are twice as likely to experience an unintended pregnancy in comparison to their white peers. Cohen SA. *Abortion and Women of Color: The Bigger Picture.* The Guttmacher Institute; 2008: 3. Available at: http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.pdf. [Last accessed on July 9, 2014].

[x] Centers for Disease Control and Prevention. HIV/AIDS. HIV Among Latinos. http://www.cdc.gov/hiv/risk/racialethnic/hispaniclatinos/facts/index.html [Last accessed on July 9, 2014].

[xi] Planned Parenthood Federation of America. Fully Covering Rx Birth Control, June/July 2010, Hart Research for Planned Parenthood Federation of America. http://www.plannedparenthood.org/about-us/newsroom/press-releases/survey-nearly-three-four-voters-america-support-fully-covering-prescription-birth-control. [Last accessed on July 9, 2014].

[xii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 13. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].

[xiii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 14. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].

[xiv] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 14. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].

[xv] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 14. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xvi] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 13. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xvii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 14. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xviii]Boonstra HD. The heart of the matter: Public funding of abortion for poor women in the United States. *Guttmacher Policy Review.* 2007; 10 (1): 16. Available at: http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html [Last accessed on July 9, 2014].
[xix] Aaronson B. Groups Target Abortion Waiting Period Requirement. The Texas Tribune. March 6, 2013. Available at: http://www.texastribune.org/2013/03/06/representative-seeks-repeal-abortion-restriction/ [Last accessed on July 9, 2014].
[xx] Lang J. What Happens to Women Who are Denied Abortions? The New York Times. June 12, 2013: 4. Available at: http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=1&tntemail0=y&_r=1&emc=tnt [Last accessed on July 9, 2014].
[xxi] National Immigration Law Center. Health Care for DACA Grantees; 2013. Available at: http://www.nilc.org/acadacafaq.html#part2 [Last accessed on July 9, 2014].
[xxii] National Immigration Law Center. Immigrants and the Affordable Care Act; 2014. Available at: http://www.nilc.org/immigrantshcr.html [Last accessed on July 9, 2014].
[xxiii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 25. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xxiv] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 6-7. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xxv] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 24. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 18, 2014].
[xxvi] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 24. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 18, 2014].
[xxvii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 21. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xxviii] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 26, 33-35. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xxix] For instance, in 2012, the majority of services provided by Planned Parenthood Federation of America were STI/STD testing and treatment and contraceptive care, respectively 41 percent and 34 percent of all their services. Planned Parenthood Federation of America. Services; 2014:3. Available at: http://www.plannedparenthood.org/files/4013/9611/7243/Planned_Parenthood_Services.pdf. [Last accessed on July 9, 2014].
[xxx] Center for Reproductive Rights & National Latina Institute for Reproductive Health. Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley; 2013: 32. Available at: http://www.nuestrotexas.org/resources/. [Last accessed on July 9, 2014].
[xxxi] The White House. Executive Order 13535-Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions on the Use of Federal Funds for Abortion. March 24, 2010. Available at: http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst [Last accessed on July 9, 2014].

[xxxii] Lake Research Partners, Reproductive Health Technologies Project & National Latina Institute for Reproductive Health. Poll: Latino Voters Hold Compassionate Views on Abortion; 2011: 1. Available at: http://latinainstitute.org/Latinopoll. [Last accessed on July 9, 2014].

Twenty-Five Faith-Based Organizations Express Support for the Women's Health Protection Act

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, DC 20510

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

As faith-based organizations that work to ensure every person in the United States has affordable access to safe and effective healthcare, including reproductive healthcare, we write to express our strong support for **S 1696, the "Women's Health Protection Act of 2013."**

Our faith traditions compel us to speak out for social justice and the right of every person to follow their own conscience in making decisions concerning their reproductive health and their families. We are committed to the most marginalized members of our society, especially those with limited financial means or those who live in areas without access to services. Laws that eliminate options for some based on their geographic location are profoundly unjust because they most harm low-income women, women of color and women in rural areas. We cannot in good conscience stand idly by as state laws transform our country into a map of haves and have-nots.

We believe that women are moral agents who have the capacity, right and responsibility to make their own reproductive decisions, no matter where they live, what their faith tradition or moral beliefs or how much money they have. Laws that result in limiting the availability of abortion disrespect women's human dignity; erode their constitutional rights; and can have far-reaching health and economic consequences for them and their families. Similarly, qualified medical professionals whose beliefs compel them to provide abortion care deserve protection for their conscience-based decisions to serve their communities.

We affirm that every woman has a right to religious liberty, which is integrally bound to her reproductive freedom. Religious liberty includes the right to follow one's own faith or moral code in making critical, personal reproductive health decisions and the right to be free from constraints imposed by others. While we respect the right of every individual, including our lawmakers, to hold their own personal and religious beliefs, our faith traditions and our country's constitution demand that no one should impose one religious viewpoint on all through civil law or regulation.

The **Women's Health Protection Act** is urgently needed. From 2011 through 2013, state legislatures enacted more laws restricting abortion access than in the entire preceding decade. This egregious trend has resulted in large swaths of the country losing access to safe, timely abortion care. This critical bill would protect at the federal level the right of every woman to make her own decisions about whether and when to have children, each led by her own conscience—without being stymied by her economic strata, employment status or zip code. It would invalidate state laws designed to restrict abortion access and make it more difficult to pass such laws in the future. And it would ensure that medical providers are able to care for patients who seek comprehensive reproductive healthcare.

Twenty-Five Faith-Based Organizations Express Support for the Women's Health Protection Act

Protecting safe, legal access to abortion is a moral imperative, rooted in our deeply held beliefs in social justice, moral agency and religious liberty. As people of faith, we value every person as a moral decision-maker who is free to make personal decisions about their reproductive lives based on their own consciences. The **Women's Health Protection Act** is critical legislation that embodies these shared ideals.

Today, and every day, we stand up as people of faith for women's health and reproductive choices. We thank you for calling a hearing on the **Women's Health Protection Act** and urge you and your colleagues to move this critical legislation forward. We ask this based on our diverse faith traditions, and because protecting the health and well-being of women and families is the right thing to do.

Respectfully,

A Critical Mass: Women Celebrating Eucharist
Bend the Arc: A Jewish Partnership for Justice
Catholics for Choice
Chicago Women-Church
Clergy Advocacy Board, Planned Parenthood Federation of America
CORPUS
Disciples Justice Action Network
Global Faith and Justice Project
Global Justice Institute
Hadassah, The Women's Zionist Organization of America
Jewish Women International
Keshet
Methodist Federation for Social Action
Metropolitan Community Churches
Muslims for Progressive Values
National Coalition of American Nuns
National Council of Jewish Women
Religious Coalition for Reproductive Choice
Religious Coalition for Reproductive Choice of Connecticut, Inc.
Religious Institute, Inc.
Society for Humanistic Judaism
United Church of Christ, Justice and Witness Ministries
Unitarian Universalist Women's Federation
Women's Alliance for Theology, Ethics, and Ritual
Women's Ordination Conference

For more information, please contact Amy Cotton at (202) 375-5067 or amy@ncjwdc.org, or Sara Hutchinson Ratcliffe at (202) 986-6093 or shutchinson@catholicsforchoice.org.

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

We, the undersigned state medical organizations representing physicians who care for women and their families every day, urge your support of the Women's Health Protection Act of 2013 (S. 1696/H.R. 3471).

For decades, politicians across the country have passed laws rolling back a woman's ability to make health care decisions for herself, by restricting access to safe, legal abortions. These laws and regulations severely hamper our ability to care for our patients in accordance with the most recent, evidence-based practice guidelines as well as our professional clinical judgment. In many states, the effect has been dire. Safe abortion care has become virtually impossible to find for far too many women. In fact, six states - Arkansas, Mississippi, Missouri, North Dakota, South Dakota, and Wyoming - currently only have one abortion clinic.

Our physician members work every day to make sure women receive the high-quality health care they need in a safe, respectful environment. State laws regulating the provision of abortion care in the name of women's health and safety frequently promote NEITHER health NOR safety.

Every woman must be able to make personal medical decisions -- without political interference -- according to her own unique circumstances. Similarly, physicians must be able to practice high quality medicine, without political interference.

Our patients and physicians can do neither when states:

- Require health care providers to perform tests and procedures on our patients that are not medically necessary;
- Require health care providers to practice according to outdated, rather than the best and most current, medical guidelines;
- Prohibit use of telemedicine advancements for abortion, technology that is especially important in underserved and rural areas;
- Impose medically unnecessary regulations on women's health centers that serve only to force clinics to close their doors;
- Require abortion providers to maintain admitting privileges at local hospitals, a business arrangement that only serves to reduce the number of providers, not to improve patient safety in any way. Complications are very rare and admitting privileges are not needed in the unlikely event that a patient needs hospital care;
- Require a woman to make multiple unnecessary trips to her abortion provider; and
- Require a woman to visit an anti-abortion "crisis pregnancy center" before her procedure.

Our organizations oppose these restrictions. They target abortion providers and women seeking abortion care with rules and limitations not imposed on any other clinicians or patients. And they're passed under the pretext of improving women's health, when in fact they don't reflect good medical practice or scientific evidence.

The Women's Health Protection Act will help protect women and their health from these politically-driven state efforts, and preserve our ability to deliver the best possible care to our patients. Medical care should not be dictated by geographic boundaries, and a woman's ability to obtain a safe and legal abortion should not depend on her zip code.

Sincerely,

California – District IX of ACOG

District of Columbia Section of ACOG

Florida – District XII of ACOG

Georgia Obstetrical and Gynecological Society

Georgia Section of ACOG

Hawaii, Guam & American Samoa Section of ACOG

Indiana Section of ACOG

Maryland Section of ACOG

Montana Section of ACOG

Nevada Section of ACOG

New Jersey Section of ACOG

New Mexico Section of ACOG

Ohio Section of ACOG

Pennsylvania Section of ACOG

Texas Section of ACOG

University of Utah OBGYN Residency Program

Virginia Section of ACOG

Washington Section of ACOG

Wisconsin Section of ACOG

PHYSICIANS FOR REPRODUCTIVE HEALTH

Headquarters:
55 West 39th Street
Suite 1001
New York, NY 10018-3889
Tel: 646-366-1890
Fax: 646-366-1897

Additional Locations:
San Francisco, CA
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President/CEO

July 22, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley:

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. A large number of the doctors Physicians represents practice in the field of obstetrics and gynecology, but many are pediatricians, family physicians, cardiologists, neurologists, radiologists, and others. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

We write to follow up on the hearing held on July 15, 2014, on the Women's Health Protection Act of 2014 (S. 1696). This critical bill would ensure that all women are able to make personal decisions about reproductive health care, regardless of where they live. Abortion should not be singled out for politically motivated restrictions that threaten women's health. Below we share information about the safety of abortion, the importance of access to legal abortion, and the widespread acceptance within the medical community of both of these facts.

I. Safety of Abortion

When it is legal and accessible, abortion has an excellent safety record. Abortion is one of the safest medical procedures in the United States. At last week's hearing, several witnesses distorted statistics around the safety of abortion. Physicians would like to share correct information with the Judiciary Committee. For example, Representative Diane Black (R-TN) claimed that women that have an abortion are 18% more likely to develop breast cancer. The National Cancer Institute has found no link between abortion and an increased risk of breast cancer.[1] She also claimed that after an abortion, a woman is 81% more likely to develop a mental health issue, is at a 37% increased risk of depression, is at a 110% increased risk of alcohol abuse, and is at a 155% increased risk of suicide. These specious claims have similarly been debunked by national, reputable medical organizations, including the American Psychological Association.[2]

[1] Summary report: Early reproductive events and breast cancer workshop. Bethesda, MD: National Cancer Institute (2003). Available at http://www.cancer.gov/cancertopics/causes/ere/workshop-report.
[2] See, e.g. American Psychological Association, Task Force on Mental Health and Abortion, *Report of the Task Force on Mental Health and Abortion*, 2008.

The risk of a major complication from first-trimester abortion, when 88% of abortions take place, is very small—less than 0.05%.[3] Abortions performed in the first trimester pose virtually no long-term risk of such problems as infertility, ectopic pregnancy, spontaneous abortion (miscarriage) or birth defect, and little or no risk of preterm or low-birth-weight deliveries.[4] The risk of death associated with legal, accessible abortion is 14 times less than the risk associated with continued pregnancy and delivery.[5] As the pregnancy advances, the medical risks with abortion increase from one death for every one million abortions at or before eight weeks to one per 29,000 at 16 to 20 weeks—and one per 11,000 at 21 weeks or later.[6] In comparison, the risk of death from continued pregnancy and delivery is approximately 8.8 per 100,000.[7] Given the gradual increase in risks with gestation for women seeking abortion, prompt access to abortion, free of politically motivated restrictions, is crucial for women's health.

Representative Black, Representative Marsha Blackburn (R-TN), and Chairman Grassley (R-IA) discussed the atrocious, criminal acts of Kermit Gosnell at length. Physicians, like the rest of the medical community, was horrified by this criminal's actions in Pennsylvania. He was flagrantly unethical and in breach of all accepted medical standards. It is important to note that Pennsylvania is a state that had multiple, medically unnecessary laws on the books that restrict women's access to abortion care. The lack of access to safe, compassionate care and the stigma surrounding abortion made it possible for Gosnell to prey upon women. Additional medically unnecessary restrictions on abortion will force more women to turn to immoral actors like Gosnell, as reputable clinics are forced to close.

II. Importance of Access to Abortion

Access to legal, safe abortion is critical to the health and well-being of women. The medical community has recognized this fact since before the U.S. Supreme Court's decision in *Roe v. Wade*, and indeed advocated for the decriminalization of abortion before *Roe* to protect women's health.[8] In 1972, 100 professors of obstetrics and gynecology published a letter to the medical and legal communities.[9] These 100 signers were national leaders in the field, most being chairs of departments at top medical schools. In September 2013, 100 new leading professors of obstetrics from across the United States came together to write a letter for the current generation of physicians caring for women. In response to the dangerously growing restrictions on safe abortion care, they wrote: "We have had 40 years of medical progress but have witnessed political regression that the [original] 100 professors did not anticipate."[10] They go on to describe the various restrictions at the state level that are impeding abortion access and note that they "will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices."[11] The 2013 letter is attached for the Committee's reference.

After a Texas law requiring hospital admitting privileges went into effect in November 2013, 19 of 33 abortion clinics closed, including clinics in McAllen. The closure of the McAllen clinic, located in the Rio

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[3] Weitz TA et al., Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver, *American Journal of Public Health*, 2013, 103(3):454–461.
[4] Id.
[5] Raymond EG and Grimes DA, The comparative safety of legal induced abortion and childbirth in the United States, *Obstetrics & Gynecology*, 2012, 119(2): 215–219.
[6] Bartlett LA et al., Risk factors for legal induced abortion-related mortality in the United States, *Obstetrics & Gynecology*, 2004, 103(4):729–737.
[7] Raymond, supra note 5.
[8] For example, ACOG submitted amicus briefs in both *Roe v. Wade* and *Doe v. Bolton* supporting abortion access.
[9] A statement on abortion by one hundred professors of obstetrics, *American Journal of Obstetrics and Gyneology* 1972, 112: 992-998, http://www.ajog.org/article/0002-9378%2872%2990826-5/pdf.
[10] One Hundred Professors of Obstetrics and Gynecology, A statement on abortion by 100 professors of obstetrics: 40 years later, *American Journal of Obstetrics and Gynecology*, 2013, 209(3): 193-199.
[11] Id.

Grande Valley (one of the poorest regions in the nation), has forced women to make an estimated two-and-a-half hour (150 mile) drive to Corpus Christi, a four-hour (240 mile) drive to San Antonio, or a five-hour (310 mile) drive to Austin.[12] These distances can prove to be insurmountable obstacles for low-income women, leading some to seek more accessible but illegal abortion pills from Mexico.[13] The stark and established fact is that when abortion is less accessible, it becomes less safe. This current reality in Texas is unacceptable from a public health standpoint.

Legal abortion in the United States has improved women's health outcomes. From 1958-1967, at least 3,400 women died from abortion procedures, almost all of which were illegal.[14] For each death suffered from unsafe abortion, many other women had illegal abortions in circumstances that were degrading and led to dangerous complications. The number of deaths fell rapidly after abortion was legalized, as the medical community had predicted. We have long known that legal, accessible abortion means safe abortion. And we see this scenario play out internationally as well. According to the World Health Organization, one in eight maternal deaths (13%) is due to unsafe abortion.[15] Globally, the unsafe-abortion-related maternal death rate is some 350 times higher than the rate associated with legal induced abortions in the United States (0.6 per 100,000 abortions).[16] The World Health Organization observes that women are more likely to resort to unsafe abortion when abortion is restricted, unavailable, or inaccessible and that when it is highly restricted, abortions are mostly unsafe.[17]

III. Conclusion

Physicians for Reproductive Health is deeply concerned at the lack of access to safe, compassionate, legal abortion that is already occurring in parts of the United States, such as the Rio Grande Valley of Texas, where all clinics have closed, and Mississippi, where only one clinic remains open. We stand with medical professionals across the nation and from the past 40 years to reaffirm that women's health and dignity depends on ready, unimpeded access to abortion care. That is why we support the Women's Health Protection Act. We thank the Senate Judiciary Committee for holding a hearing on this important bill and for the opportunity to submit materials.

Sincerely,

Nancy Stanwood, MD, MPH
Board Chair, Physicians for Reproductive Health
Associate Professor of Obstetrics, Gynecology & Reproductive Sciences, Yale University School of Medicine

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[12] Manny Fernandez, Abortion Law Pushes Texas Clinics to Close Doors, THE NEW YORK TIMES, (March 6, 2014), http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html?_r=0.
[13] Rick Jervis, Texas abortion law creates obstacles for Valley women, USA TODAY, (May 17, 2014), http://www.usatoday.com/story/news/nation/2014/05/17/texas-abortion-law-women-valley/8804871/.
[14] Stanley Henshaw, Unintended pregnancy and abortion in the USA: Epidemiology and public health impact, *Management of Unintended and Abnormal Pregnancy* at 33 (2009).
[15] World Health Organization, *Unsafe abortion incidence and mortality: Global and regional levels in 2008 and trends during 1990 – 2008* (2012), http://apps.who.int/iris/bitstream/10665/75173/1/WHO_RHR_12.01_eng.pdf.
[16] Id.
[17] Id.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 13, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing on behalf of the National Women's Health Network, a nonprofit advocacy organization that works to improve the health of all women, to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

The Network brings the voices of women consumers to policy and regulatory decision-making bodies. We are supported by our members and do not take financial contributions from drug companies, medical device manufacturers, insurance companies, or any other entity with a financial stake in women's health decision-making. The Network supports access to the full range of reproductive healthcare services, including abortion, no matter where a woman lives or how much money she makes. We promote the provision of evidence-based healthcare practices and information without restrictions driven by ideology.

For nearly 40 years, the Network has advocated for women's access to abortion and to safe and effective drugs and medical devices. Our long-time work in these two areas comes together in our defense of medical abortion – mifepristone is a safe and effective prescription medication approved to end a pregnancy. My testimony will focus on medication abortion restrictions in the states, which restrict everything from who can administer mifepristone to where and how it can be administered. Additionally, the Network strongly supports the full range of protections for abortion access that the Women's Health Protection Act would ensure.

Sincerely,

Cynthia A. Pearson
Executive Director
National Women's Health Network

1413 K Street, N.W., 4th Floor
Washington, D.C. 20005
202.682.2640
Fax 202.682.2648
www.nwhn.org

Testimony for the Record

Submitted to the United States Senate Committee on the Judiciary

Hearing on S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

July 13, 2014

By Cynthia A. Pearson, Executive Director, National Women's Health Network

Dear Chairman Leahy, Ranking Member Grassley and members of the Committee,

The National Women's Health Network, a nonprofit advocacy organization that works to improve the health of all women, is pleased to submit written testimony to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

The Network brings the voices of women consumers to policy and regulatory decision-making bodies. We are supported by our members and do not take financial contributions from drug companies, medical device manufacturers, insurance companies, or any other entity with a financial stake in women's health decision-making. The Network supports access to the full range of reproductive health services, including abortion, no matter where a woman lives or how much money she makes. We promote the provision of evidence-based healthcare practices and information without restrictions driven by ideology.

A woman's ability to access an abortion should not be determined by her zip code, yet that is exactly what is happening as more and more states introduce and pass harmful restrictions on healthcare providers and abortion services. These state legislative attacks target everything from when, where and how an abortion is performed to what is said and who says it. While some politicians claim that these restrictions are for women's safety, they actually endanger women's health by delaying services, requiring unnecessary procedures and shutting down clinics. In fact, abortion is very safe and well regulated and these state laws are singling out reproductive healthcare for onerous regulations that are not imposed in other areas of medicine. This proliferation of state restrictions in recent years has had the practical effect of making abortion inaccessible to many women across the country.

1413 K Street, N.W., 4th Floor
Washington, D.C. 20005
202.682.2640
Fax 202.682.2648
www.nwhn.org

For nearly 40 years, the Network has advocated for women's access to abortion and to safe and effective drugs and medical devices. Our long-time work on these two initiatives comes together in our defense of medical abortion – mifepristone is a safe and effective prescription medication approved to end a pregnancy. My testimony will focus on medication abortion restrictions, though the Network strongly supports the full range of protections for abortion access that the Women's Health Protection Act would ensure.

When personal healthcare decisions need to be made, people appreciate having options available, and abortion care is no different. Access to medication abortion provides women in the U.S. with the option to end a pregnancy safely, without a surgical procedure and offers the potential to expand access and allow a woman more alternatives about where her abortion will take place. However, many of these state attacks specifically target medication abortion and run the gamut from restricting who can administer the abortion pill to limiting where or how it can be provided to women. Superfluous regulations do not advance health and only serve to decrease access, increase cost and expose women to unnecessary potential harm.

In 38 states, mifepristone – the medication abortion pill – can only be provided by a physician. This restriction eliminates entire categories of health practitioners from being able to offer this medication to their patients, despite research showing that nurse-midwives, nurse practitioners and physician assistants can provide it to their patients safely and effectively. These laws both delay and decrease access to abortion care by unnecessarily limiting the type of clinician who can provide medication abortion.

In 12 states, mifepristone can only be provided in the physical presence of a physician. This restriction implies that speaking with a clinician via teleconference is inherently less safe than speaking in person prior to taking mifepristone. However, studies show that medication abortion with a doctor connected by teleconference is as safe and effective as a conventional office visit. Telemedicine abortion services can meet the health needs of women that would otherwise have to travel hundreds of miles to reach an abortion provider. These restrictions are not applied to other healthcare services that use telemedicine – they have nothing to do with the quality or safety of health care and everything to do with preventing a woman from getting abortion services.

Medication abortion restrictions that restrict who can administer mifepristone and where it can be administered only serve to decrease access to abortion care and disproportionately impact women that already have poor access to healthcare services such as low-income women, women of color, young women and women living in rural areas. The Women's Health Protection Act would ensure that medication abortion is not singled out for unnecessary additional regulations that even further limit women's access to the full range of healthcare providers and services.

When people seek out healthcare services they expect their clinician to provide safe, effective and evidence-based procedures and treatments. Unfortunately however, political interference in the practice of medicine at the state level means that women in some states can no longer expect this kind of high-quality healthcare. In Ohio, Texas and soon in Oklahoma, medication abortion must be provided in strict compliance with the protocol specified on the label, which was approved by the Food and Drug Administration nearly 15 years ago. Again, some politicians claim this is a safety regulation. However, the longer a drug is on the market, the more healthcare providers learn about it and they often use this additional information to make evidence-based changes to the original dose or directions for use. Consequently, requiring healthcare providers to use a 15-year-old protocol does not protect women's health.

This prohibition on what is known as "off-label use" is unnecessary and also potentially less safe for women seeking a medication abortion. The dose of mifepristone prescribed back in 2000 when the drug was first approved was three times the amount now commonly administered under the evidence-based practice followed by healthcare providers today. Also under the original protocol, women are not allowed to self-administer the follow-up dose, requiring them to complete the abortion at a clinic rather than in the comfort and privacy of their own home, even though studies have shown this to be safe. The Network strongly supports the Women's Health Protection Act because it would preserve women's access to this safe and effective option for early abortions.

The insidious harm done by opponents of abortion in attacking off-label use of mifepristone is that it makes people think abortion providers are acting differently than other clinicians. However, doctors in almost all areas of medicine prescribe medications off-label – in fact, 20 percent of all prescription drugs in the United States are used by physicians for purposes or doses that are not covered on the original label. For example, many cancer drugs are used off-label, as are most drugs prescribed to children. Laws that restrict how medication abortion can be provided set a dangerous precedent for political interference in the practice of medicine. Evidence-based health regulations ensure that healthcare is safe, effective and of high quality for all people and must be protected.

The restrictions on medication abortion described here are only part of the larger scale attacks on women's reproductive health and autonomy. State legislatures have passed burdensome requirements that single out abortion clinics, providers and services and do nothing to advance women's health or safety – and, in fact, ultimately jeopardize women's health by making abortion inaccessible to many women in this country. Each woman faces her own unique circumstances and much be able to make the decision that is best for her without interference from politicians. We thank you for calling a hearing on this vitally important legislation and strongly support passage of the Women's Health Protection Act.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, DC

July 16th, 2014

Dear Chairman Leahy and Ranking Member Grassley:

With more than 200 abortion restrictions passing in the states over the past 3 years[i], we agree that we must remove the onerous restrictions that have been placed on abortion providers and that obstruct women's health. Because of our commitment to reproductive health access, we applaud the Women's Health Protection Act (WHPA) of 2013 and support the removal of the many unnecessary and harmful restrictions that for too many put safe and timely abortion care out of reach. However, the WHPA's exclusion of parental consent and notification laws, which exist in 39 states[ii] and leave many young women afraid and alone, highlights the need to address parental involvement laws.

Young people are at the forefront of the reproductive rights, health, and justice movements. We need to stand with them against the harmful parental involvement restrictions that can put their health and well being at risk by removing restrictions placed on young women's ability to obtain abortion services. Parental involvement laws disproportionately impacts young people of color, who are more likely to experience unintended pregnancy as minors and are disproportionately living in states where parental involvement laws are in effect.[iii]

Parental involvement laws, including parental consent and parental notification laws, single out young people's access to abortion care. In many states, minors may independently consent to a range of sensitive health care services, including access to contraceptives, prenatal care, and STI care.[iv] This trend is based on the fact that young people are less likely to seek these sensitive services if they require parental involvement, especially when conditions at home are unsafe.[v] The American Medical Association, the Society for Adolescent Medicine, APHA, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and other health professional organizations stand in agreement against mandatory parental involvement in abortion decision making.[vi] Still, young women's access to abortion care requires parental consent or notification in a majority of states.

Ideally, any woman, including a young woman, who is faced with an unintended pregnancy can seek the advice of those who care for her. Studies show that most young women will seek support from a parent or family member when they find themselves with an unintended pregnancy. But for those who can't, those afraid to anger or disappoint, or who face the threat of violence in their homes— we believe it would be best for them to seek the advice of a trained medical professional than to face the situation alone and afraid.

The fact is that the majority of young people seeking abortions do consult a parent, no matter what state they live in.[vii] But those who are unable to involve their parents have good reasons. Fifty percent of pregnant teens have experienced violence;[viii] thirty percent of teens who don't tell their parents about their abortions fear the threat of violence or being forced to leave home.[ix] We all hope daughters and sons can turn to their parents when they make important decisions. But we cannot and should not legislate parent-child communication.

As an example, the unfortunate circumstances of a 16-year old young woman in Nebraska illustrate all too well the harmful impact of parental notification laws. Instead of her abortion being a private medical decision this young woman could make in consultation with her health care provider and those who support her, it was left in the hands of a judge who decided that at the age of sixteen, the young woman wasn't "mature" enough to decide for herself and denied her the abortion.[x] This judge decided to play politics with a young woman's life to advance his own extreme ideological agenda.

We hope that moving forward with this bill, and any other bill seeking to protect women's access to abortion, our legislators work to include younger women and protect their access to safe, legal, and affordable abortion care.

Sincerely,
Advocates for Youth

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[i] Guttmacher Institute. "State Legislation in 2011/2012/2013 Related to Reproductive Health." Accessed from http://www.guttmacher.org/statecenter/updates/2011newlaws.pdf, http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf, http://www.guttmacher.org/statecenter/updates/2013Newlaws.pdf.

[ii] Guttmacher Institute. "State Policies in Brief: Parental Involvement in Minors' Abortions." Accessed from http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

[iii] Guttmacher Institute. "Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement in Contraception." Accessed from http://www.guttmacher.org/pubs/journals/3618204.pdf

[iv] Guttmacher Institute. "State Policies in Brief: Minors' Access to Contraceptive Services." Accessed from http://www.guttmacher.org/statecenter/spihs/spib_MACS.pdf.

[v] Dailard C and Richardson CT. "Tecnagers' Access to Confidential Reproductive Health Care Services." *The Guttmacher Report on Public Policy,* 2005: 8(4).

[vi] American Medical Association. "Opinion 5.055 – Confidential Care for Minors." Accessed from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion5055.page on November 8, 2013. American Public Health Association. "Ensuring Minors' Access to Confidential Abortion Services." Accessed from http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1415 on November 8, 2013. American Academy of Pediatrics. "Achieving Quality Health Services for Adolescents." Accessed from http://pediatrics.aappublications.org/content/121/6/1263.full?sid=7322b383-0e96-4d24-a3ba-2914a99307bb on November 8, 2013. Center for Adolescent Medicine. *Policy Compendium on Confidential Health Care Services for Adolescents, 2nd Edition.* Accessed from http://www.cahl.org/PDFs/PolicyCompendium/PolicyCompendium.pdf.

[vii] Dennis A et al., The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review, New York: Guttmacher Institute, 2009

[viii] American Psychological Association, Parental Consent Laws for Adolescent Reproductive Health Care: What Does the Psychological Research Say? (Feb. 2000), citing A.B. Berenson, et al., Prevalence of Physical and Sexual Assault in Pregnant Adolescents, 13 J. of Adolescent Health 466-69 (1992).

[ix] Martin Donohoe, Parental Notification and Consent Laws for Teen Abortions: Overview and 2006 Ballot Measures MEDSCAPE Ob/Gyn & Women's Health, February 9, 2007

[x] Nebraska Supreme Court. *In Re Petition of Anonymous 5, a Minor.* Accessed from http://supremecourt.ne.gov/sites/supremecourt.ne.gov/files/sc/opinions/s13-510009.pdf.

National
Family Planning
& Reproductive Health Association

July 15, 2014

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
152 Dirksen Senate Office Building
Washington, DC 20510

Re: **The Women's Health Protection Act (S. 1696)**

Dear Chairman Leahy and Ranking Member Grassley:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to submit this statement in support of the Women's Health Protection Act of 2013 (S.1696). By prohibiting state activity that impedes women's access to abortion services, the Women's Health Protection Act (WHPA) is designed to roll back the onslaught of state-level attacks on the legal right to have an abortion and on the clinicians who provide abortion services.

NFPRHA is a national membership organization representing the nation's family planning providers - nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

As an advocate for providers, NFPRHA works to ensure that health professionals are able to offer a comprehensive range of sexual and reproductive health services, including abortion, to each patient based on their individual health needs. NFPRHA works to maintain access to and coverage for abortion services, while also promoting effective family planning, including contraceptive use, which helps to reduce unintended pregnancies.

Restrictive laws targeting abortion are frequently proposed under the guise of protecting women's health and increasing safety. However, the safety of abortion is well-documented[1] and the ultimate goal of these restrictions is to eliminate abortion in the United States entirely. A member of the board of Pro-Life Mississippi stated: "These incremental laws are part of a greater strategy to end abortion in our country. It's part of it, and one day, our country will be abortion free."[2] The reality is that these restrictions on abortion don't deter women from seeking out abortion care. Instead, restricting access to abortion just increases cost and potential risk by lengthening the time it takes for a woman to obtain the procedure once she's made her decision.[3] The strategy of limiting access as a means to a total ban on abortion has led to a proliferation of state restrictions on abortion services and providers. From 2011 to 2013, 30 states enacted 205 laws restricting abortion services and providers. In the ten years prior (2001-2010), a total of 189 state laws restricting abortion were passed.[4]

NFPRHA believes that in the face of unprecedented assault on women's health and rights in the states, it is past time to take a stand at the federal level. The Women's Health Protection Act would do just that, and would ensure that a woman's access to abortion is not dependent upon her zip code or income. The bill sets a baseline for women across the country that respects their decision-making and re-establishes the right for all women to make medical decisions in private consultation with her health care provider. In addition, the bill protects health care professionals committed to providing abortion services. Many of the more recent state-level restrictions on abortion services have targeted providers, leading to the closing of multiple sites across the country. Abortion providers deserve to be free of the targeted, discriminatory policies that have become all too common.

For all of these reasons, NFPRHA supports WHPA and thanks the Committee for calling a hearing on this bill.

Thank you for the opportunity to submit testimony on S. 1696. If you require additional information about the issues raised in this letter, please contact Mindy McGrath at 202-293-3114 ext. 206 or at mmcgrath@nfprha.org.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO

[1] Guttmacher Institute, *Induced Abortion in the United States*, accessed 2014, http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[2] Jeremy Alford and Erik Eckholm, "With New Bill, Abortion Limits Spread in South," *New York Times*, May 21, 2014, accessed July 10, 2014, http://www.nytimes.com/2014/05/22/us/politics/new-bill-spreads-abortion-limits-in-south.html?module=Search&mabReward=relbias%3Aw%2C%7B%222%22%3A%22RI%3A18%22%7D&_r=0.

[3] Jenna Jerman and Rachel K. Jones, "Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment," *Women's Health Issues* 24-4 (2014): e419-e424. http://www.guttmacher.org/pubs/journals/j.whi.2014.05.002.pdf

[4] Heather D. Boonstra and Elizabeth Nash, "A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs," *Guttmacher Policy Review* 17, no. 1 (Winter 2014), 9-15.

Hearing on S. 1696
Women's Health Protection Act (WHPA)
Senate Judiciary Committee

Testimony of
National Asian Pacific American Women's Forum (NAPAWF)

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

The National Asian Pacific American Women's Forum is writing to support the Women's Health Protection Act of 2013 (S.1696), which will protect critical access to reproductive health care for women of color including Asian American and Pacific Islander women.

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue organization devoted to advancing human rights for and increasing the power and impact of Asian American and Pacific Islander (AAPI) women and girls. We're changing policy, strengthening our communities and building the next generation of AAPI women leaders. Since our founding in 1996, we have 15 chapters across the country and 3 national offices. With over 19 million AAPIs in the United States, AAPIs are the fastest-growing racial group in the country.

NAPAWF seeks to achieve reproductive justice through advancing human rights for AAPI women and girls and increasing their influence, which will require that every AAPI woman has the resources and power she needs to make her own reproductive decisions. Stereotypes of AAPI women and girls, such as "model minority" stereotype, ignore the diverse needs and complexity of our communities. AAPI women and girls face barriers to reproductive health and justice, including racial inequity, economic status, language barriers, cultural stigma, sexual orientation, gender identity, and immigration status.

Access to reproductive healthcare has increasingly been under attack all across the nation, as evidenced by the Supreme Court's decision in *Burwell v. Hobby Lobby* and *McCullen v. Coakley*, and the growing number of abortion restrictions at the state level. Women of color and low income women are the most affected by these restrictions.

Under the Women's Health Protection Act (WHPA), states could no longer impose oppressive and medically unnecessary requirements on reproductive health care providers. In 2013 alone, more than 330 state lawmakers proposed 476 anti-abortion provisions.[1] Some of the restrictions include prohibiting insurance coverage for abortion services, restricting medication abortion, denying women and doctors the opportunity to use telemedicine, denying services to young abortion seekers, requiring extended waiting periods or mandatory ultrasounds, and trying to

[1] Lee, Jacah, and Molly Redden, *Meet 330 Anti-abortion Lawmakers Who Made 2013 "a Terrible Year for Women's Health* MOTHER JONES. (Jan. 24 2014), http://www.motherjones.com/politics/2014/01/state-legislators-sponsored-abortion-restriction-2014.

regulate abortion clinics via unnecessary medical standards. These types of restrictions slowly chip away at abortion access and make comprehensive reproductive health care virtually impossible to obtain for many, especially low income women and women of color.

WHPA would also protect against abortion bans based on a woman's reasoning. As an AAPI women's organization, we are especially concerned about the passage of sex-selective abortion bans. This past year, sex selective abortion bans were the 2nd most proposed bill at state legislatures across the country.[2] These types of bills now exist in eight different states.[3]

Sex-selective abortion bans rely on racial stereotypes, increase stigma about AAPI women and girls, and undermine women's health. They hurt our communities and do nothing to help women. They are masked attempts to restrict abortion access and increase abortion stigma under the guise of ending gender discrimination. These types of bills exploit racial stereotypes that the AAPI community only prefers sons, causing AAPI women to face increased scrutiny around our motives for seeking abortion care. Threatening providers with criminal and civil penalties also has a chilling effect; it can mean that providers are less likely to serve members of the AAPI community. Proponents of the bill point to male biased sex-ratios in countries like China and India and claim that AAPI women are bringing sex-selective abortion to the United States and must be stopped. However, new research shows that in fact, AAPIs are having more girls overall than white Americans.[4]

Abortion access is critical for the health of AAPI women. AAPI women experienced increased unintended pregnancy and teen pregnancy over the past decade, and there is evidence to show women in our community are much less likely than others to use contraception. Moreover, national data reveals that 35 percent of pregnancies end in abortion for AAPI women, the second highest percentage for all racial/ethnic groups, compared to 18 percent for white women.[5] In spite of the need for accessible abortion care, there are gaps in services directed at AAPI women, who face language, financial, and cultural barriers to getting the care they need.

These restrictions are yet another barrier to AAPI women who already face significant health disparities and barriers to insurance access. AAPI women already have some of the highest rates of cervical cancer. Studies show that 24.1% of AAPI women have not had a pap test in the last three years.[6] Many AAPI women lack health coverage: 20.6% of AAPI women are uninsured.[7]

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[2] *Id.*

[3] ARIZ. REV. STAT. §§ 13-3603.02 (2013); 720 ILL. COMP. STAT. § 510/6-8 (2013); KAN. STAT. § 65-6726 (2013); N.C. GEN. STAT. § 90-21.121 (2013); N.D. CENT. CODE § 14-02.1-04.1 (2013); OKLA. STAT. TIT. 63 § 1-731.2 (2013); 18 PA. CONS. STAT. § 3204 (2013); H.B. 1162, 89th Leg., Reg. Sess. (S.D. 2014) (enacted);

[4] THE UNIVERSITY OF CHICAGO LAW SCHOOL INTERNATIONAL HUMAN RIGHTS CLINIC, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM and ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, REPLACING MYTHS WITH FACTS: SEX-SELECTIVE ABORTION LAWS IN THE UNITED STATES (2014) *available at*: http://napawf.org/programs/reproductive-justice-2/sex-selection/race-and-sex-selective-abortion-bans/prenda/prenda-report/?key=52408357.

[5] Courtney Chappell, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, RECLAIMING CHOICE, BROADENING THE MOVEMENT: SEXUAL AND REPRODUCTIVE JUSTICE AND ASIAN PACIFIC AMERICAN WOMEN (2005), *available at* http://napawf.org/wp-content/uploads/2009/working/pdfs/NAPAWF_Reclaiming_Choice.pdf.

[6] THE HENRY J. KAISER FAMILY FOUNDATION, PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL, TABLE 2.7 (June 10, 2009), *available at* http://www.kff.org/minorityhealth/upload/7886.pdf.

[7] MARCH OF DIMES, CENSUS DATA ON UNINSURED WOMEN AND CHILDREN (2009) *available at*: http://www.marchofdimes.com/chapterassets/files/Uninsured_Highlights09.pdf

AAPI women do not need another obstacle in accessing health care. Making abortion harder to obtain will only exacerbate health outcomes for our community.

We believe the Women Health Protection Act is vital to protecting women's safe and legal access to reproductive healthcare, especially for women of color and low-income women. This bill provides necessary protections against xenophobic sex-selective abortion bans as well as other attacks on abortion access. Removing these barriers is critical to guaranteeing the constitutionally protected reproductive rights of AAPI women and other communities of color.

We ask that you support the Women's Health Protection Act of 2013 to make sure that all women, particularly AAPI women and women of color, have the ability to make decisions based on their own personal values, the advice of the medical professionals she trusts, and what's right for her family. Thank you for your time and attention to this important issue.

The National Asian Pacific American Women's Forum
Washington, DC

For any questions please contact Shivana Jorawar, Reproductive Justice Program Director, at sjorawar@napawf.org

Statement of Americans United for Life
in opposition to S. 1696, the "Women's Health Protection Act"

before the United States Senate committee on the Judiciary
July 15, 2014

Americans United for Life (AUL) is a national public interest law firm with a practice in abortion and bioethics law. AUL attorneys are experts on constitutional law and abortion jurisprudence. After thoroughly reviewing S. 1696, which would invalidate most regulations of abortion and prevent future enactment of these laws, AUL appreciates this opportunity to submit a statement in opposition to the legislation.

I. Overview

S. 1696 attempts to override U.S. Supreme Court precedent and other legal standards and would permit abortion providers to set the standard of care for their patients with no oversight from the state and no effective remedies for the abortion industry's deficiencies and frequent malfeasance.

The enactment of S. 1696 would invalidate hundreds of abortion-related laws specifically including: abortion bans (*e.g.* gestational limits and sex-selection bans); clinic regulations; admitting privileges requirements; regulations on abortion-inducing drugs; reflection periods and other informed consent requirements; ultrasound requirements; and limitations on the use of state funds and facilities for abortion training.

In fact, S.1696 could be reasonably interpreted to invalidate virtually any type of state restriction or regulation on abortion and to endanger healthcare

freedom of conscience. It would also prohibit the future enactment of any of these laws.[1] S.1696 is the *Freedom of Choice Act* (FOCA) by another name.

II. The bill's findings and purpose sections are replete with inaccurate, misleading, and condescending language.

S. 1696 adopts the myth that abortion is good for women, asserting that abortion is "essential to women's health," and, condescendingly, that abortion is "central to women's ability to participate equally in the economic and social life of the United States."

The purpose of bill is given as "ensuring that abortion services will continue to be available and that abortion providers are not singled out for *medically unwarranted restrictions* that harm women by preventing them from *accessing* safe abortion services" (emphasis added). However, this purpose assumes that existing restrictions on abortion are "medically unwarranted," and that it is necessary to women's health to access abortion. Further, the purpose fails to acknowledge a state interest in protecting unborn children.

In reality, abortion poses serious risks to women's health. The short-term risks of abortion are undisputed, and include blood loss; blood clots; incomplete abortions, which occur when part of the unborn child or other products of pregnancy are not completely emptied from the uterus; infection, which includes pelvic inflammatory disease and infection caused by an incomplete abortion; and injury to the cervix and other organs, which includes cervical lacerations and incompetent cervix—a condition that affects subsequent pregnancies.[2]

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[1] The bill purports not to target some abortion laws such as laws related to "clinic violence," limits on insurance coverage for abortion, and parental involvement and argues that Congress should act separately on these. Notably, among the items not specifically precluded from possible invalidation are restrictions on government funding for abortion.

[2] *Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women*, Dr. Byron C. Calhoun & Mailee R. Smith, esq., DEFENDING LIFE 2013: ROE AT 40 (Attachment).

The three most documented long-term risks of abortion include 1) an increased risk of pre-term birth in subsequent pregnancies; 2) an increased risk of placenta previa in subsequent pregnancies; and 3) an increased risk of breast cancer.[3] Further, numerous peer-reviewed studies have examined the effect abortion has on women's mental health, confirming that abortion "poses significant risks, including increased risk of depression, anxiety, and even suicide."[4] Health risks increase substantially with gestation.

Further, United States Supreme Court recognizes that the states have "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." *Roe v. Wade*, 410 U.S. 113, 150 (1973).

The Court has also 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 state has an interest in protecting unborn children, as well as their mothers.

III. The bill's definitions are inadequate, unscientific, and overly broad.

S. 1696 fails to define two key terms, "*medically comparable procedure*" and "*health*," expansively defines "*abortion provider*," and improperly defines "*pregnancy*."

The term "*medically comparable procedure*" to abortion is used throughout the bill. However, as the Supreme Court and other federal courts have explicitly and repeatedly acknowledged, abortion is "unlike" any other medical procedure. Abortion is the only procedure that involves the

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[3] Attachment 1, *supra*.
[4] Id.

intentional destruction of human life. It is "fraught with consequences" that do not exist with other "procedures." Thus, the Court has permitted abortion to be regulated differently from other (arguably) comparable (in terms of complexity and risk) procedures.

The bill does not define "*health*." Presumably then, the sponsors rely on the Supreme Court's broad *Doe* definition (*i.e.*, virtually anything can serve as a "health" justification for abortion), "cherry-picking" the parts of Supreme Court jurisprudence they like and ignoring what they do not (*e.g.*, *Gonzales v. Carhart*, and the Court's approval of many abortion regulations that this bill attempts to rescind).

"*Abortion provider*" is expansively defined to include physicians, certified nurse-midwives, nurse practitioners, and physician assistants who are "competent to perform abortions based on clinical training." This, coupled with other language in the bill, would seemingly target physician-only requirements for elimination.

Finally, "*pregnancy*" is defined as beginning at implantation, not fertilization. Human life begins at the moment of egg-sperm fusion, well before "implantation."

IV. The Bill's language is very broad and would likely be interpreted to prohibit most—if not all—existing state abortion regulations and restrictions.

The bill declares as "unlawful" and seeks to prohibit certain laws because the sponsors "single out the provision of abortion services for restrictions that are more burdensome than those restrictions imposed on medically comparable procedures, they do not significantly advance women's health or the safety of abortion services, and they make abortion services more difficult to access."

Without any qualification, S. 1696 would prohibit:

- Bans on abortion before fetal viability and bans on post-viability abortions performed for reasons of "health." This, of course, means that post-viability abortions would not be prohibited given the U.S. Supreme Court's broad definition of "health" in the context of abortion.
- Restrictions on an "immediate abortion" when a delay would pose a risk to a woman's health (see first bullet). This might endanger limitations the use of state facilities and personnel to perform abortions and freedom of conscience protections for certain providers and facilities.
- Restrictions on abortions "based on [the woman's] reasons or perceived reasons" for seeking an abortion or that require her to state those reasons. This would prohibit bans on sex-selective abortions and bans on abortions for genetic abnormalities.

Additionally, S. 1696 would specifically prohibit:

- Requirements that certain tests or medical procedures be performed in connection with an abortion. This would include ultrasound requirements and fetal heart tone auscultation.
- Limits on an abortion provider's ability to delegate tasks. This would likely implicate physician-only laws, informed consent counseling (in states that require the physician to personally do the counseling), and the like.
- Limitations on the administration of abortion-inducing drugs including prohibitions on the use of "telemedicine." Specifically, it precludes limiting or proscribing "an abortion provider's ability to provide abortion services via telemedicine." This provision is not specifically limited to chemical abortions.
- Abortion clinic regulations.
- Requirements that abortion providers have admitting privileges or transfer agreements.
- Reflection periods required by informed consent laws.

- Prohibitions and restrictions on medical training for abortion procedures which would implicate limits on the use of public funding and facilities for such training.

Importantly, S. 1696 also contains a broad, "catch-all" provision that would prohibit any "measure or action that restricts the provision of abortion services or the facilities that provide abortion services that is similar to any of the prohibited limitations or requirements" if "such measure or action singles out abortion services, makes abortion services more difficult to access and does not *significantly* advance women's health or the safety of abortion services" (emphasis added).

It is likely that this provision is intended to impact—and invalidate—virtually any abortion-related law, regulation, or restriction. Arguments that this bill is narrowly tailored to address a very specific subset of abortion regulations are inexplicable, given the breadth of this law.

V. S. 1696 Shifts the Legal Burden to States to Justify a Law.

It would be very easy for abortion providers to meet the *prima facie* standard required to maintain a legal challenge to a state abortion-related law under S. 1696. Importantly, the bill then explicitly—and improperly—shifts the burden to the states to justify the enactment of an abortion-related law, and does so by setting an extremely high standard for the states to meet in order to maintain/enforce an abortion regulation or restriction.

Under S. 1696, anyone challenging an abortion-related law simply has to show that the law "singles out the provision of abortion services or facilities in which abortion services are performed"; *or* the law "impedes women's access to abortion services." The bill lists several factors for the court to consider in determining whether a law "impedes" access including:

- Whether the law interferes with the abortion provider's ability to provide care and services according to his or her own good-

faith judgment. Thus, it allows abortion providers to set the standard of care—essentially, the "Gosnell prerogative."

- Whether the law would delay some women in obtaining abortions.
- Whether the law would directly or indirectly increase the costs of abortions (to either the provider or the women).
- Whether the law requires or is reasonably likely to require "a trip to the offices of the abortion provider that would not otherwise be required."
- Whether the law is likely to "decrease" the "availability of abortion services in the [S]tate."
- Whether the measure includes criminal or civil penalties that are not imposed on other health care professionals for comparable conduct or failures to act.
- The cumulative impact of the challenged law combined with existing requirements or restrictions applicable to abortion.

Once a *prima facie* case is made, the burden will shift to the state to show, by clear and convincing evidence, that the measure "significantly advances the safety of abortion services or the health of women"; *and* that the safety of abortion services or the health of women cannot be advanced by a less restrictive, alternative measure or action. In practice, this is a very high burden – one the dwarfs the *de minimus* burden on a party challenging the law.

Clearly, the "Women's Health Protection Act" is designed to ensure that virtually all abortion-related regulations and restrictions are summarily struck down.

Conclusion

S. 1696 would preempt and invalidate hundreds of democratically enacted laws—most at the state level—that were written to protect women and their unborn children. Further, it would prevent legislators from enacting more protections in the future. AUL opposes this bill and urges members of the Senate to vote against it. Thank you.

July 14, 2014

Senator
U.S. Senator
Washington, DC 20510

Dear Senator,

We, the undersigned representing millions of Americans in states across the country, are in strong opposition to the Women's Health Protection Act of 2013, S. 1696, introduced by Senator Richard Blumenthal (D-CT). If passed, this bill would undermine laws in our states that we have worked with state legislatures and Governors to pass in order to protect unborn children and to improve the health standards of abortion clinics to protect women's health.

Our states have worked to pass reasonable and commonsense restrictions on abortion including hospital admitting privileges, bans on abortion at 20 weeks, bans on tele-medicine and webcast chemical abortion and abortion clinic health regulations. The Supreme Court ruled in *Planned Parenthood v. Casey* that states have the authority to regulate and place reasonable restrictions on abortion. Even a liberal Supreme Court has upheld some restrictions on abortion as constitutional. This bill would go beyond current abortion jurisprudence and overturn state laws and reasonable protections, which many Americans support.

Americans are increasingly identifying themselves as pro-life. A recent Gallup Poll (May 2014) found that 47% of registered voters identified as pro-choice, while 46% of registered voters identified themselves as pro-life. However, when asked whether there should be reasonable restrictions and limitations on abortion, even voters who identify themselves as pro-choice agree that abortion should not be on demand and unrestricted. Of those who identify as pro-choice, 50% believe that abortion should be legal only under certain circumstances while only 28% believe that abortion should be legal under any circumstances. Even Americans who identify themselves as pro-choice support reasonable restrictions on abortion; this law is completely out of touch with the constituents in our states.

We believe, and the Supreme Court has affirmed, that abortion is unlike any other medical procedure. We have taken steps to protect women and unborn children in our state and these important measures have saved countless lives in our states. Additionally, each year more state pro-life laws are being introduced and passed (21 measures this year alone) and year after year our constituents are electing representatives to the state legislature who represent their views, their priorities and their positions. Senator Blumenthal's bill would undermine the will of the people and restrict their voice in the political and lawmaking process.

Again, on behalf of Americans we represent in states across the country, we oppose the Women's Health Protection Act sponsored by Senator Blumenthal. The federal government

should not trump our ability to protect women and unborn children in our state with reasonable and constitutional restrictions on abortion.

Sincerely,

Tony Perkins, President
Family Research Council

Phil Burress, President
Citizens for Community Values Action

David E. Smith, Executive Director
Illinois Family Institute

Bryan McCormack, Executive Director
Cornerstone Action (New Hampshire)

Kent Ostrander, Executive Director
The Family Foundation (Kentucky)

Nicole Stacy, Public Policy Assistant
Family Institute of Connecticut

Cathi Herrod, President
Center for Arizona Policy

Gene Mills, President
Louisiana Family Forum

Jerry Cox, President
Arkansas Family Council

Thomas J. Shaheen, Vice President for Policy
Pennsylvania Family Council

David Bydalek, Policy Director
Nebraska Family Alliance

Jason McGuire, Executive Director
New Yorkers for Constitutional Freedoms

Nicole Theis, President
Delaware Family Policy Council

John Helmberger, CEO
Minnesota Family Council

TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

July 15, 2014

United States Senate Committee on the Judiciary
Attn: Patrick Leahy, Chairman, and Chuck Grassley, ranking member
224 Dirksen Senate Office Building
Washington, D.C. 20510-6050

Dear Chairman Leahy and Ranking Member Grassley,

We are writing in opposition to S. 1696. If enacted, this bill will invalidate hundreds of laws that protect unborn children and women who are considering abortion. This legislation would prevent states from enacting lifesaving protections such as ultrasound requirements, informed consent requirements, regulations of abortion-inducing drugs, health and safety standards for abortion facilities, and limitations on dangerous late-term abortions.

The United States Supreme Court recognizes that the states have "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Roe v. Wade*, 410 U.S. 113, 150 (1973). This legislation would remove the ability of states to enact medically necessary and widely supported regulations of the abortion industry. When a law is passed it is generally presumed to be constitutional. However, S. 1696 only requires that an abortion provider or anyone else challenging an abortion-related law demonstrate that the law "singles out the provision of abortion services or facilities in which abortion services are performed" or that it "impedes women's access to abortion services." S. 1696 would then place a high burden on the state to justify the law.

We believe in protecting innocent human life and preventing the serious health risks abortion poses to women, including:

- Short term risks of blood loss, blood clots, incomplete abortion, and infections;
- Increased risk of pre-term birth or placenta previa in future pregnancies;
- Increased instances of mental health problems, including anxiety and depression; and,
- A risk of maternal death three times greater than with childbirth.

Kermit Gosnell's "House of Horrors" illustrates the dangers of a self-regulated abortion industry. We believe in promoting women's health and protecting those who cannot protect themselves. S. 1696 seeks to prevent the states from accomplishing these goals.

We respectfully urge you to oppose this legislation.

Sincerely,

Terry E. Branstad
Governor of Iowa

Kim Reynolds
Lieutenant Governor of Iowa

STATE CAPITOL DES MOINES, IOWA 50319 515.281.5211 FAX 515.725.3527 WWW.GOVERNOR.IOWA.GOV

STATE OF INDIANA
OFFICE OF THE GOVERNOR
State House, Second Floor
Indianapolis, Indiana 46204

Michael R. Pence
Governor

July 21, 2014

United States Senate Committee on the Judiciary
Attn: Chairman Patrick Leahy and Ranking Member Chuck Grassley
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Leahy and Ranking Member Grassley:

I am writing to express my strong opposition to S. 1696. This bill will infringe upon Indiana's ability to regulate the abortion industry, just as Indiana regulates many other medical procedures to help ensure the maximum safety for the patient.

Indiana has taken numerous steps to better inform women who may be considering the difficult decision of abortion, and we have put regulations in place to help protect their health and safety if that is the path they choose. If enacted, S. 1696 would invalidate many of these life-saving protections such as Indiana's restriction on the distribution of abortion inducing drugs via telemedicine, our informed consent laws, requirements for hospital admitting privileges, and numerous other safeguards that protect women.

I believe in the sanctity of every human life, and we must remain diligent in protecting the unborn children and women who are considering abortion. Indiana takes this responsibility seriously, and I urge this Committee to recognize the role of states in this instance by not moving forward with further consideration of S. 1696. Thank you for your consideration of our views on this measure.

Sincerely,

Michael R. Pence
Governor of Indiana

Cc: Senator Dan Coats, Senator Joe Donnelly

http://www.politicsdaily.com/2011/01/23/kermit-gosnells-pro-choice-enablers-how-clinics-become-death-t/

Kermit Gosnell's Pro-Choice Enablers (Is This What an Industry That Self-Regulates Looks Like?)

10 hours ago

Melinda Henneberger
Editor in Chief

The ultimate non-partisan body – a criminal grand jury – has supplied us with the graphic, 261-page horror story of Kermit Gosnell, M.D., who stands accused of butchering seven babies – yes, after they were born alive -- and fatally doping a refugee from Nepal with Demerol in a clinic that smelled of cat urine, where the furniture was stained with blood and the doctor kept a collection of severed baby feet. As often as possible, the report says, Gosnell induced labor for women so pregnant that, as he joked on one occasion, the baby was so big he could "walk me to the bus stop." Then, hundreds of times over the years, he slit their little necks, according to the grand jury report:

> **[He] regularly and illegally delivered live, viable, babies in the third trimester of pregnancy – and then murdered these newborns by severing their spinal cords with scissors. The medical practice by which he carried out this business was a filthy fraud in which he overdosed his patients with dangerous drugs, spread venereal disease among them with infected instruments, perforated their wombs and bowels – and, on at least two occasions, caused their deaths. Over the years, many people came to know that something was going on here. But no one put a stop to it.**

And the kicker? This nightmare facility had not been inspected in 17 years – other than by someone from the National Abortion Federation, whom he actually invited there. For whatever reason, Gosnell applied for NAF membership two days after the death of the 41-year-old Nepalese woman, Karnamaya Mongar. Even on a day when the place had been scrubbed and

spiffed up for the visit, the NAF investigator found it disgusting and rejected Gosnell's application for membership. But despite noting many outright illegalities, including a padlocked emergency exit in a part of the clinic where women were left alone overnight, the grand jury report notes that the NAF inspector did not report any of these violations to authorities:

> So too with the National Abortion Federation. NAF is an association of abortion providers that upholds the strictest health and legal standards for its members. Gosnell, bizarrely, applied for admission shortly after Karnamaya Mongar's death. Despite his various efforts to fool her, the evaluator from NAF readily noted that records were not properly kept, that risks were not explained, that patients were not monitored, that equipment was not available, that anesthesia was misused. It was the worst abortion clinic she had ever inspected. Of course, she rejected Gosnell's application. She just never told anyone in authority about all the horrible, dangerous things she had seen.

The report says outright that the lack of oversight after pro-life Democrat Bob Casey left the Pennsylvania governor's office in 1993 was overtly political. When pro-choice Republican Tom Ridge took over for Casey, the report says,

> ...[t]he Pennsylvania Department of Health abruptly decided, for political reasons, to stop inspecting abortion clinics at all. The politics in question were not anti-abortion, but pro. With the change of administration from Governor Casey to Governor Ridge, officials concluded that inspections would be "putting a barrier up to women" seeking abortions. Even nail salons in Pennsylvania are monitored more closely for client safety. Without regular inspections, providers like Gosnell continue to operate; unlawful and dangerous third-trimester abortions go undetected; and many women, especially poor women, suffer.

This is where those of you who are pro-choice may well want to cross your arms over your chest, but the kind of regulation that *if enforced* might have prevented this atrocity is in all cases seen as an infringement by abortion rights advocates, and thus is strenuously opposed. In Evansville, Indiana, for instance, the pro-choice community was outraged in 2008 after county commissioners passed an ordinance requiring abortion clinic doctors to have hospital admitting privileges. As an Evansville Courier editorial decrying the ordinance put it, "Abortion rights groups see it as an attempt to harass abortion providers and to limit women's access to legal abortions." But wouldn't such a requirement also provide a degree of protection to women – particularly the poor, immigrant population Gosnell preyed upon? Not surprisingly, Gosnell had no such hospital admitting privileges, though he was well known to local hospital doctors who, the report says, regularly had to clean up after him, and treat patients like the 19-year-old who had to have a hysterectomy after Gosnell punctured her uterus.

Abortion-rights activists call such regulations "TRAP laws" – short for Targeted Regulation of Abortion Providers; these laws attempt to regulate abortion clinics at the same level of other outpatient surgical centers, for instance by requiring that

hallways be wide enough to get a gurney through if something goes wrong. What difference could that possibly make? Well, it took Emergency Medical Service workers 20 minutes to get Karnamaya Mongar out of Gosnell's clinic and into an ambulance because the hallways were blocked and the emergency exit padlocked. (Here, Tarina Keene, the executive director of NARAL Pro-Choice Virginia, registers the standard complaint that such regulation is too costly and is "really just designed to shut these places down. It has nothing to do with medical care.")

Only, on the day of the annual marches marking the 38th anniversary of Roe v. Wade, I want to ask my pro-choice friends whether opposing all regulation is in fact in the best interest of the women I know you care about. Wherever you stand on this issue – and I am a liberal Catholic who is not pro-choice – we agree that what Gosnell is accused of doing exceeds all bounds of decency. But without regulation and enforcement, how can we be sure there aren't other Gosnells out there?

Other kinds of free-standing ambulatory clinics are inspected periodically by state health departments, but abortion clinics are not, says Mary Spaulding Balch, of National Right to Life, who tracks legislation and regulations in all 50 states. And, again quoting from the grand jury report, here is what the lack of enforcement of regulations already on the books looks like:

> Almost a decade ago, a former employee of Gosnell presented the Board of Medicine with a complaint that laid out the whole scope of his operation: the unclean, unsterile conditions; the unlicensed workers; the unsupervised sedation; the underage abortion patients; even the over-prescribing of pain pills with high resale value on the street. The department assigned an investigator, whose investigation consisted primarily of an offsite interview with Gosnell. The investigator never inspected the facility, questioned other employees, or reviewed any records. Department attorneys chose to accept this incomplete investigation, and dismissed the complaint as unconfirmed.

Shortly thereafter the department received an even more disturbing report – about a woman, years before Karnamaya Mongar, who died of sepsis after Gosnell perforated her uterus. The woman was 22 years old. A civil suit against Gosnell was settled for almost a million dollars, and the insurance company forwarded the information to the Department of State. That report should have been all the confirmation needed for the complaint from the former employee that was already in the department's possession. Instead, the department attorneys dismissed this complaint, too. They concluded that death was just an "inherent" risk, not something that should jeopardize a doctor's medical license.

The same thing
happened at least twice more: The department received complaints about lawsuits against Gosnell, but dismissed them as meaningless. A department attorney said there was no "pattern of conduct." He never bothered to check a national litigation database, which would have shown that Gosnell had paid out damages to at least five different women whose internal organs he had punctured during abortions."

Kermit Gosnell's clinic. (Matt Rourke, AP)

Though we're constantly told that there are only a handful of brave doctors performing late-term abortions, an '06 survey by the pro-choice Guttmacher Institute in New York found that about 1.5 percent of the 1.2 million abortions performed annually -- in other words, about 18,000 abortions a year -- are performed at 21 weeks or later. Nearly a quarter of providers, according to Guttmacher, offer abortions after 20 weeks, and slightly more than 1 in 10 will perform an abortion after 24 weeks. That translates to 140 known providers doing truly late-term procedures. But as the National Right to Life's Douglas Johnson asks, "Do you suppose this guy in Philadelphia was dutifully filling out the Guttmacher reports and turning them in?"

I'm well aware that the counter-argument is that if late-term abortions in particular were more readily accessible and less stigmatized, there would be fewer Gosnells in this world. But how stigmatized was he, pocketing $1.8 million a year while allegedly maiming women and killing their living, breathing children with no apparent fear of detection from officials who according to the grand jury feared that inspections would pose obstacles to choice?

Though I've never heard of any case this grisly, Johnson says it's "not all that isolated a case, but usually they're just local news stories." Last year, the license of New Jersey abortion doctor Stephen Brigham was pulled after authorities learned he was routinely starting illegal late-term abortions in New Jersey then transporting the women to Maryland to finish the job. And how was he discovered? Again, by accident. According to a recent story by The Associated Press, "Brigham's practices first caught the attention of Maryland regulators after a patient was hospitalized with a ruptured uterus and small intestine."

This story reports on the owners of several shoddy Florida clinics, including the one in Hialeah where in 2006, an 18-year-old who was 23 weeks pregnant gave birth to a child whose body was discovered, according to the police, after someone reported hearing crying coming from a trash can. Officers who searched the clinic said they finally found the body where it had been moved -- in a biohazard bag stashed on the clinic's roof.

And a case that made the news 20 years ago now involved New York's Abu Hayat, whom the tabloids dubbed "The Butcher of Avenue A." As it happened, I knew Hayat by sight – and talk about the banality of evil -- because he lived in my building, where I frequently wound up sharing a lap lane with him in the pool.

In each of these well-known cases, many more victims came forward after some particularly gruesome event brought these doctors' methods to light; how many more like them go undetected?

In 2002, a piece of legislation called the "Born-Alive Infant Protection Act" began requiring doctors to treat children born alive during abortions the same way they treat other newborns. Initially, advocates for choice adamantly opposed that legislation, too, as an assault on Roe v. Wade.

But what about assaults on children who, having somehow gotten out of the birth canal alive, we agree *are* children? And what of the assaults on women, who uniformly deserve sterile conditions and an unlocked emergency exit? How can we know they are treated competently without the regulation and oversight of this, as any other industry? Just like other industries, the abortion industry prefers the self-policing that in the Gosnell case did not prevent tragedy any more than the self-regulation and lax enforcement of the oil industry prevented the BP oil spill.

On Saturday, President Obama affirmed his support for Roe v. Wade by saying that "government should not intrude on private family matters." But it's a hands-off lack of oversight that allowed Kermit Gosnell to do so much damage before he was finally stopped – by accident, by authorities investigating him for over-prescribing OxyContin.

Perhaps Gosnell himself best summed up the underlying problem at his arraignment, where he reportedly seemed confused by the proceedings: "I understand the one count, because a patient died," he told the court, "but I didn't understand the seven counts." It apparently never occurred to him that the dead infants – one of them photographed in a plastic shoe box, another kept frozen in a gallon of spring water – were people, too.

Maternal - Fetal Medicine
Obstetrics and Gynecology
ROBERT C. BYRD
HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY
Charleston Division

Byron C. Calhoun, MD, FACOG, FACS, FASAM, MBA
Professor and Vice Chair, Department OB/GYN
West Virginia University-Charleston
800 Pennsylvania Ave
Division of Maternal-Fetal Medicine
Charleston, WV 25302
Phone: (304) 388-1599
FAX: (304) 388-2915
Email: byron.Calhoun@camc.org
11 July 2014

Dear Chairman Leahy and Ranking Member Grassley,

I, the undersigned individual and member of organizations whose members include physicians and other healthcare professionals, am writing to urge you to oppose S. 1696, the so-called "Women's Health Protection Act." We all share a profound interest in protecting the health and welfare of women considering abortion and their unborn children and support federal and state laws that advance these efforts. Quite the opposite, the enactment of S. 1696 would invalidate hundreds of federal and state abortion-related laws and permit abortion providers to set the standard of care for their patients with no oversight from state officials and no effective remedies for the abortion industry's deficiencies and frequent malfeasance.

S. 1696 adopts the myth that abortion is "essential to women's health," and asserts that laws restricting the practice are "medically unwarranted" and "harm women." In reality, laws regulating abortion have the dual effect of protecting women and their unborn children. Abortion bans (*e.g.* gestational limits and sex-selection bans), health and safety standards for abortion facilities, admitting privileges requirements, regulations on abortion-inducing drugs, reflection periods and other informed consent requirements, and ultrasound requirements—all of which would be invalidated under S. 1696—protect women from the dangers inherent to abortion.

Abortion can cause serious physical and psychological (both short- and long-term) complications for women, including but not limited to: uterine perforation, uterine scarring, cervical perforation or other injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies *(at least 140 peer review articles supporting this risk)*, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, an increased risk of breast cancer, psychological or emotional complications such as depression, anxiety, sleeping disorders *(at least 116 peer review articles supporting these risks)*, and death. **Calhoun BC.** Systematic Review: The maternal mortality myth in the context of legalized abortion. The Linacre Quarterly; 80 (3) 2013, 264–276. **DOI:** http://dx.doi.org/10.1179/2050854913Y.0000000004.

However, S. 1696 would invalidate every law specifically requiring the disclosure of these risks to women, as well as abortion provider regulations enacted to ensure that women suffering complications from abortion receive appropriate medical care.

Importantly, abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at eight (8) weeks gestation or earlier, the relative risk increases exponentially at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTETRICS & GYNECOLOGY 103(4):729 (2004). As noted in the Bartlett study, gestational age is the strongest risk factor for abortion-related mortality (731). Compared to abortion at eight weeks gestation, the relative risk of mortality increases significantly (by 38 percent for each additional week) at higher gestations (729-31).

In other words, a woman seeking an abortion *at 20 weeks is 35 times more likely to die from abortion* than she was in the first trimester. *At 21 weeks or more, she is 91 times more likely to die* from abortion than she was in the first trimester.

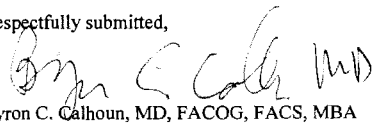
Yet, S. 1696 would invalidate laws limiting late-term abortion. In fact, even post-viability abortions bans would require a "health" exception so broad that virtually all abortions would be permitted.

Fundamentally, the United States Supreme Court has long recognized that the states have "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." *Roe v. Wade*, 410 U.S. 113, 150 (1973).

The Court has also 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 acknowledgement of this distinct difference between abortion and other procedures has led the Court to grant states increasing latitude in the regulation of abortion. Invalidating these laws and regulations through one sweeping federal bill would greatly harm women and their unborn children.

S. 1696 will not protect women's health—it will only protect the abortion industry. I respectfully urge you to oppose this dangerous legislation. If you have questions do not hesitate to contact me at 304-388-1599 or my email at byron.Calhoun@camc.org.

Respectfully submitted,



Byron C. Calhoun, MD, FACOG, FACS, MBA
Vice-Chair, Department of Obstetrics and Gynecology
Virginia University-Charleston
Charleston, WV

Attch: Preterm birth (140 references) & & Psychological Effects (116 references) Publication lists

cc: Members of the United States Senate Judiciary Committee

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley,

We, the undersigned individuals and organizations whose members include physicians and other healthcare professionals are writing to urge you to oppose S. 1696, the so-called "Women's Health Protection Act." We share a profound interest in protecting the health and welfare of women considering abortion and their unborn children and support federal and state laws that advance these efforts. Quite the opposite, the enactment of S. 1696 would invalidate hundreds of federal and state abortion-related laws and permit abortion providers to set the standard of care for their patients with no oversight from state officials and no effective remedies for the abortion industry's deficiencies and frequent malfeasance.

S. 1696 adopts the myth that abortion is "essential to women's health," and asserts that laws restricting the practice are "medically unwarranted" and "harm women." In reality, laws regulating abortion have the dual effect of protecting women and their unborn children. Abortion bans (*e.g.* gestational limits and sex-selection bans), health and safety standards for abortion facilities, admitting privileges requirements, regulations on abortion-inducing drugs, reflection periods and other informed consent requirements, and ultrasound requirements—all of which would be invalidated under S. 1696—protect women from the dangers inherent to abortion.

Abortion can cause serious physical and psychological (both short- and long-term) complications for women, including but not limited to: uterine perforation, uterine scarring, cervical perforation or other injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, an increased risk of breast cancer, psychological or emotional complications such as depression, anxiety, sleeping disorders, and death.

However, S. 1696 would invalidate every law specifically requiring the disclosure of these risks to women, as well as abortion provider regulations enacted to ensure that women suffering complications from abortion receive appropriate medical care.

Importantly, abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at eight (8) weeks gestation or earlier, the relative risk increases exponentially at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTETRICS &

GYNECOLOGY 103(4):729 (2004). As noted in the Bartlett study, gestational age is the strongest risk factor for abortion-related mortality (731). Compared to abortion at eight weeks gestation, the relative risk of mortality increases significantly (by 38 percent for each additional week) at higher gestations (729-31).

In other words, a woman seeking an abortion *at 20 weeks is 35 times more likely to die from abortion* than she was in the first trimester. *At 21 weeks or more, she is 91 times more likely to die* from abortion than she was in the first trimester.

Yet, S. 1696 would invalidate laws limiting late-term abortion. In fact, even post-viability abortions bans would require a "health" exception so broad that virtually all abortions would be permitted.

Fundamentally, the United States Supreme Court has long recognized that the states have "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." *Roe v. Wade*, 410 U.S. 113, 150 (1973).

The Court has also 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 acknowledgement of this distinct difference between abortion and other procedures has led the Court to grant states increasing latitude in the regulation of abortion. Invalidating these laws and regulations through one sweeping federal bill would greatly harm women and their unborn children.

S. 1696 will not protect women's health—it will only protect the abortion industry. We respectfully urge you to oppose this dangerous legislation.

Sincerely,

The Association of American Physicians & Surgeons

American Association of Pro-life Obstetricians and Gynecologists

Catholic Medical Association

Christian Medical Association

Physicians for Life

National Association of Catholic Nurses-U.S.A.

National Association of Pro-life Nurses

Steve Calvin MD, Medical Director, the Minnesota Birth Center

John M. Thorp Jr. MD,MSC

cc: Members of the United States Senate Judiciary Committee

July 15, 2014

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Minority Member
Committee on the Judiciary
United States Senate
Washington, DC 201510

Dear Chairman Leahy and Senator Grassley:

We, the undersigned state officeholders, write to register our strong opposition to Sen. Richard Blumenthal's proposed legislation, S.1696. As a coalition of pro-life women lawmakers devoted to measures that enhance the well-being of women and respect for the intrinsic value of human life, we are profoundly alarmed by Congressional consideration of an extreme and unwarranted measure like S.1696. At one fell stroke this legislation would undo decades' worth of commonsense legislation that has passed muster with the people of our state, their elected representatives, and our courts.

This radical bill will expose women and their unborn children to an ungovernable regime of abortion until the time of birth. It will, among other harms:

- overturn any and all efforts to provide legislative response to abortionists like Kermit Gosnell who operate under filthy and dangerous conditions;
- destroy protections for children in the womb late in pregnancy – even after the fifth month, by which time the baby can feel excruciating pain;
- eradicate legislation to provide informed consent and a reflection period before an abortion can be performed;
- compel public funding for the performance of abortions and require non-physicians to be permitted to train for and carry out abortions; and
- expose the unborn to abortion merely on account of their sex – in nearly all cases because they are, like us, female.

Rather than promote consensus legislation on this issue that respects the differences between the federal and state roles in our system of government, S. 1696 would uproot literally hundreds of protective laws that have passed legislative scrutiny and judicial review. It will, instead, create a void into which the worst practitioners of abortions like Kermit Gosnell will surely and swiftly rush.

We plead with the members of this honorable committee to refrain from so rash and ill-considered a proposal and to recognize the strong opposition of the American people to S. 1696.

Sincerely,

The Honorable Wendy Nanney, House of Representatives, South Carolina
The Honorable Key Ivey, Lieutenant Governor, Alabama
The Honorable Bette Grande, House of Representatives, North Dakota
The Honorable Lori Saine, House of Representatives, Colorado
The Honorable Jeanine Notter, House of Representatives, New Hampshire
The Honorable Vicky Steiner, House of Representatives North Dakota
The Honorable Stacey Guerin, House of Representatives, Maine
The Honorable Angela Hill, Senate, Mississippi
The Honorable Cathy Giessel, Senate, Arkansas
The Honorable Nancy Jacobs, Senate, Maryland
The Honorable Lenette Peterson, House of Representatives, New Hampshire
The Honorable Kathy Rapp, House of Representatives, Pennsylvania
The Honorable Pam Peterson, House of Representatives, Oklahoma
The Honorable Karen Rohr, House of Representatives, North Dakota
The Honorable Alison Littell McHose, Assembly, New Jersey
The Honorable Leslie Nutting, Senate, Wyoming
The Honorable Donna Hicks Wood, House of Representatives, South Carolina
The Honorable Donna Oberlander, House of Representatives, Pennsylvania
The Honorable Ruth Samuelson, House of Representatives, North Carolina
The Honorable Margaret Sitte, Senate, North Dakota
The Honorable Kimberly Yee, Senate, Arizona
The Honorable Marian Cooksey, House of Representatives, Oklahoma
The Honorable Jacqueline Schaffer, House of Representatives, North Carolina
The Honorable Joyce Fitzpatrick, House of Representatives, Maine
The Honorable RoseMarie Swanger, House of Representatives, Pennsylvania
The Honorable Ellie Espling, House of Representatives, Maine
The Honorable Janice Bowling, Senate, Tennessee
The Honorable Marti Coley, House of Representatives, Florida
The Honorable Terri Collins, House of Representative, Alabama
The Honorable Paulette Rakestraw-Braddock, House of Representatives, Georgia

Bibliography of Peer-Reviewed Studies on Abortion and Psychological Health

Allanson, S., & Astbury, J. (2001). Attachment style and broken attachments: Violence, pregnancy, and abortion. *Australian Journal of Psychology, 53,* 146-151.

Amaro H., Zuckerman B, & Cabral H. (1989). Drug use among adolescent mothers: profile of risk. *Pediatrics, 84,* 144-151.

Barnett, W., Freudenberg, N., & Wille, R. (1992). Partnership after induced abortion: A prospective controlled study. *Archives of Sexual Behavior, 21*(5), 443-455.

Bianchi-Demicheli, F. et al (2002). Termination of pregnancy and women's sexuality. *Gynecological and Obstetric Investigation, 53,* 48-53.

Boesen, H.C., Rorbye C., Norgaard, M., Nilas, L. (2004). Sexual behavior during the first eight weeks after legal termination of pregnancy. *Acta Obstetricia et Gynecologica Scandinavica, 83,*1189-1192.

Bradley, C.F. (1984) Abortion and subsequent pregnancy. *Canadian Journal of Psychiatry, 29,* 494.

Bradshaw, Z., & Slade, P. (2003). The effects of induced abortion on emotional experiences and relationships: A critical review of the literature. *Clinical Psychology Review, 23,* 929-958.

Bradshaw, Z., & Slade, P. (2005). The relationship between induced abortion, attitudes toward sexuality, and sexual problems. *Sexual and Relationship Therapy, 20,* 390-406.

Brockington, I.F. (2005). Post-abortion psychosis, *Archives of Women's Mental Health 8*: 53–54.

Broen, A. N., Moum, T., Bodtker, A. S., Ekeberg, O. (2004) Psychological impact on women of miscarriage versus induced abortion: A 2-year follow-up study. *Psychosomatic Medicine* 66: 265-71.

Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005) Reasons for induced abortion and their relation to women's emotional distress: A prospective, two-year follow-up study. *General Hospital Psychiatry* 27: 36-43.

Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). The course of mental health after miscarriage and induced abortion: a longitudinal, five-year follow-up study. *BMC Medicine* 3(18).

Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2006) Predictors of anxiety and depression following pregnancy termination: A longitudinal five-year follow-up study. *Acta Obstetricia et Gynecologica Scandinavica* 85: 317-23.

Burnell, G. M., & Norfleet, M. A. (1987). Women's self-reported responses to abortion. *The Journal of Psychology, 121*, 71–76.

Butlet, C. (1996). Late psychological sequelae of abortion: Questions from a primary care physician. *Journal of Family Practice, 43*, p. 396-401.

Campbell, N., Franco, K. & Jurs, S. (1988). Abortion in adolescence. *Adolescence 23*, 813-823.

Cohan, C. L., Dunkel-Schetter, C., & Lydon, J. (1993). Pregnancy decision making: Predictors of early stress and adjustment. *Psychology of Women Quarterly, 17*, 223-239.

Coleman, P. K. (2005). Induced Abortion and increased risk of substance use: A review of the evidence. *Current Women's Health Reviews 1*, 21-34.

Coleman, P. K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. *Journal of Youth and Adolescence, 35*, 903-911.

Coleman, P.K.. (2009) The Psychological Pain of Perinatal Loss and Subsequent Parenting Risks: Could Induced Abortion be more Problematic than Other Forms of Loss? Current Women's Health Reviews, 5, 88-99.

Coleman, P.K. (2011). Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009. British Journal of Psychiatry, 199, 180-186

Coleman, P.K., Coyle, C. T., & Rue, V.M. (2010). Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms, Journal of Pregnancy, vol. 2010, Article ID 130519.

Coleman., P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009), Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. *Journal of Psychiatric Research, 43, 770– 776.*

Coleman, P. K., Maxey, C. D., Rue, V. M., & Coyle, C. T. (2005). Associations between voluntary and involuntary forms of perinatal loss and child maltreatment among low-income mothers. *Acta Paediatrica, 94*(10), 1476-1483.

Coleman, P. K., & Maxey, D. C., Spence, M. Nixon, C. (2009). The choice to abort among mothers living under ecologically deprived conditions: Predictors and consequences. *International Journal of Mental Health and Addiction 7, 405-422.*

Coleman, P. K., & Nelson, E. S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. *Journal of Social & Clinical Psychology, 17,* 425-442.

Coleman, P. K., Reardon, D. C., & Cougle, J. (2002). The quality of the caregiving environment and child developmental outcomes associated with maternal history of abortion using the NLSY data. *Journal of Child Psychology and Psychiatry, 43,* 743-757.

Coleman, P. K., Reardon, D. C., & Cougle, J. R. (2005). Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. British *Journal of Health Psychology, 10* (2), 255-268.

Coleman, P. K., Reardon, D. C., Rue, V. M., & Cougle, J. (2002a). A history of induced abortion in relation to substance use during subsequent pregnancies carried to term. *American Journal of Obstetrics and Gynecology, 187,* 1673-1678.

Coleman, P. K., Reardon, D. C, Rue, V. M., & Cougle, J. (2002b). State-funded abortions versus deliveries: A comparison of outpatient mental health claims over 4 years. American *Journal of Orthopsychiatry, 72,* 141-152.

Coleman, P. K., Reardon, D. C., Strahan, T., & Cougle, J. R. (2005). The psychology of abortion: A review and suggestions for future research. *Psychology and Health, 20,* 237-271.

Coleman, P.K., Rue, V.M., Coyle, C.T. & Maxey, C.D. (2007). Induced abortion and child-directed aggression among mothers of maltreated children. *Internet Journal of Pediatrics and Neonatology, 6* (2), ISSN: 1528-8374.

Coleman, P.K., Rue, V.M., Spence, M. & Coyle, C.T. (2008). Abortion and the sexual lives of men and women: Is casual sexual behavior more appealing and more common after abortion? *International Journal of Health and Clinical Psychology, 8* (1), 77-91.

Coleman, P.K., Rue, V.M. & Coyle, C.T. (2009). Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey. *Public Health, 123,* 331-338.DOI: 10.1016/j.puhe.2009.01.005

Coleman, P. K., Rue, V., & Spence, M. (2007). Intrapersonal processes and post-abortion relationship difficulties: A review and consolidation of relevant literature. *Internet Journal of Mental Health,* 4 (2).

Congleton, G. K., & Calhoun, L. G. (1993). Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations. *International Journal of Social Psychiatry, 39,* 255-265.

Conklin, M. P., & O'Connor, B. P. (1995). Beliefs about the fetus as a moderator of postabortion psychological well-being. *Journal of Social & Clinical Psychology, 14,* 76-95.

Cote-Arsenault, D., Dombeck, M. T. B. (2001). Maternal assignment of fetal personhood to a previous pregnancy loss: Relationship to anxiety in the current pregnancy. *Health Care forWomen International 22*, 649-665.

Cougle, J. R., Reardon, D. C., & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. *Medical Science Monitor, 9* (4), CR105-112.79.

Cougle, J. R., Reardon, D. C., & Coleman, P. K. (2005). Generalized anxiety following unintended pregnancies resolved through childbirth and abortion: A cohort study of the 1995 National Survey of Family Growth. *Journal of Anxiety Disorders, 19*, 137-142.

Cozzarelli, C. (1993). Personality and self-efficacy as predictors of coping with abortion. *Journal of Personality and Social Psychology, 65*, 1224-1236.

Coyle, C.T., Coleman, P.K. & Rue, V.M. (2010). Inadequate preabortion counseling and decision conflict as predictors of subsequent relationship difficulties and psychological stress in men and women. *Traumatology, 16* (1), 16-30. DOI:10.1177/1534765609347550

David, H., Rasmussen, N. & Holst, E. (1981). Postpartum and postabortion psychotic reactions. *Family Planning Perspectives, 13*, 88-91.

Dingle, K., et al. (2008). Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study. *The British Journal of Psychiatry, 193*, 455-460.

Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. *Journal of Obstetrics and Gynecology, 5*, 504-509.

Fergusson, D. M., Horwood, L. J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47*, 16-24.

Fergusson, D. M., Horwood, L. J., & Boden, J.M. (2009). Reactions to abortion and subsequent mental health. *The British Journal of Psychiatry, 195*, 420-426.

Fielding, S. L., & Schaff, E. A. (2004). Social context and the experience of a sample of U.S. women taking RU-486 (Mifepristone) for early abortion. *Qualitative Health Research, 14*, 612-627.

Franz, W., & Reardon, D. (1992). Differential impact of abortion on adolescents and adults. *Adolescence, 27*(105), 161-172.

Gissler, M., Hemminki, E., & Lonnqvist, J. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal, 313*, 1431-1434.

Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health, 15*, 459-463.

Guilbert, E., & Rotter, D. (1997). Assessment of satisfaction with induced abortion procedure. *The Journal of Psychology, 131,* 157-166.

Harlow, B. L., Cohen, L. S., Otto, M. W., Spiegelman, D., & Cramer, D. W. (2004). Early life menstrual characteristics and pregnancy experiences among women with and without major depression: the Harvard Study of Mood and Cycles. *Journal of Affective Disorders, 79,* 167176.

Hemmerling, F., Siedentoff, F., & Kentenich, H. (2005). Emotional impact and acceptability of medical abortion with mifepristone: A German experience. *Journal of Psychosomatic Obstetrics & Gynecology, 26,* 23-31.

Henshaw, R., Naji, S., Russell, I., & Templeton, A. (1994). Psychological responses following medical abortion (using mifepristone and gemeprost) and surgical vacuum aspiration: A patient-centered, partially randomized prospective study. Acta Obstetrica et *Gynecologica Scandinavica,73,* 812-818.

Hittner, A. (1987). Feelings of well-being before and after abortion. *American Mental Health Counselors Association Journal, 9,* 98-104.

Hope, T. L., Wilder, E. I., & Terling Watt, T. (2003). The relationships among adolescent pregnancy, pregnancy resolution, and juvenile delinquency. *Sociological Quarterly, 44,* 555-576.

Husfeldt, C., Hansen, S. K., Lyngberg, A., Noddebo, M., & Pettersson, B. (1995). Ambivalence among women applying for abortion. *Acta Obstetricia et Gynecologia Scandinavica, 74,* 813-17.

Kero, A., Hoegberg, U., Jacobsson, L., & Lalos, A. (2001). Legal abortion: A painful necessity. *Social Science and Medicine, 53,* 1481-1490.

Kero, A., Hoegberg, U., & Lalos, A. (2004). Wellbeing and mental growth - long-term effects of legal abortion. *Social Science and Medicine, 58,* 2559-2569.

Kero A, Lalos A. (2000). Ambivalence - a logical response to legal abortion: a prospective study among women and men. *Journal of Psychosomatic Obstetrics and Gynecology, 21,* 81-91.

Kitamura, T., Toda, M. A., Shima, S., & Sugawara, M. (1998). Single and repeated elective abortions in Japan: A psychosocial study. *Psychosomatic Obstetrics and Gynecology, 19,* 126-134.

Lauzon, P., Roger-Achim, D., Achim, A., & Boyer, R. (2000). Emotional distress among couples involved in first-trimester induced abortions. *Canadian Family Physician, 46,* 2033-2040.

Lazarus, A. & Stern, R. (1986). Psychiatric Aspects of Pregnancy Termination" Clinics in

Obstetrics & Gynaecology 13, 125-134.

Lazarus, A. (1985). Psychiatric Sequelae of Legalized Elective First Trimester Abortion. *Journal of Psychosomatic Obstetrics &Gynecology, 4*, 141-150.

Lemkau, J. P. (1988). Emotional sequelae of abortion: Implications for clinical practice. *Psychology of Women Quarterly, 12*, 461–472.

Lewis, W. J. (1997). Factors associated with post-abortion adjustment problems: Implications for triage. *The Canadian Journal of Human Sexuality, 6*, 9-17.

Llewellyn, S. P., & Pytches, R. (1988). An investigation of anxiety following termination of pregnancy. *Journal of Advanced Nursing, 13*, 468–471.

Lodl, K. McGettigan, A. & Bucy, J. (1985). Women's Responses to Abortion. *Journal of Social Work & Human Sexuality, 3*, 119-132.

Lydon, J., Dunkel-Schetter, C., Cohan, C. L., & Pierce, T. (1996). Pregnancy decision-making as a significant life event: A commitment approach. *Journal of Personality and Social Psychology, 71*, 141-151.

Major, B. (1989). Self-blame, Self-efficacy and Adjustment to Abortion. *Journal of Personality and Social Psychology, 5*, 1059-1068.

Major, B., Cozzarelli, C., Cooper, M.L., Zubek, J., Richards C., Wilhite, M., & Gramzow, R.H. (2000).Psychological responses of women after first trimester abortion. *Archives of General Psychiatry, 57*, 777-84.

Major, B. Cozzarelli, C., Sciacchitano, A. M., Cooper, M. L., Testa, M., & Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 59*, 186-197.

Major, B.,& Gramzow, R. H. (1999).Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology,77*, 735-745.

Miller, W. B. (1992). An empirical study of the psychological antecedents and consequences of induced abortion. *Journal of Social Issues, 48*, 67-93.

Miller, W. B., Pasta, D. J., & Dean, C. L. (1998). Testing a model of the psychological consequences of abortion. In L. J. Beckman and S. M. Harvey (eds.), *The new civil war: The psychology, culture, and politics of abortion*. Washington, DC: American PsychologicalAssociation.

Morgan, C., Evans, M., Peter, J. R., & Currie, C. (1997). Mental health may deteriorate as a direct result of induced abortion. *British Medical Journal, 314*, 902.

Moseley, D. T., Follongstad, D. R., Harley, H., & Heckel, R.V. (1981). Psychological factors that predict reaction to abortion. *Journal of Clinical Psychology, 37*, 276-279.

Mota, N.P. et al (2010). Associations between abortion, mental disorders, and suicidal behaviors in a nationally representative sample. *The Canadian Journal of Psychiatry, 55* (4), 239-246.

Mueller, P., Mufel, N., Speckhard, A. & Sivuha, S. (2002) Predictors of Posttraumatic Stress Disorder Following Abortion in a Former Soviet Union Country. *Journal of Prenatal & Perinatal Psych & Health,17,* 41-61.

Ney, P. G., Fung, T., & Wickett, A.R. (1993). Relations between induced abortion and child abuse and neglect: Four studies. *Pre and Perinatal Psychology Journal, 8*, 43-63.

Ney, P. G., Fung, T., Wickett, A. R., & Beaman-Dodd, C. (1994). The effects of pregnancy loss on women's health. *Social Science & Medicine, 38*, 1193-1200.

Ostbye, T., Wenghofer, E. F., Woodward, C. A., Gold, G., & Craighead, J. (2001). Health services utilization after induced abortions in Ontario: A comparison between community clinics and hospitals. *American Journal of Medical Quality, 16*, 99-106.

Patterson, M. J., Hill, R. P., & Maloy, K. (1995). Abortion in America: A consumer-based perspective. *Journal of Consumer Research, 21*, 677-694.

Pedersen, W. (2008). Abortion and depression: A population-based longitudinal study of young women. *Scandinavian Journal of Public Health, 36*, No. 4, 424-428.

Pedersen, W. (2007). Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study. *Addiction, 102* (12), 1971-78.

Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? *Journal of Adolescent Health, 29*, 2-11.

Posavac, E., & Miller, T. (1990). Some problems caused by not having a conceptual foundation for health research: An illustration from studies of the psychological effects of abortion. *Psychology and Health, 5*, 13-23.

Prommanart, N., et al. (2004). Maternal grief after abortion and related factors. *Journal of the Medical Association of Thailand, 87*, 1275-1280.

Reardon, D. C., & Coleman, P. K. (2006). Relative treatment for sleep disorders following abortion and child delivery: A prospective record-based study. *Sleep, 29* (1), 105-106.

Reardon, D. C., Coleman, P. K., & Cougle, J. R. (2004). Substance use associated with unintended pregnancy outcomes in the National Longitudinal Survey of Youth. *American Journal of Drug and Alcohol Abuse, 30* (2), 369-383.

Reardon, D. C., & Cougle, J. R. (2002a). Depression and unintended pregnancy in the National Longitudinal Survey of Youth: A cohort study. *British Medical Journal, 324* (7330), 151-152.

Reardon, D. C., & Cougle, J. R. (2002b). Depression and unintended pregnancy in the National Longitudinal Survey of Youth: A cohort study: Reply. *British Medical Journal, 324* (7345), 1097-1098.

Reardon, D. C., Cougle, J. R., Rue, V. M., Shuping, M. W., Coleman, P. K., & Ney, P. G. (2003). Psychiatric admissions of low-income women following abortion and childbirth.*Canadian Medical Association Journal, 168*, 1253-1256.

Reardon, D. C., & Ney, P. G. (2000). Abortion and subsequent substance abuse. *AmericanJournal of Drug and Alcohol Abuse, 26*, 61-75.

Reardon, D. C., Ney, P. G., Scheuren, F., Cougle, J., Coleman, P. K., & Strahan, T. W. (2002). Deaths associated with pregnancy outcome: A record linkage study of low income women. *Southern Medical Journal, 95* (8), 834-841.

Rees, D. I. & Sabia, J. J. (2007) The Relationship Between Abortion and Depression: New Evidence from the Fragile Families and Child Wellbeing Study. *Medical Science Monitor 13*(10): 430-436

Remennick, L. I., & Segal, R. (2001). Sociocultural context and women's experiences of abortion: Israeli women and Russian immigrants compared. *Culture, Health, And Sexuality, 3*, 49-66.

Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: Preliminary comparison of American and Russian women. *Medical Science Monitor, 10*, SR5-16.

Schleiss, L., Mygind, K. A., Borre, R. V., & Peterson, B. H. (1997). Psychological consequences of induced abortion. *Ugeskrift Laeger, 159*, 3603-3606.

Sivuha, S. (2002). Predictors of Posttraumatic Stress Disorder Following Abortion in a Former Soviet Union Country. *Journal of Prenatal & Perinatal Psychology & Health, 17*, 41-61.

Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. *British Journal of Obstetrics and Gynecology, 105*, 1288-1295.

Soderberg, H., Andersson, C., Janzon, L., & Slosberg, N-O. (1997). Continued pregnancy among abortion applicants. A study of women having a change of mind. *Acta Obstetricia Gynecologica Scandinavia, 76*, 942-947.

Söderberg H, Janzon L and Sjöberg NO (1998). Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden. *European Journal of Obstetrics and Gynecology and Reproductive Biology 79*, 173-8.

Speckhard, A. & Mufel, N. (2003) Universal responses to abortion? Attachment, trauma, and grief in women following abortion. *Journal of Prenatal & Perinatal Psychology & Health*, 3-37.

Speckhard, A. C., & Rue, V. M. (1992). Postabortion syndrome: An emerging public health concern. *Journal of Social Issues, 48*, 95-119.

Suliman et al. (2007) Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia versus intravenous sedation. *BMC Psychiatry, 7* (24), p.1-9.

Tamburrino, M. B., Franco, K. N., Campbell, N. B., Pentz, J. E., Evans, C. L., & Jurs, S. G. (1990). Postabortion dysphoria and religion. *Southern Medical Journal, 83*, 736-738.

Thorp, J. M., Hartmann, K. E., & Shadigin, E. (2003). Long-term physical and psychological health consequences of induced abortion: Review of the evidence. *Obstetrical & Gynecological Survey, 58* (1), 67-79.

Tornbom, M. and Moller, A. (1999). Repeat abortion: A qualitative study. *Journal of Psychosomatic Obstetrics and Gynecology, 20*, 21-30.

Turell, S., Armsworth, M., & Gaa, J. (1990). Emotional Response to Abortion: A Critical Review of the Literature. *Women & Therapy 9*, 49-68.

Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. *British Journal of Obstetrics and Gynecology, 98*, 396-99.

Williams, G. B. (2001). Short-term grief after an elective abortion. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 30* (2), 174-183.

Wilmoth, G. H., deAlteriis, M., & Bussell, D. (1992). Prevalence of psychological risks following legal abortion in the U.S.: Limits of the evidence. *Journal of Social Issues, 48*, 37–66.

Yamaguchi, D., & Kandel, D. (1987). Drug use and other determinants of premarital pregnancy and its outcome: a dynamic analysis of competing life events. *Journal of Marriage and the Family, 49*, 257–270.

10

13 February 14 Version

1960s

1 Barsy G, Sarkany J. Impact of induced abortion on the birth rate and infant mortality. Demografia 1963;6:427-467.

2 Miltenyi K. On the effects of induced abortion. Demografia 1964;7:73-87.

3 Furusawa Y, Koya Y. The Influence of artificial abortion on delivery.
In: Koya Y, ed. Harmful effects of induced abortion. Tokyo:
Family Planning Federation of Japan,1966:74-83.

4 Arvay A, Gorgey M, Kapu L. La relation entre les avortements (interruptions de la grossesse) et les accouchements prematures.
Rev Fr Gynecol Obstet 1967;62:81-86

1970s

5 Drac P, Nekvasilova Z. Premature termination of pregnancy after previous interruption of pregnancy. Cesk Gynekol 1970;35:
332-333.

6 Dolezal A, Andrasova V, Tittlbachova S, et al. Interruption of pregnancy and their relation to premature labous and hyptrophic foetuses. Cesk Gynekol 1970:36:331

7 Pantelakis SN, Papadimitriou GC, Doxiadis SA.Influence of induced and spontaneous abortions on the outcome of subsequent pregnancies. Amer J Obstet Gynecol. 1973;116:
799-805.

!!8 Van Der Slikke JW, Treffers PE. Influence of induced abortion on gestational duration in subsequent pregnancies. BMJ 1978;1:
270-272 [>95% confident of preterm risk for gestation less than 32.0 weeks].

9 Richardson JA, Dixon G. Effect of legal termination on subsequent pregnancy. British Med J 1976;1:1303-1304.

+10 Papaevangelou G, Vrettos AS, Papadatos D, Alexiou C. The
Effect of Spontaneous and Induced Abortion on Prematurity and Birthweight. The J Obstetrics and Gynaecology of the British Commonwealth. May 1973;80:418-422.

+11 Bognar Z, Czeizel A. Mortality and Morbidity Associated with
Legal Abortions in Hungary, 1960-1973. AJPH 1976;66:568-575.

12 Grindel B, Lubinski H, Voigt M. Induced abortion in primigravidae and subsequent pregnancy, with particular attention of underweight. Zentralbl Gynaekol 1979;101:1009-1114.

+13 Obel E, et al. Pregnancy Complications Following Legally
Induced Abortion With Special Reference to Abortion Technique. Acta Obstet Gynecol Scand 1979;58:147-152.

14 World Health Organization Task Force on the Sequelae of Abortion. Gestation, birthweight and spontaneous abortion.
Lancet 1979;1:142-145.

15 Ratten G et al. Effect of Abortion on Maturity of Subsequent Pregnancy. Med J Australia June 1979: 479-480.

16 Roht LH, Aoyama H, Leinen GE, et al. The association of multiple induced abortions with subsequent prematurity and spontaneous abortion. Acta Obstet Gynaecol Jpn 1976;23:
140-145.

17 Harlap S, Davies AM. Late sequelae of induced abortion:
Complications and Outcome of Pregnancy and Labor.
Amer J Epidemiology 1975;102:219-224.

18 Koller O, Eikhom SN. Late Sequelae of Induced Abortion in Primigravidae. Acta Obstet Gynecol Scand 1977;56:311-317.

19 Lean TH, Hogue CJR, Wood J. Low birth weight after induced abortion in Singapore, Presented at the 105th Annual Meeting of the Americal Public Health Association, Washington DC, Oct.
31, 1977.

20 World Health Organization. Special Programme of Research, Development and Research Training in Human Reproduction:
Seventh Annual Report, Geneva, Nov. 1978.

21 Hungarian Central Statistical Office. The effect of the number of abortions on premature births and perinatal mortality in Hungary.
Budapest: 1972.

22 Czeizel A, Bognar Z, Tusnady G, et al. Changes in mean birth weight and proportion of low-weight births in Hungary. Br J Prev Soc Med 1970;24:146-153.

23 Dziewulska W. Abortion in the past versus the fate of the subsequent pregnancy. State of the newborn. Ginekol Pol
1973;44:1143-1148 [Poland].

24 Kaminski M, Goujard J, Rumeau-Roquette. Prediction of low birthweight and prematurity by a multiple regression analysis with maternal characterisitics known since the beginning of the pregnancy. Intl J Epidem 1973;2:195-204

25 Chabada J, Pontuch A, Sutta I, Pohlova G. Interruptions of gravidity as a cause of premature labour Cesk Gynekol 1974;49(5):329-330

26 Fredrick J. Antenatal identification of women at high risk of spontaneous preterm birth. BJOG 1976;83:351-354

27 Pohanka O, Balogh B, Rutkovszky M. The impact of abortion on the birth weight of newborns. Orb Hetil 1975;116:1983-1989

28 Mikolas M. The effect of the legalization of abortion on public health and some of its social concomitants in Hungary.
Demografia 1973;16:70-113

29 Link M, Wichmann A. Pregnancy in adolescents. Zentrabl Gynekol
1976;98(11):682-689

30 Knarre P. Influence of abortions and interruptions of pregnancy in subsequent deliveries. II Cause of labor. Zentrabl Gynekol
1976;98(10):591-594

31 Kreiblich H, Ehring E. Zentralfl Gynokol 1978;100(19):1254-1260

32 Macku F, Rokytova V, Titmann O. Artificial Interruption of Pregnancy in Primigravidae as a risk factor in future pregnancies. Cesk Gynekol
1978;43(5):340-343

33 Zwahr C, Coigt M, Kunz L, Thielemann F, Lubinski H. Multidimensional investigations to elucidate relationships between case histories of interrupted pregnancies and premature deliveries and low birth weight.
Zentrabl Gynekol 1979;101(23):1502-1509

34 von Lembrych, S.: Schwangerschafts – Geburts – und Wochenbett verlauf nach kunsticher Unterbrechung der ersten Graviditat. Zentrabl Genaecol 1972;
94:164

1980s

35 Zwahr C, Voigt M, Kunz L, et al. Relationships between interruption abortion, and premature birth and low birth weight.
Zentrabl Gynaekol 1980;102:738-747.

36 Kreibich H, Ludwig A. Early and late complications of abortion in juvenile primigravidae (including recommended measures).
Z Aerztl Fortbild (Jena) 1980;74:311-316.

!!+37 Levin A, Schoenbaum S, Monson R, Stubblefield P, Ryan K.
Association of Abortion With Subsequent Pregnancy Loss.
JAMA 1980;243(24):2495-2499

38 Legrillo V. Quickenton P, Therriault GD, et al. Effect of induced abortion on subsequent reproductive function. Final report to NICHD. Albany, NY: New York State Health Department, 1980.

+39 Obel EB. Long-Term sequelae following legally induced abortion.
Danish Medical Bulletin 1980;27(2):61-74

40 Slater PE, Davies AM, Harlap S. The Effect of Abortion Method on the Outcome of Subsequent Pregnancy. J Reprod Med 1981;28:123-128.

41 Lerner RC, Varma AO. Prospective study of the outcome of pregnancy subsequent to previous induced abortion. Final report, Contract no. (N01-HD-62803). New York: Downstate Medical Center, SUNY, January 1981.

+42 Berkowitz GS. An Epidemiologic Study of Preterm Delivery.
American J Epidemiology 1981;113:81-92.

43 Lampe LG, Ratar I, Bernard PP, et al. Effects of smoking and of induced abortion on pregnancy outcome. IPPF Med Bull 1981;15:3

44 Madore C, Hawes WE, Many F, Hexter AC. A study on the effects of induced abortion on subsequent pregnancy outcome. Amer J Obstet Gynecol 1981;139(5):516-521

45 Schoenbaum LS, Monson RR. No association between coffee consumption and adverse outcomes of pregnancy. N Engl J Med 1982;306:141-145

46 Pompe-Tansek NM, Andolsek L, Tekovcic B. Jugosl Ginekol Opstet Sept.-Dec. 1982;22(5-6):118-120

+47 Puyenbroek J, Stolte L. The relationship between spontaneous
and induced abortions and the occurrence of second-trimester abortion in subsequent pregnancies. Eur J Obstet Gynecol Reprod Biol 1983;14:299-309 [this is the only study in this entire list that uses second-trimester miscarriage as a surrogate for PTB risk].

48 Zwahr C, Voigt M. The effect of various parameters on the incidence of premature births. Zentralbl Gynakol 1983;105:1307-1312

49 Schuler D, Klinger A. Causes of low birth weight in Hungary.
Acta Paediatrica Hungarica 1984;24:173-185

50 Pickering RM, Forbes J. Risk of preterm delivery and small- for-gestational age infants following abortion: a population study.
British J Obstetrics and Gynecology 1985;92:1106-1112.

!!+51 Lumley J. Very low birth-weight (less than 1500g) and previous induced abortion: Victoria 1982-1983. Aust NZ J Obstet Gynecol 1986;26:268-272.

+52 Shiono PH, Lebanoff MA. Ethnic Differences and Very
Preterm Delivery. Am J Public Health 1986;76:1317-1321.

53 Peterlin A Ardolsek L. The effect of induced abortion in adolescence on the manifestations of spontaneous abortion, premature abortion, and birth weight. Jugosl Ginekol Perinatol May-Aug 1986;26(3-4):49-52

54 Ross MG, Hobel CJ, Bragenier JR, Bear MB, Bemis RL.
A simplified risk-scoring system for prematurity. Amer J Perinatology 1986;3:339-344

55 Lieberman E, Ryan KJ, Monson RR, Schoenbaum SC. Risk Factors Accounting For Racial Differences in the rate of premature birth. NEJM 1987;317:743-748.

56 Krasomski G, Gladysiak A, Krajerski J. Fate of subsequent pregnancies after induced abortion in primiparae. Wiad Lek

1 December 1987;40(23):1593-1595

57. Main DM, Richardson D, Gabbe SG, Strong S, Weller SC, Prospective Evaluation of a Risk Scoring System for Predicting Preterm Delivery in Black Inner City Women. Obstetrics & Gynecology 1987;69:61-66

58 Seidman DS, Ever-Hadani P, Slater PE, Harlap S, et al. Child- b5earing after induced abortion: reassessment of risk. J Epidemiology Community Health 1988;42:294-298.

59 Zwahr, C, Neubert D,, Triebel U,Voight M, Kruppel KH.
Correlation between some environmental, anamnestic and social markers of pregnant patients and the delivery of autotrophic premature and hypotrophic newborn infants.
Zentralbl Gynakol 1988;110:479-487

!! +60 Mueller-Heubach E, Guzick DS. Evaluation of risk scoring in a preterm birth prevention study of indigent patients. Am J Obstetrics & Gyn 1989;160:829-837.

1990s

+61 Vasso L-K, Chryssa T-B, Golding J. Previous obstetric history
and subsequent preterm delivery in Greece. European J Obstetrics & Gynecology Reproductive Biology 1990;37:
99-109. [Study Population: Greek women]

62 Li YJ, Zhou YS. study of factors associated with preterm delivery.
Zhongjua Liu Xing Bing Xue Za Chi. Aug 1990;11(4):229-234 [Study Population: Chinese women]

63 Harger JH, Hsing AW, Tuomala RE, Gibbs RS, et al. Risk factors for preterm premature rupture of fetal membranes: A multicenter case-control study. Am J Obstet Gynec 1990;163:130-137 [Study Population: U.S. women]

64 McGregor JA, French J, Richter R. Antenatal microbiologic and maternal risk factors associated with prematurity.
Amer J Obstet Gynecol 1990;163:1465-1473 [Study Population:
U.S. women]

65 Pickering RM, Deeks JJ. Risks of Delivery during 20th to the 36th Week of Gestation. Intl. J Epidemiology 1991;20:456-466.
[Study Population: British women]

!!+66*Zhang J, Savitz DA. Preterm Birth Subtypes among Blacks and Whites. Epidemiology 1992;3:428-433. [Study Population:
U.S. women]

67*Michielutte R, Ernest JM, Moore ML, Meis PJ, Sharp PC, Wells HB, Buescher PA. A Comparison of Risk Assessment Models for Term and Preterm Low Birthweight. Preventive Medicine 1992;21:98-109. [Study Population: U.S.-women]

68 Gong JH. Preterm delivery and its risk factors. Zhounghua Fu Chan Ke Za Chi Jan. 1992;27(1):22-24 [Study Population: Chinese women]

69 Mandelson MT, Maden CP, Daling JR. Low Birth Weight in Relation Multiple Induced Abortions. Am J Public Health 1992;82;391-394
[Note: More than a few authors refer to the 'Mandelson' study as NOT finding higher risk of Low Birth Weight for women with prior induced abortions; such authors should be checked for 'seeing glasses', since Mandelson et al found that women with ANY (i.e. 1, 2, 3, or more) prior induced abortions BEFORE a first delivery had SIGNIFICANTLY higher risk of low birthweight babies; so, you are invited to get a copy of the Mandelson study & read it yourself.] [Study Population: U.S. Women] URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1694356/pdf/amjph00540-0065.pdf

70 Chumnijarakij T, Nuchprayon T, Chitinand S., Onthuam N, et al. Maternal risk factors for low birth weight in Thailand. J Med Assoc Thai 1991;75(8):445-452 [Abstract URL: http://www.ncbi.nlm.nih.gov/pubmed/1300361]

!!+71 Lumley J. The epidemiology of preterm birth. Bailliere's Clin Obstet Gynecology. 1993;7(3):477-498 [Study Population: Australian women]

!!72 Algert C, Roberts C, Adelson P, Frammer M. Low birth weight in New South Wales, 1987: a Population-Based Study. Aust New Zealand J Obstet Gynaecol 1993;33:243-248 [Study Population: Australian women]

73 Ekwo EE, Grusslink CA, Moawad A. Previous pregnancy outcomes and subsequent risk of premature rupture of amniotic sac membranes.
Brit J Obstet Gynecol 1993;100(6):536-541 [Study Population:
U.S. women]

74 Lekea-Karanika V, Tzoumaka-Bangoula C. Past obstetric history of the mother and its association with low birth weight of a subsequent child: a population-based study. Paediatr Perinat Epidemiol 1994;8:173-187 [Abstract URL: http://www.ncbi.nlm.nih.gov/pubmed/8047485
; Study Population: Greek women]S

75 Guinn D, Goldenberg RL, Hauth JC, Andrews WA et al. Risk factors for the development of preterm premature rupture of membranes after arrest of preterm labor. AJOG 1995;173 (4):1310-1315. [Study Population: U.S. women]

76 *Hillier SL, Nugent RP, Eschenbach DA, Krohn MA,et al.
Association Between Bacterial Vaginosis And Preterm Delivery Of A Low-Birth-Weight Infant. NEJM 1995;333:
1737-1742. [Study Population: U.S. women]

77 Khalil AK, El-Amrawy SM, Ibrahim AG, et al. Pattern of growth and development of premature children at the age of two and three years in Alexandria, Egypt. Eastern Mediterranean Health Journal 1995;1(2):186-193. [Study Population:
Egyptian women]

78 Meis PJ, Michielutte R, Peters TJ, Wells HB. Factors associated with preterm birth in Cardiff, Wales. Amer J Obstet Gynecol 1995;
173:590-596 [Study Population: Welsh women]

+79 Lang JM, Lieberman E, Cohen A. A Comparison of Risk

Factors for Preterm Labor and Term Small-for-Gestational-Age Birth. Epidemiology 1996;7:369-376. [Study Population: U.S. women]

*80 Hagan R, Benninger H, Chiffings D. Evans S, French H. Very preterm birth - a regional study. Part 1: Maternal and obstetric factors. BJOG 1996;103:230-238 [Study Population: Australian women]

81 Chie-Pein Chen, Kuo-Gon Wang, Yuh-Cheng Yang, Lai-Chu See.
Risk factors for preterm birth in an upper middle class Chinese population. Eur J Obstet Gynecol Reprod Bio 1996;70(1):53-59 [Study Population: Chinese women]

*82 Jacobsen G, Schei B, Bakketeig LS. Prepregnant reproductive risk and subsequent birth outcome among Scandinavian parous women. Norsk Epidemiol
1997;7(1):33-39 [Study Populations: Swedish women and Norwegian women]

!!+83 Lumley J. The association between prior spontaneous abortion, prior induced abortion and preterm birth in first singleton births. Prenat Neonat Med 1998;3:21-24. [Study
Population: Australian women]

!!+84 Martius JA, Steck T, Oehler MK, Wulf K-H. Risk factors associated with preterm (<37+0 weeks) and early preterm (<32+0 weeks): univariate and multi-variate analysis of
106 345 singleton births from 1994 statewide perinatal survey of Bavaria. European J Obstetrics & Gynecology Reproductive Biology 1998;80:183-189.
[Study Population: German women]

85 Small Babies in Scotland A Ten Year Overview 1987-1996.
Information and Statistics Division. The National Health Service in Scotland. Scottish Program for Clinical Effectiveness. Edinburgh 1998 ISBN 1-902076-07-9.
[Study Population: Scottish women]

86 Lee KS, Lee WC, Meng KH, Lee Ch, Kim SP. Maternal Factors Associated with the Premature Rupture of Membrane in the Low BIrth Weight Infant Deliveries. Korean J Prev Med 1998;21(2): 207-216 [Study Population: Korean women]

!!+*87 Ancel PY, Saurel-Cubizolles M-J, Renzo GCD, Papiernik E, Breart G. Very and moderate preterm births: are the risk factors different?
British J Obstetrics and Gynaecology 1999;106:1162-1170. [Study Population:
Women in: Germany, Finland, France, Italy, Hungary, Ireland, The Netherlands, Poland, Scotland, Sweden, The Czech Republic, Spain, Slovenia, Greece, Romania, Russia, and Turkey]

!!+88 Zhou W, Sorenson HT, Olsen J. Induced Abortion and Subsequent Pregnancy Duration. Obstetrics & Gynecology 1999;94:948-953.
[Study Population: Danish women]

89* Ancel PY, Saurel-Cubizolles, Di Renzo GC, Papiernik E, Breart G.
Social Differences of very preterm birth in Europe: interaction with obstetric history. American J Epi 1999;149(10):908-915.
[Study Population: Women in: Germany, Finland, France, Italy, Hungary, Ireland, The Netherlands, Scotland, Sweden, The Czech Republic, Poland, Spain, Slovenia, Greece, Romania, Russia, and Turkey]

2000-2009

90 Foix-L'Helias L, Ancel PY, Blondel B. Changes in risk factors of preterm delivery in France between 1981 and 1995.
Paediatric and Perinatal Epidemiology. Oct 2000;14(4):
314-323. [Study Population: French women]

91 Foix-L'Helias L, Ancel, Blondel B. Risk factors for prematurity in France and comparisons betweeen spontaneous prematurity and induced labor; results from the National Perinatal Survey 1995. J Gy necol Obstet Bio Reprod
(Paris) Feb 2000;29(1);55-65 [Study Population: French women]

*92 Gardosi J, Francis A. Early Pregnancy predictors of preterm
birth: the role of a prolonged menstruation-conception interval.
BJOG 2000;107(2):228-237 [Study Population: Australian women]

93 Bettiol H, Rona RJ, Chin S, Goldani M, Barberi M. Risk Factors Associated with preterm births in Southeast Brazil: a comparison of two birth cohorts born 15 years apart. Paediatric Perinatal Epidemiol 2000;14(1):30-38 [Study Population: Brazilian women]

94 Ancel PY, Saurel-Cubizolles M-J, Renzo GCD, Papiernik E, Breast G. Risk factors for 14-21 week abortions: a case-control study in Europe. Human Reproduction 2000;15(11):2426-2432 [Study Population: French women]

95 Letamo G, Majelantle RG. Factors Influencing Low Birth Weight and Prematurity in Botswana. J Biosoc Sci 2001;33(3):391-403 [Study Population: women in Botswana]

96 Henriet L, Kaminski M. Impact of induced abortions on subsequent pregnancy outcome: the 1995 French national perinatal survey.
BJOG 2001;108(10):1036-1042 [Study Population: French women]

97 Grimmer I, Buhrer C, Dudenhausen JW. Preconceptional factors associated with very low birth weight delivery: a case control study. BMC Public Health 2002; 2:10 [Study Population:
German women].

98 Balaka B, Boeta S, Aghere AD, Boko K, Kessie K, Assimadi K.
Risk factors associated with prematurity at the University of Lme, Togo. Bull Soc Pathol Exot Nov 2002;95(4):280-283 [Study Population: women in Togo]

99 Han WH, Chen LM, Li CY. Incidences of and Predictors for Preterm Births and Low Birth Weight Infants in Taiwan. Chinese Electronic Periodical Services 2003:131-141 [Study Population: Taiwanese women]

100 El-Bastawissi AY, Sorensen TK, Akafomo CK, Frederick IO, Xiao R, Williams MA. History of Fetal Loss and Other Adverse Pregnancy Outcomes in Relation to Subsequent Risk of Preterm Delivery.
Maternal Child Health J 2003;7(1):53-58 [Study Population: U.S.
women]

101 Reime B, Schuecking BA, Wenzlaff P. Perinatal outcomes of teenage pregnancies according to gravidity and obstetric history.
Annals of Epidemiology 2004;14(8):619-619 [Study Population:
German women]
http://www.sciencedirect.com/science?_ob=3DGatewayURL&_method=3DcitationSearch&_uoikey=3D

B6T44-4D8V8F5-
2R&_origin=3DSDEMFRASCII&_version=3D1&md5=3De73601c4adf512cbb49d79b556183ab7

!!+102 Ancel PY, Lelong N, Papiernik E, Saurel-Cubizolles MJ, Kaminski M. History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey. Human Repro 2004; 19(3): 734-740.
[Study Population: from ten (10) countries:
Czech Republic, Finland, Germany, Hungary, Italy, Romania, Russia, Sweden, Scotland, Slovenia]

103 Umeora OUJ, Ande ABA, Onuh SO, Okubor PO, Mbazor JO.
Incidence and risk factors for preterm delivery in a tertiary health institution in Nigeria. J Obstetrics Gynaecology Nov. 2004;
24(8):895-896 [Study Population: Nigerian women]

!!+104 Moreau C, Kaminski M, Ancel PY, Bouyer J, et al. Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study. British J Obstetrics Gynaecology 2005;112(4):430-437 [France] [abstract online: www.blackwell-synergy.com/ links/doi/10.1111/j.1471-0528.2004.00478.x/abs/ ; Study Population:
French women]

105 Conde-Agudelo A, Belizan JM, Breman R, Brockman SC, Rosas-Bermudez. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. Int J Gynaecol & Obstet 2005;89 (Supp. 1):S34-S40.
[Study Population: from Latin American countries]

!!106 Stang P, Hammond AO, Bauman P. Induced Abortion Increases the Risk of Very Preterm Delivery; Results from a Large Perinatal Database. Fertility Sterility Sept 2005;S159 [Study Population: German women]

107 Etuk SJ, Etuk IS, Oyo-Ita AE. Factors Influencing the Incidence of Pre-term Birth in Calabar, Nigeria. Nigerian J Physiological Sciences 2005;20(1-2):63-68 [Study Population:
Nigerian women]

108 Poikkens P. Unkila-Kallio L, Vilska S, Repokari L. et al.
Impact of Infertility Characteristics and treatment modalities on singleton pregnancies after assisted reproduction. Reproductive Tiomed July 2006;13(1):135-144 [Study Population: Finnish women]

109 Samin A, Al-Dabbagh, Wafa Y Al-Taee. Risk factors for preterm birth in Iraq: a case-control study. Pregnancy and Childbirth. BMC 2006;6:13 [Study Population: women in Iraq]

110 K.K. Roy, Jinee Baruah, Sunesh Kumar, Neena Malhotra, A.K. Deorari, J.B. Sharma. Maternal Antenatal Profile and Immediate Neonatal Outcome in VLBW and ELBW Babies.
Indian Journal of Pediatrics 2006;73(8):669-673 [Study Population: Indian women in India]

!!111 Smith GCS, Shah I, White IR, Pell JP, Crossley JA, Dobbie R.
Maternal and biochemical predictors of spontaneous preterm birth among nulliparous women: a systematic analysis in relation to degree of prematurity. Intl J Epidem 2006;35(5):1169-1177 [Study Population: Scottish women]

112 Teramoto S, Soeda A, Hayashi Y, Urashima M. Physical and socioeconomic predictors of birth weight in Japan. Pediatrics

International 2006;48(3):274-277

113 Losa SM, Gonzalez E, Gonzalez G. Risk Factors for Preterm
Birth. Prog Obstet Ginecol 2006;49(2):57-65

114 Briunsma F, Lumley J, Tan J, Quinn M. Precancerous changes in the cervix and risk of subsequent preterm birth. BJOG Jan. 2007;114(1):70-80 { Study Population: Australian women]

115 Jackson JE, Grobman WA, Haney E, Casele H. Mid-trimester dilation and evacuation with laminaria does not increase the risk for severe subsequent pregnancy complications. Intl J Gynecol Obstet 2007;96:12-15 [Study Population: U.S. women]

116 Chung-Chin Lo, Jenn-Jeih Hsu, Ching-Chang Hsieh, T'sang-T-sang Hsieh, Tai-Ho Hung. Risk Factors For Spontaneous Preterm Delivery Before 34 Weeks of Gestation Among Taiwanese Women. Taiwan J Obstet Gynecol 2007;46(4):389-394 [Study Population: Taiwanese women]

117 Curry AE, Vogel I, Drews C, Schendel D, Skogstrand K, et al.
Mid-pregnancy maternal plasma levels of interleukin 2, 6, and 12, tumor necrosis factor-alpha, interferon-gamma, and granulocyte-macrophage colony-stimulating factor and spontaneous preterm delivery. Acta Obstectica et Gynecologica 2007:86:1103-1110 [Study Population:
Danish women]

118* Brown TS, Adera T, Masho SW. Previous abortion and the risk of low birth weight and preterm births. J Epidemiol Commun Health
2008;62:16-22 [Study Population: U.S. women]

119 Reime B, Schuecking BA, Wenzlaff P. Reproductive Outcomes in Adolescents Who Had a Previous Birth or an Induced Abortion Compared to Adolescents' First Pregnancies. BMC Pregnancy and Childbirth
2008;8:4 [Study Population: German women]

!!+120 Voigt M, Olbertz D, Fusch C, Krafczyk D. Briese V, Schneider KT.
The infuluence of previous pregnancy terminations, miscarriages, and still-birth on the incidence of babies with low birth weight and premature births as well as somatic classication of newborns.
Z Geburtshilfe Neonatol 2008;212:5-12 [Study Population:
German women]

121* Sareer Badshah, Linda Mason, Kenneth McKelvie, Roger Payne, Paulo JG Lisboa. Risk factors for low birthweight in the public- hospitals at Peshawar NWFP-Pakistan 2008;8:197-206 [Study Population: Pakistani women]

122 Visintine J, Berghella V, Henning D, Baxter J. Cervical length for prediction of preterm birth in women with multiple prior induced abortions. Ultrasound Obstetrics Gynecology 2008;31(2):198-200 [Study Population: U.S. women]

123 Freak-Poli R, Chan A, Gaeme J, Street J. Previous abortion and risk of preterm birth: a population study. J Maternal-Fetal Med Jan. 2009;
22(1):1-7 [Study Population: Australian women]

124 Voigt M, Henrich W, Zygmunt M, Friese K, Straube S, Briese V.

Is induced abortion a risk factor in subsequent pregnancy? Journal Perinatal Medicine 2009;37:144-149 [Study Population: German women]

2010-2019

125 Yuan W, Duffner AM, Chen L, Hunt LP, Sellers SM, Bernal AL.
Analysis of preterm deliveries below 35 weeks' gestation in a tertiary hospital in the UK. A case-control survey.. BMC Research Notes
2010;3:119

126+ Watson LF, Rayner J-A, King J, Jolley D, Forster D, Lumley J.
Modelling prior reproductive history to improve predication of risk for very preterm birth. Paediatric Perinatal Epidemiology 2010;24:402-415

127+ Watson LF, Rayner J-A, King J, Jolley D, Forster D, Lumley J.
Modelling sequence of prior pregnancies on subsequent risk of very preterm birth. Paediatric and Perinatal Epidemiology 2010;24:416-423

128 Ammar M Alfadhli, Ali M Hajia, Farida AK Mohammed, Hamdiya A Alfadhli, Medhat K El-Shazly. Incidence and Potential Risk Factors of Low Birth Weight Among Full Term Deliveries 2010;46(2):157-164 [Study Population: Kuwaiti women]

129 Junli G, Weiyue Z. Influence of artificial abortion on preterm labor and risk in subsequent pregnancy. Chinese J Obstet Gynaecol Pediatrics[Electronic] 2010;447-451

130 Furquim MA, Alencar GP, Schoeps D, Novaes HMD, Campbell O, et al. Survival and risk factors nor neonatal mortality in a cohort of very low birth weight infants in the southern region of San Paulo city, Brazil. Cadernos de Saude Publica 2011;27(6)

131 Liao H, Wei Q, Duan L, Ge J, Zhou Y, Zeng W. Repeated medical abortions and the risk of preterm birth in subsequent pregnancies. Arch Gynecol Obstet 2011;289:579-586 URL:
http://www.springerlink.com/content/d5mt821806512570/

132 Renzo GCD, Giardina I, Rosati A, Clerici G, Torricelli M, et al. Maternal risk factors for preterm birth: a country based population analysis. European J Obstetrics Gynecology and Reproductive Biology. December 2011;159(2):342-346 URL:
http://www.sciencedirect.com/science/article/pii/S0301211511005392

133 Watson LF, Rayner J-A, Forster D. Identifying risk factors for very preterm birth: A reference for clinicians. [In Press} Midwifery 2012

134 Bhattacharya S, Lowit A, Bhattacharya S, Raja EA, Lee AM, Mahmood T,Templeton A.
Reproductive outcomes following induced abortion; a national register-based cohort study in Scotland. BMJ OPEN 2012;2:e000911 [doi:10.1136/bmjopen-2012-000911 ; URL:
http://bmjopen.bmj.com/content/2/4/e000911.full.pdf]

135 Klemetti R, Gissler M, Niinimaki M, Hemminki E. Birth outcomes after induced abortion: a nationwide register-based study of first births in Finland. Human Reproduction 2012 August 29 [Epub ahead of print]
http://www.ncbi.nlm.nih.gov/pubmed/22933527

136 Heaman M, Kingston D, Chalmers B, Sauve R, Lee L, Young D. Risk Factors for Preterm Birth and Small-for-gestational-age among Canadian Women. Paediatric Perinatal Epidemiology 2013;27:54-61

137 Ghislain Hardy, Alice Benjamin, Haim A. Abenhaim. Effects of Induced Abortions on Early Preterm Births and Adverse Perinatal Outcomes. Journal of Obstetricsand Gynaecology Canada 2013;35(2):138-143

138 Raisanen S, Gissler M, Saari J, Kramer M, Heinon S.Contribution of Risk Factors to Extremely, Very and Moderately Preterm Term Births- Register-Based Analysis of 1,390,742 Singleton Births. PLOS ONE April 2013;8(4):1-7.

139 Scholten BL, Page-Christiaens GCML, Franx A, Hukkelhoven CWPM, Koster MPH. The influence of pregnancy termination on the outcome of subsequent pregnancies: a retrospective cohort study. BMJ Open 2013;3:e002803.doi:10.1136/bmjopen-2013-002803.

140 Marthy FP, Khashan AS, North RA, Rahma MB, Walker JJ, Baker PN, Dekker G, Post L, McCowan LME, O'Donoghue K, Kenny LC. Pregnancy loss managed by cervical dilatation and curettage increases the risk of spontaneous preterm birth. Human Repro Open 2013;Vol 0, No 0, 1-10. Doi10.1093/humrep/det332.

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The following is a significant APB study but is not part of the 'official' list above since it involves predominantly 'illegal' induced abortions:

Okonofus FE, Onwudiegwu U, Odutayo R. Pregnancy outcomes after illegal induced abortions in Nigeria: a retrospective referenced historical study. Africa J Med Science 1994;23:165-169

*** studies that included spontaneous and induced abortions but did not report PTB/LBW risk separately for each**
+ studies that found dose/response (the more SIAs, the higher the risk)

Twenty-one (21) Statistically Significant AVPB and AVLBW Studies

A1+ Watson LF, Rayner J-A, King J, Jolley D, Forster D, Lumley J.
Modelling prior reproductive history to improve predication of risk for very preterm birth. Paediatric Perinatal Epidemiology 2010;24:402-415

A2+ Watson LF, Rayner J-A, King J, Jolley D, Forster D, Lumley J.
Modelling sequence of prior pregnancies on subsequent risk of very preterm birth. Paediatric and Perinatal Epidemiology 2010;24:416-423

A3 Reime B, Schuecking BA, Wenzlaff P. Reproductive Outcomes in Adolescents Who Had a Previous Birth or an Induced Abortion Compared to Adolescents' First Pregnancies. BMC Pregnancy and Childbirth 2008;8:4

A4+ Voigt M, Olbertz D, Fusch C, Krafczyk D. Briese V, Schneider KT.
The influence of previous pregnancy terminations, miscarriages, and still-birth on the incidence of babies with low birth weight and premature births as well as somatic classification of newborns.
Z Geburtshilfe Neonatol 2008;212:5-12

A5 Smith GCS, Shah I, White IR, Pell JP, Crossley JA, Dobbie R.
Maternal and biochemical predictors of spontaneous preterm birth among nulliparous women: a systematic analysis in relation to degree of prematurity. International J Epidemiology 2006;35(5): 1169-1177

A6 Stang P, Hammond AO, Bauman P. Induced Abortion Increases the Risk of Very Preterm Delivery; Results from a Large Perinatal Database. Fertility Sterility. Sept 2005;S159 [Study only published as an abstract]

A7+ Moreau C, Kaminski M, Ancel PY, Bouyer J, et al. Previous
induced abortions and the risk of very preterm delivery: results of the EPIPAGE study. British J Obstetrics Gynaecology 2005;112(4):
430-437 [abstract online: www.
blackwell-synergy.com/links/doi/10.1111/j.1471-0528.2004.00478.x/abs/]

A8 Ancel PY, Lelong N, Papiernik E, Saurel-Cubizolles MJ, Kaminski M.
History of induced abortion as a risk factor for preterm birth in European
countries: results of EUROPOP survey. Human Reprod 2004;19(3):734-740.

A9+ Ancel PY, Saurel-Cubizolles M-J, Renzo GCD, Papiernik E, Breart G.
Very and moderate preterm births: are the risk factors different?
British J Obstetrics Gynaecology 1999;106:1162-1170.

A10+ Zhou W, Sorenson HT, Olsen J. Induced Abortion and Subsequent
Pregnancy Duration. Obstetrics & Gynecology 1999;94:948-953.

A11+ Martius JA, Steck T, Oehler MK, Wulf K-H. Risk factors associated
with preterm (<37+0 weeks) and early preterm (<32+0 weeks): univariate and multi-variate analysis of 106 345 singleton births from
1994 statewide perinatal survey of Bavaria. European J Obstetrics Gynecology Reproductive Biology 1998;80:183-189.

A12+ Lumley J. The association between prior spontaneous abortion,
prior induced abortion and preterm birth in first singleton births.
Prenat Neonat Med 1998;3:21-24.

A13+ Lumley J. The epidemiology of preterm birth. Bailliere's Clin
Obstet Gynecology 1993;7(3):477-498

A14+ Algert C, Roberts C, Adelson P, Frammer M. Low birth weight
in New South Wales, 1987: a Population-Based Study. Aust New Zealand J Obstet Gynaecol 1993;33:243-248

A15+* Zhang J, Savitz DA. Preterm Birth Subtypes among Blacks
and Whites. Epidemiology 1992;3:428-433.

A16+ Mueller-Heubach E, Guzick DS. Evaluation of risk scoring
in a preterm birth prevention study of indigent patients. Amer J Obstetrics & Gynecol 1989;160:829-837.

A17+ Lumley J. Very low birth-weight (less than 1500g) and
previous induced abortion: Victoria 1982-1983. Aust NZ J Obstet Gynecol 1986;26:268-272.

A18 Schuler D, Klinger A. Causes of low birth weight in Hungary. Acta Paediatrica Hungarica
1984;24:173-185

A19+ Levin A, Schoenbaum S, Monson R, Stubblefield P,
Ryan K. Association of Abortion With Subsequent Pregnancy Loss. JAMA 1980;243(24):2495-2499

A20 Van Der Slikke JW, Treffers PE. Influence of induced abortion on gestational duration in subsequent
pregnancies. BMJ 1978;
1:270-272 [>95% confident of preterm risk for gestation less than 32.0 weeks].

A21 Watson LF, Rayner J-A, Forster D. Identifying risk factors for very preterm birth: A reference for
clinicians. [In Press} Midwifery 2012

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*** studies that included spontaneous and induced abortions but did not report PTB/LBW risk separately for each**
+ studies that found dose/response (the more SIAs, the higher the risk)
!! Significant VPB (Very Preterm Birth) and/or AVLBW (Very Low Birth Weight)

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Representative Duffy Daugherty
New Hampshire State Representative Coos District 1
98 Harvey Swell Road
Colebrook, NH 03576-3424

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley,

We the undersigned state legislators write in opposition to the disingenuously named *Women's Health Protection Act,* S. 1696. If enacted, this bill would invalidate hundreds of laws seeking to protect women considering abortion and their unborn children. Furthermore, it would bar our states from enacting common sense protections such as ultrasound requirements, informed consent requirements, regulations of abortion-inducing drugs, health and safety standards for abortion facilities, and limitations on dangerous late-term abortion—protections that can save the lives of unborn children and protect women.

The United States Supreme Court recognizes that the states have "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." *Roe v. Wade*, 410 U.S. 113, 150 (1973).

It would be inappropriate for the Federal government to strip away the ability for state legislators to enact medically appropriate and widely supported regulations of abortion—but that is exactly what S. 1696 seeks to do.

Further, S. 1696 improperly shifts the burden to justify life-affirming legislation to the states. Usually when a law is passed, it is presumed to be constitutional and permissible by the courts, and it is the responsibility of the parties challenging the law to prove that the law is improper.

However, the enactment of S. 1696 would improperly shift that burden. An abortion provider or anyone else challenging an abortion-related law would only be required to demonstrate that an abortion-related law "singles out the provision of abortion services or facilities in which abortion services are performed" or that the law "impedes women's access to abortion services." Presumably then, a self-interested abortion provider could simply submit an affidavit claiming that the law would impede or interfere with his or her current operations and that would suffice to shift the burden to state officials to defend the law. Moreover, S. 1696 then places a very high burden on states to justify the law.

We know that abortion is deadly for an unborn child and that abortion poses serious risks to a woman's health, including:

- Short term risks of blood loss, blood clots, incomplete abortion, infections, cervical lacerations, and injuries to other organs;
- Increased risk of pre-term birth or placenta previa in future pregnancies;
- Increase instances of mental health problems, including anxiety, depression, alcohol abuse, and suicide ideation; and, that
- The risk of maternal death three times greater with abortion than with childbirth.

Despite the overwhelming evidence of the harm to women from abortion, S. 1696 seeks to tie the hands of the state legislators from enacting protections for women and their unborn children, and instead relies on the abortion industry to regulate itself. Kermit Gosnell's "House of Horrors" is all the evidence that Americans need to oppose a self-regulated abortion industry.

We respectfully urge you to oppose this dangerous legislation.

Sincerely,

Duffy Daugherty

cc: Members of the United States Senate Judiciary Committee

Oklahoma State Senate

Greg Treat
District 47

July 15, 2014

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2300 N. Lincoln Blvd. State Capitol • Oklahoma City, OK 73105-4808 • (405) 521-5632 • FAX: (405) 521-5623 • e-mail: treat@oksenate.gov

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We respectfully urge you to oppose this dangerous legislation.

Sincerely,

Senator Greg Treat, District 47

cc: Members of the United States Senate Judiciary Committee

Representative Randy Grau
Assistant Majority Floor Leader
House District 81
State Capitol Building
2300 N. Lincoln Blvd., Room 338
Oklahoma City, OK 73105
Phone (405) 557-7360
Fax (405) 962-7804
Email: randy.grau@okhouse.gov

House of Representatives

STATE OF OKLAHOMA

Committees

Vice Chairman:
A&B Higher Education

Committee Member:
Judiciary
Public Health
Public Safety

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

The *Women's Health Protection Act*, S. 1696 does not protect women, but in fact, as written, it would detrimentally affect the health of women throughout this nation. If enacted, this bill would roll back many of the advancements made in protecting women and ensuring that the best health care is available for every patient. It would likely invalidate the laws of several states that address reasonable safeguards for women considering abortion.

It is well within the constitutional authority of the state of Oklahoma to regulate the practice of medicine within its borders. This legislation would prohibit states such as mine from enacting common sense protections such as ensuring that patients are informed fully regarding all medical options and that certain clinics maintain the highest levels of safety standards. It may also undermine FDA regulatory authority by allowing certain drugs to be used outside of tested and approved protocols despite the evidence of serious harm to women treated in an unapproved manner.

As the author of landmark legislation in Oklahoma regarding women's health, as well as a member of both the House Public Health and Judiciary committees, I understand fully the overreach of federal power contained within this legislation. It is clear that through this legislation some of your number are attempting to strip away the ability of state legislators to enact medically appropriate and widely supported regulations of abortion. Regulations that in fact DO protect women's health, as opposed to this in deceptively named legislation.

Well-defined parameters are in place for the enactment of legislation addressing abortion-related issues. The states must work within this framework. Nevertheless, this legislation attempts to demolish these parameters, and instead, rob the states of their constitutional authority. As such, this legislation must not be enacted.

Sincerely,

Randon J. Grau
State Representative

cc: Members of the United States Senate Judiciary Committee

July 14, 2014

The Honorable
United States Senate
Washington, D.C. 20510

Dear Senator,

On behalf of our 500,000 members nationwide, Concerned Women for America Legislative Action Committee (CWALAC) wishes to express our opposition to S. 1696, the Women's Health Protection Act (WHPA). Despite its carefully chosen name, this bill, introduced by Sen. Blumenthal, would actually be a threat to women's health.

In 2011 alone, state lawmakers passed 92 abortion-restricting laws, including waiting periods, parental notification, clinic safety, ultrasound, and informed consent mandates.[1] The WHPA will deem most, if not all, of these previously enacted state laws illegal, overturning good abortion regulatory state legislation, all in the name of "women's health." These laws to protect women's health exist because of the grave concerns of state lawmakers.

History has shown us that when regulations on abortion clinics and doctors are dismissed, women are at a high risk of receiving poor care, being maimed, or even dying! The atrocities committed by abortion doctor Kermit Gosnell testify to this horrific truth. If abortion-restricting measures are stripped away and abortion providers are entrusted to set their own standards, women will be taken advantage of and a low standard in regards to their health and safety will become precedent. It is a dishearteningly ironic that the very name of this legislation stands in direct opposition to its inevitable outcomes.

It is frightening that the WHPA grants the abortion provider, not the states, the authority to set standards of care for their patients. This is deeply concerning as it demands that the interests of the *for-profit* abortion clinic doctors supersede that of their patients!

We urge you to boldly oppose S. 1696 in order to protect women. If this legislation is considered on the Senate floor, CWALAC will score against it and will include the vote in our annual scorecard.

Sincerely,

Penny Nance

Penny Young Nance
Chief Executive Officer and President
Concerned Women for America Legislative Action Committee

[1] "States Enact Record Number of Abortion Restrictions in 2011," *Guttmacher Institute*. January 5, 2012 http://www.guttmacher.org/media/inthenews/print/2012/01/05/endofyear.html (accessed on July 8, 2014).

CONCERNED WOMEN FOR AMERICA LEGISLATIVE ACTION COMMITTEE
1015 Fifteenth St., N.W. • Suite 1100 • Washington, D.C. 20005 • Phone (202) 488-7000 • Fax (202) 488-0806 • www.cwalac.org

ADDITIONAL SUBMISSIONS FOR THE RECORD

A list of material and links can be found below for Submissions for the Record not printed due to voluminous nature, previously printed by an agency of the Federal Government, or other criteria determined by the Committee:

Case files documented August 19, 2011:
http://www.cruz.senate.gov/files/documents/20141218__Stories.pdf

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