

Regulating Abortion Facilities and Providers

Combating the True Back-Alley

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For decades, abortion proponents have argued that legalized abortion is beneficial to the health and well-being of American women. In support of this assertion, they have put forth a litany of purported advantages. A primary advantage they often cite is increased medical safety for women undergoing abortions.

When their campaign to legalize abortion began, proponents argued that if abortion were legal the procedure would be safer for women because it would become an accepted part of mainstream medical care, women would receive care in properly staffed and maintained facilities, and skilled and reputable gynecologists and surgeons would perform the procedure. Legalized abortion would eliminate the 5,000 to 10,000 deaths abortion advocates falsely claimed resulted from illegal or “back alley” abortions each year.²

Proponents also argued that legalizing abortion would ensure women receive proper care before, during, and after the procedure. Proper care would obviously include appropriate post-operative monitoring and follow-up care. Legalized abortion would ensure that no woman would bleed to death alone and in pain following an unsafe abortion.

These were the promises. But has it proven to be the reality? Has 39 years of legalized abortion eliminated these problems from our national consciousness? Plainly, it has not. Instead, abortion clinics across the nation have become the true “back alleys” of abortion mythology.

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There is abundant evidence to support the contention that abortion clinics are the true “back alleys” about which abortion advocates warned us. A quick review of just a few cases of substandard abortion care poignantly contrasts the reality of abortion in America today with what abortion advocates promised legalized abortion would eradicate.

CASE STUDY – Pennsylvania

On both February 18 and February 23, 2010, federal agents raided Kermit Gosnell’s West Philadelphia abortion clinic, the Women’s Medical Society, and found “deplorable and unsanitary” conditions including blood on the floors; parts of aborted children stored in jars; post-operative recovery areas that consisted solely of recliners; padlocked emergency exits; and broken and inoperable emergency equipment. During the course of the investigation, it was discovered that Gosnell typically did not



[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.

- EXCERPT FROM GRAND JURY REPORT ON KERMIT GOSNELL

arrive at the clinic until 6 pm each day, and sanctioned the performance of gynecological exams and the administration of controlled substances and prescription medication by non-licensed staff at the clinic.

Following the raids, Gosnell's license to practice medicine was immediately suspended and the clinic was closed down. During a later grand jury investigation, prosecutors learned that state health officials had ignored dozens of complaints against Gosnell and that the clinic had not been inspected since 1993. They also learned that Gosnell had been illegally performing late-term abortions, delivering viable babies and killing them by cutting their spinal cords with scissors.³

CASE STUDY – Arizona

A young mother bled to death from a two-inch laceration in her uterus. As she lay in what medical assistants described as a pool of blood that soaked the bedding and ran down the woman's legs, she was heard crying for help and asking what was wrong with her. Where was her doctor? He was eating lunch in the break room, refusing requests to check her

condition, and later left her bleeding and unconscious to visit his tailor. The woman died after bleeding for two to three hours. Sadly, a hospital emergency room was less than five minutes down the street.⁴

CASE STUDY – Kansas

Two inspections of the same Topeka, Kansas, abortion clinic revealed fetal remains stored in the same refrigerator as food; a dead rodent in the clinic hallway; overflowing, uncovered disposal bins containing medical waste; unlabeled, pre-drawn syringes with controlled substances in an unlocked refrigerator; improperly labeled and expired medicines; a carpeted floor in the surgical procedure room; and visible dirt and general disarray throughout the clinic. Dr. Krishna Rajanna, who operated the unsanitary clinic, also consistently violated the practice guidelines for conscious sedation.⁵

Tragically, these case studies are indicative of what some American women experience when they enter an abortion clinic. Enacting comprehensive abortion clinic regulations is a critical and sensible solution to the problem of unsafe, “back-alley” abortions in America.



These regulations are designed to safeguard against unsanitary conditions, inferior equipment, and the employment of unsuitable and untrained personnel. They are also intended to put an end to substandard medical practices that injure and kill untold numbers of women each year.

Moreover, to further ensure women's health and safety, states also should consider additional commonsense laws including physician-only mandates, admitting privileges requirements, and comprehensive reporting requirements for abortions and abortion complications.

ISSUES

Abortion Clinic Regulations

Abortion providers do not foster or maintain a patient-physician relationship with women.

A significant percentage of all abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.

Abortion is an invasive surgical procedure that can lead to numerous and serious medical complications.

Potential complications for first-trimester abortions include, among others, bleeding, hemorrhage, infection, uterine perforation,

blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, fertility problems, emotional problems, and even death.⁶

The risks for second-trimester abortions are greater than for first-trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.

As the author of a leading abortion textbook writes, “[T]here are few surgical procedures given so little attention and so underrated in its potential hazard as abortion.”⁷

The courts have historically supported the need for abortion clinic regulations.

Since *Roe v. Wade*, the U.S. States Supreme Court has repeatedly recognized that a state has “a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient.”⁸

Federal courts have also repeatedly recognized that for the purposes of regulation, abortion is rationally distinct from other routine medical services because of the “particular gravitas of the moral, psychological, and familial aspects of the abortion decision.”⁹

Comprehensive abortion clinic regulations passed in the years immediately following the 1992 U.S. Supreme Court decision in *Planned Parenthood v. Casey* were derived, in substantial part, from standards and protocols



promulgated by abortion providers and abortion advocacy groups, specifically the Planned Parenthood Federation of America and the National Abortion Federation (NAF). The use of national abortion care standards and protocols has been a significant factor cited by federal courts in upholding these regulations against constitutional challenges by abortion providers.¹⁰

To assist states in enacting comprehensive regulations for abortion clinics, AUL has developed the “Abortion Patients’ Enhanced Safety Act,” which imposes ambulatory surgical center standards on abortion clinics, and the “Women’s Health Protection Act,” which mandates that abortion clinics meet national abortion care standards.

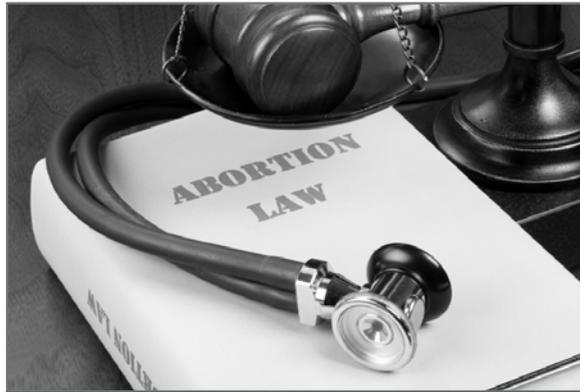
Physician-Only Laws and Admitting Privileges Requirements

The number of abortion providers nationwide is declining and pro-abortion groups are seeking ways to incorporate and increase the number of non-physician providers.

In recent years, pro-abortion organizations like NAF and the Center for Reproductive Rights (CRR) have pushed to expand access to RU-486 (“the abortion pill”) and so-called “emergency contraception,” while simultaneously bemoaning the declining number of abortion providers in the U.S. To deal with these competing issues, they have vowed to work “in

collaboration with partner organizations to explore different strategies for expanding scope of practice [of physician assistants, nurses, midwives, and others] in states.”¹¹ At this juncture, this concerted effort by pro-abortion groups and their allies is focused on access to abortion-inducing drugs, but their tactics and goals are readily transferable to efforts to expand the scope of practice for surgical abortions.

Abortion Reporting



The current voluntary abortion reporting system administered by the CDC is seriously flawed, resulting in inaccurate, unreliable, and incomplete abortion data.

Although the majority of the states require the reporting of some abortion-related information to state agencies, the states are not required to submit these reports to the Centers for Disease Control (CDC) or other federal or national reporting agencies.¹² The individual states are responsible for setting up and enforcing abortion reporting policies and systems, and for deciding what information (if any at all) should be submitted to the CDC. Some estimates suggest state reports to the CDC lack information on as many as 45-50 percent of the abortions performed annually.¹³

Accurate data on late-term abortions is virtually non-existent.

The states do not specifically require abortion providers to report late-term abortions. Al-



though many states require reporting of the gestational age of the unborn child at the time of the abortion, the majority of the states do not. Hence, there is no way of knowing how many late-term abortions are performed. Consequently, important information on the safety, efficacy, and complications of late-term abortions is lacking. Even the pro-abortion Alan Guttmacher Institute has admitted “specific data on the frequency of late-term abortions are limited, and data on the use of dilation and extraction [i.e., partial-birth abortion] do not exist either at the state or national level.”¹⁴

The majority of the states do not require reporting on long-term complications.

Abortion complications can be severe and lasting, and may even lead to death.¹⁵ Unfortunately, the abortion reporting laws of the majority of the states, as well as the U.S. Standard Report of Induced Termination of Pregnancy form,¹⁶ do not require abortion providers to report on long-term complications.

Additionally, many women who suffer complications are treated at hospitals or urgent care or similar facilities, and not at the clinic where they underwent their abortions. Abortion providers are not required to record or report complications (including deaths) that occur and are treated outside their clinics or offices.

However, at least one state, Mississippi, has made a noticeably positive step in improving abortion complication reporting. Mississippi’s statute requires all physicians treating abortion patients—not just abortion providers—to file “a written report with the State Department of Health regarding each patient who comes under the physician’s professional care and requires medical treatment or suffers death that

the attending physician has a reasonable basis to believe is a primary, secondary, or tertiary result of an induced abortion.”¹⁷

RU-486’s unique risks and complications necessitate reporting requirements tailored to the use of abortifacients.

Since the FDA’s September 2000 approval of RU-486, the number of nonsurgical abortions performed each year has increased.¹⁸ Reliable information on the number and complications of non-surgical abortions (including RU-486) is unavailable, in part, because not all state abortion reporting laws require reporting on nonsurgical abortions, and even those that do require reporting on non-surgical abortions do not require that this information to be reported to the CDC.

In addition, there is an insufficient understanding of the risks and complications associated with nonsurgical abortions. Nonsurgical abortions carry unique risks because, unlike with surgical abortions, abortion-inducing drugs can be prescribed by anyone with a “medical license,” such as untrained psychiatrists, podiatrists, or dentists.¹⁹ In addition, side effects are often confusingly similar to that of an ectopic pregnancy. Lastly, RU-486 is routinely and openly administered to women contrary to its FDA-approved regimen, resulting in severe complications, including death.²⁰

Lack of uniform reporting hinders research on nationwide abortion trends.

As there is no uniform method for abortion reporting among the states, abortion data collected by the different states is, in many respects, incomparable.²¹ For example, states vary in their definitions of “abortion complications,” as well as in their methods of determining



gestational age. States also differ in how they submit information to the CDC—some states submit aggregated data prepared by a state statistical agency, whereas some states submit the individual reports without passing them through a state agency.²² Some states submit information on abortions that occurred in the state, whereas other states submit information on abortions performed on residents of the state.²³ In addition, the reporting forms issued by the various state health departments have changed throughout the years. All of these inconsistencies make it hard to compare data from the different states, track trends, understand sociological motives that lead to abortion, or state conclusively anything that accurately reflects the country as a whole.²⁴

To assist states in collecting information about abortion complications, AUL has developed that “Abortion Complication Reporting Act,” based in substantial part on Mississippi’s cutting-edge reporting law.

KEY TERMS

Abortion surveillance is the collection, analysis, and dissemination of information related to abortion procedures, abortion morbidity, and abortion mortality with the objective of preventing morbidity and mortality associated with induced abortion. Abortion surveillance is an established branch of epidemiological surveillance.²⁵

Abortion complications are the adverse short- and long-term physical, emotional, and psychological effects of abortion on women.

The U.S. Standard Report of Induced Termi-

nation of Pregnancy form is the abortion reporting form issued by the CDC, and has been used as a model by the states. The form requests reporting on: (1) name and location of the abortion facility; (2) demographic and geographic information about the patient; (3) patient ID number; (4) obstetric history (*e.g.*, date of last menses, number of prior pregnancies and abortions); (5) type of abortion procedure (including medical abortion); and (6) names of physician and person filling out the report. Some states generally follow this model report form, and some do not. The abortion reporting laws of the various states may call for more or less than what is required in the standard form.²⁶

Voluntary abortion reporting is the submission of state abortion reports and/or aggregated abortion report information by state agencies to the CDC on a voluntary and discretionary, rather than contractual, basis.

MYTHS & FACTS

Myth: Abortion clinic regulations unfairly single out abortion providers for regulation and oversight.

Fact: Federal courts have repeatedly held abortion to be “rationally distinct from other routine medical services.”²⁷ Therefore, a state may choose to regulate abortion while leaving other types of medical or surgical procedures unregulated. As the Fourth Circuit noted, “In adopting an array of regulations that treat the relatively simple medical procedures of abortion more seriously than other medical procedures, [the State] recognizes the importance of abortion practice while yet permitting it to continue, as protected by the Supreme Court’s cases on the subject.”²⁸



Myth: Individual abortion providers are already licensed (as physicians) by the state medical board and their offices are already regulated under a variety of federal and state laws. Thus, there is no need for additional and/or specifically-tailored abortion clinic regulations.

Fact: These arguments have been made and repeatedly and summarily rejected by federal courts.²⁹ Abortion clinic regulations are designed to specifically address and meet the needs of abortion patients. Physician licensing standards and other federal or state regulations (such as those applicable to onsite laboratory services, employee safety, etc.) are not specifically designed to meet the specific medical needs of women undergoing abortions.

Myth: These regulations will create an “undue burden” on women seeking abortions by increasing the cost of abortions and/or by decreasing the number of providers.

Fact: Federal courts have also summarily and repeatedly rejected these arguments.³⁰ The abortion right is the right of the “woman herself—not her husband, her parent, her doctor, or others—to make the decision to have an abortion.”³¹ It is not the right of the woman to pay a certain price for an abortion or the right of an abortion provider to remain in practice or to have a financially lucrative practice.

Further, in evaluating challenges to abortion clinic regulations, federal courts have repeatedly determined that the simple fact the regulations may inconvenience some abortion providers and/or may result in an expenditure of time and money to come into compliance with the regulations does not create a burden on the woman seeking an abortion (as opposed to the abortion provider) and, therefore, are not

enough to invalidate such regulations.

Finally, even assuming the specific regulatory scheme would lead to an increase in the cost of abortions in the state and/or result in fewer providers, the U.S. Supreme Court has held “the fact that a law which serves a valid purpose, one not designed to strike at the [abortion] right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.”³² Clearly, protecting maternal health is a valid and compelling reason for regulating abortion clinics.

Myth: Abortion reporting laws are unconstitutional.

Fact: The U.S. Supreme Court has held that abortion reporting is constitutional and does not impose an “undue burden” on a woman’s right to an abortion. For example, in *Planned Parenthood v. Casey*, the Court held “[t]he collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult.”³³

Myth: Abortion reporting laws violate women’s privacy.

Fact: Abortion reporting laws specifically protect women’s privacy. Every state abortion reporting law contains provisions prohibiting the inclusion of patient names in abortion reporting forms. Many states even mandate that any information that can “reasonably lead” to the identification of a patient must not be included in an abortion report and/or publication.

Myth: There is no need for abortion reporting laws because the data and reports published by



the Alan Guttmacher Institute (AGI) are reliable and accurate.

Fact: Abortion data published by AGI is unreliable for many reasons. First, the foremost purpose of the AGI abortion reporting system is to promote the availability of abortion. AGI has stated that “[t]he CDC, consistent with its federal function, focuses particular attention on the safety of the procedure, while AGI concerns itself with the availability of abortion services throughout the country.”³⁴ AGI’s emphasis on abortion access rather than on women’s health and safety comes as no surprise, as AGI was formerly known as the “unofficial research arm” of Planned Parenthood.³⁵

Second, AGI is a privately-funded organization and its ability to collect data and produce statistics is limited. Notably, for financial reasons, AGI has been forced to limit its collection of abortion data to every four years.³⁶

Third, AGI collects information on a voluntary basis directly from abortion providers. Although AGI claims it collects abortion information from “all known abortion providers,” they only collect information from those providers who voluntarily respond to phone call surveys or questionnaires that AGI sends through the mail. None of the abortion providers contacted are under any obligation to respond, and there is no way to assure that responses are truthful and accurate. Moreover, AGI has revealed that it does not use an authentic, comprehensive list of abortion providers. Rather, AGI has admitted it compiles a list of provider names by searching through the telephone yellow pages, the membership directory of NAF, and the Internet.³⁷ Thus, AGI cannot accurately claim they collect information from all known abortion providers.

Fourth, AGI’s scope is limited to abortion providers who are known as or advertise themselves as abortion providers. Abortions performed by private practice physicians (outside of established abortion clinics) remain mostly unreported.³⁸

Lastly, AGI does not ask abortion providers for information on short- and long-term complications, medical care provided for complications, or follow-up examinations.³⁹

Myth: The current abortion reporting system is on par with other vital statistics data collection systems.

Fact: The CDC and the medical community have long recognized that the current abortion system is substantially below par in comparison to all other systems of vital statistics data collection. In 1978, in an attempt to establish an abortion reporting system on par with other vital statistics collection systems, the National Center for Health Statistics (NCHS) sought to establish a new system that would collect information from the states on a contractual, rather than voluntary, basis. However, as a result of inadequate financial planning, NCHS failed to institute the planned system.⁴⁰ Interestingly, since 1978, the CDC and NCHS have never again attempted to establish an abortion reporting system that is on par with other vital statistics collecting systems.

Myth: Abortion reporting laws will endanger women’s health.

Fact: The medical and public health communities have emphasized that improved methods of abortion reporting are essential for improving women’s health care. Accurate statistics on abortion procedures and their outcomes and complications contribute to the body of medi-



cal knowledge that informs practicing abortion providers and physicians-in-training on (1) which abortion techniques are safest and most effective; (2) how to safely perform a specific abortion procedure; and (3) how to improve the procedure to make it safer and to avoid complications.⁴¹

Endnotes

¹ Portions of the information contained in this overview were excerpted from D. Burke, *Abortion Clinic Regulation: Combating the True Back-Alley*, THE COST OF CHOICE 122-131 (2004).

² The numbers of deaths from illegal abortion were greatly exaggerated, as were the claims that abortions were inherently unsafe before *Roe v. Wade*. For example, in 1960, Planned Parenthood's Director Mary Calderone wrote:

Abortion is no longer a dangerous procedure. This applies not just to therapeutic abortions as performed in hospitals but also so-called illegal abortions as done by physicians . . . abortion, whether therapeutic or illegal, is in the main no longer dangerous, because it is being done well by physicians.

Mary Calderone, *Illegal Abortion as a Public Health Problem*, 50 AM. J. PUB. HEALTH 949 (July 1960).

Moreover, Dr. Bernard Nathanson, a founder of National Abortion and Reproductive Rights Actions League (NARAL), later conceded these statistics were intentionally misleading:

How many deaths were we talking about when abortion was illegal? In NARAL, we generally emphasized the drama of the individual case, not the mass statistics, but when we spoke of the latter it was always "5,000 to 10,000 deaths a year." I confess that I knew the figures were totally false, and I suppose the others did too if they stopped to think of it . . . The overriding concern was to get the laws eliminated, and anything within reason which had to be done was permissible.

BERNARD NATHANSON, *ABORTING AMERICA* 193 (1979).

³ See Report of the Grand Jury, MISC. NO. 0009901-2008 (Jan. 11, 2011), available at <http://www.phila.gov/districtattorney/PDFs/GrandJuryWomensMedical.pdf> (last visited Oct. 10, 2011).

⁴ Phoenix Police Department Report, July 15, 1998; testimony of Dr. John I. Biskind, *State v. Biskind*, No. CR99-00198 (Ariz. Superior Ct.), Feb. 13, 2001.

⁵ Consent Order, Board of Healing Arts of the State of Kansas, Docket No. 50-H, Feb. 14, 2005; Final Order, Board of Healing Arts of the State of Kansas, Docket No. 50-H-58, June 14, 2005.

⁶ Information on abortion complications is drawn from depositions, responses to interrogatories, and other discovery in *Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002).

⁷ W. M. Hern, *Abortion Practice* 101 (1990).

⁸ *Roe v. Wade*, 410 U.S. 113, 150 (1973). See also *Planned Parenthood of Southeastern Penn. v. Casey*, 505 U.S. 833, 847 (1992).

⁹ *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173 (4th Cir. 2000), cert. denied, 531 U.S. 1191 (2001).

¹⁰ For example, in upholding South Carolina's abortion clinic regulations, the Fourth Circuit Court of Appeals noted, with approval, that the regulations were "little more than a codification of national medical- and abortion-association recommendations designed to ensure the health and appropriate care of women seeking abortions." *Greenville Women's Clinic*, 222 F.3d 157.

¹¹ See e.g., http://www.prochoice.org/cfc/legal_practice.html (last visited Oct. 24, 2011).

¹² Alan Guttmacher Institute, *State Policies in Brief: Abortion Reporting Requirements*, October 2007. See also R. Saul, *Abortion Reporting in the United States: An Examination of the Federal-State Partnership*, 30(5) FAMILY PLANNING PERSPECTIVES (Sept./Oct. 1998); W. Cates et al., *Abortion Surveillance at the CDC: Creating Public Health Light Out of Political Heat*, 19 AM. J. PREV. MED., No. 1S (2000); J. Smith & W. Cates, *The Public Need for Abortion Statistics*, Public Health Reports, Vol. 93, pp. 194-97.

¹³ Alan Guttmacher Institute, *Issues in Brief: The Limitations of U.S. Statistics on Abortion* (1997).

¹⁴ Saul, *supra*, n. 2. See also, *Issues in Brief, supra*, n. 3 ("There are few authoritative data to support claims regarding how many late-term abortions are performed...").

¹⁵ Abortion complications include, but are not limited to: death, uterine perforation, cervical perforation, 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, preterm delivery in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs, and mental and psychological complications such as depression, anxiety, sleeping disorders, psychiatric hospitalization, and emotional problems.

¹⁶ The "U.S. Standard Report of Induced Termination of Pregnancy" was introduced in 1978 by the National Center for Health Statistics (NCHS). The form has been generally used by the states as a model for state reporting forms. See Saul, *supra*, n. 2.

¹⁷ Miss. Reg. 15-301-044.

¹⁸ R. K. Jones, Mia R. Zolna, Stanley K. Henshaw & Lawrence B. Finer, *Abortion Incidence in the United States: Incidence and Access to Services, 2005*, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 6, 15 (March 2008).

¹⁹ Even the Alan Guttmacher Institute has admitted that untrained personnel are given unfettered authority to perform medical abortions. See R.K. Jones et al., *supra* ("Early medication abortion requires less training and equipment than surgical abortion and can be more easily provided by family planning clinics and physicians' offices. . . . Mifepristone has made it easier for health care providers, including those that do not specialize in obstetrics and gynecology, to provide abortion services.").

²⁰ M.R. Smith & A. Franzonello, *Deadly Convenience: RU-486*,



Plan B, ella, and the danger of “contraceptive equity,” in *DEFENDING LIFE* 2012, *infra*.

²¹ See e.g., Saul, *supra* (“...accurate, complete and consistent data that is comparable across the years...simply do not now exist.”).

²² L. B. Finer & Stanley K. Henshaw, *Estimates of U.S. Abortion Incidence, 2001-2003*, (The Alan Guttmacher Institute 2006).

²³ *Id.*

²⁴ See e.g., *Issues in Brief*.

²⁵ Smith & Cates, *supra*, at 194.

²⁶ For example, all states with abortion reporting laws prohibit the inclusion of the patient name, and sometimes also the patient ID number on the reporting form. All states that require reporting of the patient ID have strict requirements for maintaining the confidentiality of the patient’s identity. The abortion reporting laws of Hawaii, Kentucky, New Mexico, New York, Oregon, Tennessee, Vermont, and Virginia require only a general abortion report, with no specific requirements (e.g., the total number of abortions performed in a given time period, or merely that “all abortions shall be reported to the State”). For abortions performed on minors, Arkansas, Georgia, Louisiana, Oklahoma, South Carolina, Utah, and Wisconsin require reporting on whether or not the applicable parental notification and/or consent law was followed. Only three states—Alaska, West Virginia, and Montana—require reporting on whether or not informed consent was obtained prior to the abortion. Only three states—Arizona, Oregon, and Washington—require reporting on medical treatment provided for abortion complications. Only one state, Louisiana, requires reporting on the name and address of the facility or hospital where post-abortion complication treatment was given.

²⁷ See, e.g. *Greenville Women’s Clinic*, 222 F.3d at 172-75; *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1992).

²⁸ *Greenville Women’s Clinic*, 222 F.3d at 175.

²⁹ See *Tucson Woman’s Clinic*, No. CIV 00-141-TUC-RCC; *Greenville Women’s Clinic*, 222 F.3d 157; *Women’s Med. Ctr. of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001).

³⁰ See *Greenville Women’s Clinic*, 222 F.3d 157; *Bristol Reg’l Women’s Ctr., P.C. v. Tenn. Dep’t of Health*, No. 3:99-0465 (D. Tenn. Oct. 22, 2001).

³¹ *Casey*, 505 U.S. at 877.

³² *Id.* at 874.

³³ *Id.* at 900-901.

³⁴ *Issues in Brief, supra*.

³⁵ The connection between these two organizations is well-known—Alan Guttmacher himself was one of the original founders of Planned Parenthood.

³⁶ *Issues in Brief, supra*, n. 3 (“...the difficulties inherent in raising private funds, repeatedly, for a massive information-gathering effort limit AGI’s ability to go into the field with greater regularity.”). See also *State Policies in Brief, supra*, Saul, *supra*; Cates, *supra*; Smith & Cates, *supra*.

³⁷ R.K. Jones et al., *supra*, at 7, 15-16.

³⁸ *Id.*

³⁹ *Id.* at 7. The AGI questionnaire asks providers for information

on the number of surgical and nonsurgical abortions performed, gestational age at the time of the abortion, and the distance travelled by women receiving nonsurgical abortions. Hospitals are not asked any questions about nonsurgical abortions.

⁴⁰ Saul, *supra*.

⁴¹ In addition to physician training, abortion statistics are necessary in order to prepare hospitals and health facilities for the medical needs of women who have abortions. Hospitals and health facilities must be prepared to provide women with adequate medical care before and during an abortion, as well as any emergency care she may need after the abortion has been performed. Good abortion statistics will inform hospitals and health facilities as to what care a woman will need before, during, and after an abortion. Moreover, an improved abortion reporting system requiring increased accountability will improve women’s health care because it will provide incentive for abortion providers to ensure that adequate safety precautions are taken when performing an abortion, and better health care is provided to women after the abortion procedure.

