The Women's Protection Project

The Time is Now: DEFENDING LIFE 2014: The AUL's Women's Protection Project

By Ovide M. Lamontagne, General Counsel, Americans United for Life

Abortion harms women. This is not a slogan; it is fact – a peer-reviewed, scientifically proven fact.

It is also a demonstrable fact that Big Abortion is one of the most unregulated, unaccountable, and unsafe industries in the United States today. In 2013, only five states regulated abortion clinics in the same manner as they do facilities performing other outpatient surgeries. In many states, veterinary clinics, tattoo parlors, tanning booths, and beauty salons are more closely regulated than abortion clinics. Holding abortion providers to a higher standard of care and subjecting them to more accountability and oversight will better protect women from an inherently dangerous procedure. Additionally, lives will be saved as abortion clinics often choose to close their doors rather than comply with basic medical standards.

The current lack of meaningful regulation and oversight allows Big Abortion to profit at the expense of women, particularly economically disadvantaged women, who are increasingly subjected to substandard – and sometimes deadly – treatment. Notably, Philadelphia late-term abortionist Kermit Gosnell made millions in his legal abortion clinic, yet he refused to incur the minimal expense associated with sterilizing his equipment or complying with basic health and safety regulations.

Sadly, Kermit Gosnell is not an aberration. He represents the true face of the abortion industry – a face that abortion advocates have tried desperately to hide from the American people. The truth is every year untold numbers of women are harmed physically and emotionally – and some even die – inside the nation's abortion clinics, yet abortion in the United States is all too common and largely unregulated. With 40 percent of all unintended pregnancies in the U.S. ending in abortion – a fact confirmed by the Guttmacher Institute, the former "research arm" of Planned Parenthood –Big Abortion must be held accountable.

Americans United for Life (AUL) seeks to protect women by advocating for comprehensive regulation and oversight that will rein in the increasingly out of control abortion industry. AUL has documented that, since 2009, at least 86 abortion providers in 29 states have faced investigations, criminal charges, civil lawsuits, administrative complaints for substandard treatment and/or have been cited for violating state abortion laws. AUL continues to expose the reality that legal abortion clinics like Kermit Gosnell's are the true "back alleys" of abortion mythology. Dangerous "Gosnell-like" conditions and practices are rampant in abortion clinics across the country, but Big Abortion tries to cover them up with rhetoric about the importance of "access" to abortion.

AUL's model abortion clinic regulations address critical issues such as sanitation, equipment, adequate provisions for emergency care, record-keeping, post-operative care, and the employment of appropriately licensed and trained abortion providers and other clinic personnel. Currently, 29 states regulate abortion clinics to some degree, but only five states impose the same comprehensive standards for patient care as other facilities performing outpatient surgeries. Notably, three of these five states enacted their clinic regulation laws since Kermit Gosnell's "house of horrors" abortion clinic became headline news in January 2011.

These laws are designed to ensure that the inherent risks from abortion are reduced (although they can never be eliminated), and that women are better protected from incompetent, substandard care at abortion clinics. Tragically, the public record is rife with examples of women dying at the hands of unskilled and uncaring abortion providers. On July 20, 2012, Tonya Reaves, a 24-year old mother of a 1-year old son, entered a Planned Parenthood clinic on Michigan Avenue in Chicago. She was 16-weeks pregnant and was scheduled for a second-trimester abortion. At 11 a.m., she underwent a dilation and evacuation ("D&E") abortion; a procedure where the physician dismembers and removes the unborn child in pieces.

While in recovery, Ms. Reaves suffered significant bleeding and, more than 5 hours after the abortion, she was finally rushed by ambulance to Northwestern Memorial Hospital. At Northwestern, doctors performed an ultrasound and discovered an incomplete abortion. They performed a second D&E procedure. Ms. Reaves continued to suffer pain and other complications. A second ultrasound was then performed and doctors learned that Ms. Reaves had suffered a perforation of her uterus. She was taken into surgery where "an uncontrollable bleed" was discovered. An emergency hysterectomy was performed, but it was too late. Tonya Reaves died at 11:20 pm.[1]

An autopsy report released in early September 2012 confirmed that as a result of the "care" she received at the Chicago Planned Parenthood Clinic, Ms. Reaves:

- Suffered from an incomplete abortion. Pieces of placenta were still attached to the inside of her uterus even after the second D&E procedure performed at Northwestern;
- Had a 3/16 inch perforation in her uterus near impression marks that appeared to have been made by forceps, instruments typically used during a D&E abortion;
- Suffered an "extensive" perforation of her broad uterine ligament with the possible severing of her left uterine artery; and
- Had 1 to 1 ½ liters of blood and blood clots inside her abdominal cavity. Ms. Reaves had bled about 30 percent of her total volume of blood into her abdomen following the abortion.[2]
- Whether they find themselves in a Planned Parenthood clinic or at an unaffiliated abortion clinic, women face serious risks of harm from abortion. Among these harms are:
- Short-term risks such as blood loss, blood clots, incomplete abortion, infections such as pelvic inflammatory disease, and cervical lacerations and other injuries to organs;
- An increased risk of subsequent premature birth. More than 130 studies have shown a greatly increased risk of premature birth and low birth weight attributable to an earlier abortion;
- An increased risk of placenta previa, a condition where the placenta covers the cervix and which endangers both the mother and the child;
- An increased risk of developing breast cancer. While a woman's first full-term pregnancy reduces her lifetime risk of breast cancer, aborting a first pregnancy before 32 weeks eliminates this protective effect; and
- Risk of significant psychological harm. A 2011 study published in the *British Journal of Psychiatr*y revealed that women face an 81 percent increased risk of mental health problems after abortions.

To better protect women from the demonstrated harms of abortion and to help save the lives of their unborn children, AUL is launching the *Women's Protection Project*, an effort to help states enact several pieces of protective legislation. Our goal of exposing and confronting the atrocities of Big Abortion is the top priority of the *Women's Protection Project*. This is accomplished through our expertly crafted model legislation, specifically:

- The "Women's Health Defense Act" which prohibits abortions after five months of

pregnancy. This legislation is predicated or the harms inherent in late-term abortions and attacks the U.S. Supreme Court's main rationale for *Roe* – the "reliance interest" which presumes that abortion is safer than childbirth and benefits women. The *Women's Protection Project* also based on medical evidence of the pain endured by unborn children in later-term abortions.

- The "Women's Right to Know Act" which requires women to be given detailed information about the medical and psychological risks from abortion, the unborn child's gestational age, development, and pain capability, and the chosen abortion procedure.
- The "Abortion-Patients' Enhanced Safety Act" which requires abortion clinics to meet the same health and safety standards as facilities performing other outpatient surgeries.
- The "Abortion-Inducing Drugs Safety Act" which better protects women from unsafe "telemed" abortions, a practice where abortion-inducing drugs are administered without a face-to-face examination by a physician and which does not follow FDA-approved protocols for these dangerous drugs.
- The "Parental Involvement Enhancement Act" which amends existing state parental involvement laws by, for example, requiring identification and proof of relationship for the person giving consent or receiving notice and delineating more stringent standards for judicial bypass hearings.
- The "Child Protection Act" which strengthens requirements that family planning and abortion clinics report all cases of suspected sexual abuse of minors, requires the retention of physical evidence, and penalizes those who seek to circumvent state parental involvement laws.
- A "Statutory Enforcement Module" which provides a multiple civil, criminal, and administrative options for enforcing state abortion laws and protecting women.

An actual and quantifiable "war on women" is being waged by Big Abortion with the aid and comfort of its allies on Capitol Hill, in statehouses, and in the media. AUL's *Women's Protection Project* will educate Americans about abortion's growing harm to women, will provide a commonsense approach to holding Big Abortion accountable for its malfeasance, and will, ultimately, protect and save lives.

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[1] *See, e.g.*, "Documents Shed Light on Women's Death After Abortion," *available at* http://chicago.cbslocal.com/2012/07/24/documents-shed-light-on-womans-death-after-abortion/ (last visited Oct. 16, 2013).

[2] *See* "Autopsy Proves Planned Parenthood Killed Woman in Botched Abortion," *available at* http://www.lifenews.com/2012/09/11/autopsy-proves-planned-parenthood-killed-woman-in-botched-abortion/ (last visited Oct. 16, 2013).

2013 State Legislative Sessions: Unabashedly Pro-Life and Pro-Woman

By Mailee R. Smith, Staff Counsel, Americans United for Life

Pro-life legislation designed to protect women from the many harms inherent in abortion has once again triumphed in state legislatures across the country, revealing a trend that is quickly becoming the new norm.

In 2013, 48 states considered approximately 360 measures related to abortion, most of which were life-affirming. Of those, 69 measures protecting maternal health and the lives of unborn children were enacted. This continued a trend from 2011 and 2012, when nearly 110 life-affirming measures were enacted.

Despite threats of litigation and actual federal and state lawsuits challenging life-affirming laws enacted in 2011 and 2012, state legislators refuse to kowtow to the increasingly desperate and hyperbolic pressure being applied by abortion advocates. Instead of buying into the same old mantras—like the lie that abortion is "good" for women—legislators continue to pursue pro-life, pro-woman legislation.

When *Roe v. Wade* was decided in 1973, little medical data on the health risks to women from abortion was presented to the U.S. Supreme Court. Much has changed since that time. An increasing number of medical studies now clearly demonstrate that abortion harms women. In addition to short-term physical risks, abortion involves significant risks of long-term physical and psychological harm including increased risks of subsequent pre-term birth, depression, anxiety, suicidal ideation, suicide, and even death.[1]

With state legislators actively seeking to protect women from these and other harms, four areas of abortion legislation are emerging as central to these ongoing efforts: abortion prohibitions, abortion clinic regulations, regulation of chemical abortion, and prohibitions and limitations on taxpayer funding for abortion.

Abortion Prohibitions

Much to the consternation of abortion advocates, legislation prohibiting later-term abortions swept the nation in 2013. At least 28 states considered measures to prohibit or limit abortions.[2] Medical data demonstrates that a woman faces significant risks from an abortion as her pregnancy progresses—a woman at five months (20 weeks) of pregnancy is 35 times more likely to die from an abortion than she was in the first trimester, and at 21 weeks or later she is 91 times more likely to die from an abortion than she was in the first trimester. Given this data, most measures focused on prohibiting later-term abortion.

For example, at least 11 states considered measures to ban abortion at five months (*i.e.*, 20 weeks).[3] Arkansas, North Dakota, and Texas enacted measures prohibiting abortion at 5 months based upon the pain felt by an unborn child. In Arkansas, the proposed late-term abortion ban was so overwhelmingly supported in the legislature that it was enacted over the veto of Governor Mike Beebe. In Texas, Governor Rick Perry called a second special legislative session allowing the legislature to pass a fivemonth prohibition there, after abortion supporters resorted to mob tactics to prevent a vote on the measure in the first special session.

Despite the disruptive schemes of abortion supporters, legislators in these states were doing exactly what the American people want. Even the Huffington Post reported that the majority

of Americans support abortion prohibitions at/after five months of pregnancy.[4] With word spreading[5] that the United States is one of only four countries worldwide to allow abortion after viability for any reason, public support for later-term restrictions can only be expected to rise.

Prohibitions on abortions performed because of the sex of the child or because of a diagnosed genetic abnormality were also a significant focus of the 2013 state legislatures. Specifically, at least 16 states considered measures to prohibit abortion based on the child's sex, race, and/or diagnosed genetic abnormality; a dramatic increase from the five states that considered such legislation in 2012.[6]

Notably, North Dakota became the first state in the nation to enact a measure, based on model language from Americans United for Life, prohibiting an abortion when it is sought solely on account of the child's sex or because the child has been diagnosed with a genetic abnormality. Kansas and North Carolina also enacted bans on sex-selective abortions.

Like later-term prohibitions, restrictions on abortion performed solely because of the child's sex or disability resonate strongly with the American public. Further, such prohibitions force the "pro-choice" movement to exhibit its real agenda: abortion at any time, for any reason. It is undisputed that sex-selective abortions overwhelmingly target female children. In 2011, author Mara Hvistendahl reported in her book, *Unnatural Selection*, that 163 million girls are missing in the world because of sex-selection abortions and recent estimates place that number at 200 million.[7] It is repulsive—and inherently contradictory—for any "pro-choice" organization or advocate to claim to support "women's rights" and yet argue, in essence, that people should be able to abort a little girl simply because she is a little girl.

Abortion Clinic Regulations

In the wake of the Kermit Gosnell trial and conviction and dozens of instances of substandard abortion care in other states, abortion clinic regulations and other abortion provider requirements generated significant attention in state legislatures in 2013.

At least 17 states considered measures mandating various health and safety standards for abortion clinics.[8] New laws were enacted in Alabama, Indiana, North Carolina, North Dakota, and Texas. Significantly, Alabama and Texas now require abortion clinics to meet the same patient care standards as facilities performing other outpatient surgeries. Such measures should be universally promoted as they simply ensure that a woman seeking an abortion is treated with the same medically appropriate standard of care as a woman having any other outpatient surgical procedure. Yet these commonsense measures are ardently opposed by abortion supporters who clearly prioritize mere access to abortion and the industry's financial bottom line over women's health and safety.

Similarly, at least 15 states considered legislation delineating qualifications for individual abortion providers.[9] Alabama, North Dakota, Texas, and Wisconsin enacted measures requiring abortion providers to have admitting privileges at a local hospital, while Louisiana and North Dakota now require that abortion providers be board certified in obstetrics and gynecology.

Conversely, California enacted a dangerous law allowing non-physicians to perform surgical abortions and administer abortion-inducing drugs. Abortion advocates' vocal support of this and similar legislation demonstrates—yet again—that they are not truly interested in protecting the health of women, and are instead content with forcing women into the true "back alley" run by a largely unregulated, profit-driven abortion industry.

As with the abortion industry's opposition to other measures that protect women's health and lives, Big Abortion's *opposition* to clinic regulations and *support* for lessening health and safety standards—to the point of allowing non-physicians to perform surgical abortions—demonstrates that it is the legislatures passing clinic regulations and other abortion provider requirements that truly care for women and prioritize their continued health and safety.

Regulation of Chemical Abortions

State regulations of chemical abortion (abortion-inducing drugs) generated significant national attention in 2013—with 11 states[10] considering measures to regulate the administration of these dangerous drugs. Chemical abortion is fast becoming the proverbial "cash cow" of the abortion industry, and any threat to the industry's ability to administer the drugs in a manner that increases its profits and autonomy—while simultaneously endangering women—will certainly draw the sustained ire of Big Abortion and its supporters in the mainstream media.

Abortion providers admittedly administer abortion-inducing drugs in potentially life-threatening ways: by giving the drugs to women and sending them home to self-administer well beyond the time limit approved by the U.S. Food and Drug Administration ("off-label" use). Such intentional off-label use allows abortion providers to "serve" more women in a single business day. If women are administering the drugs at home, providers do not need to see them or provide any medical aid. The more women "served," the higher the profit margin.

Moreover, some providers practice "telemed abortion," wherein a physician in a completely different location only briefly talks with a woman and rubber stamps her abortion without a physical examination. Such examinations are medically necessary because they ensure that women do not have ectopic pregnancies, which cannot be treated with abortion-inducing drugs. Notably, the FDA has reported that two women died from ruptured ectopic pregnancies following the off-label use of the RU-486 (Mifeprex) drug regimen.[11] In addition, because the risks from a chemical abortion rise as gestational age increases, a physical examination is necessary to properly stage the pregnancy and ensure that a woman is not administering abortion-inducing drugs beyond the gestational threshold imposed by the FDA.

Significantly, in 2013, measures designed to put an end to the abortion industry's dangerous practices by adhering to FDA protocols were enacted in seven states: Alabama, Indiana, Louisiana, Mississippi, Missouri, North Carolina, and Texas.

Each of these new laws ensures, consistent with FDA protocols, that physicians are physically present when abortion-inducing drugs are provided, thereby thwarting the efforts of Planned Parenthood and others to provide "telemed abortions." Alabama, Indiana, Mississippi, and Texas went even further and enacted AUL model language requiring that the physician physically examine the woman before administering the drugs, as the FDA requires.

Limitations and Prohibitions on Taxpayer Funding of Abortion

State legislation related to abortion funding continued to garner considerable interest in 2013, with 29 states[12] and the District of Columbia considering measures to limit or eliminate taxpayer funding for abortion. Arizona, Arkansas, Iowa, Kansas, Louisiana, Maryland, and Ohio enacted new laws placing limits on abortion providers' ability to qualify for and secure taxpayer dollars. Similarly, New Jersey Governor Chris Christie vetoed legislation that would have restored public funding for certain family planning services, including funding for Planned Parenthood.

Kansas enacted a sweeping measure providing that no state funding may be expended for any abortion. Arizona enacted a measure requiring that Medicaid providers cover family planning services that do not include abortion or abortion counseling, while Iowa now requires abortion providers to meet certain informed consent requirements before performing abortions for which they plan to seek reimbursement from the state.

Other state legislatures extended existing policies. For example, Arkansas continued a state policy prohibiting the use of state funds for abortion referrals or abortion services in public schools. Maryland continued its prohibition on the use of state funds for abortions except when the mother's life or health is in danger, when the unborn baby has abnormalities, or when the pregnancy resulted from rape or incest. While a fairly weak prohibition, it demonstrates that even less conservative states are not bowing to the abortion industry's pressure to use taxpayer dollars for an ever-expanding number of abortions.

Further demonstrating that state action to prevent public funding of abortion can take many forms, the Louisiana House and Senate adopted a resolution urging state entities to investigate and monitor the practices of Planned Parenthood Gulf Coast (PPGC) to determine whether the organization is in compliance with state laws related to, among other things, restrictions on public funding of abortion clinics. The resolution also requested that all grants and reimbursements under PPGC's Medicaid provider agreement be suspended pending the outcome of an investigation and that PPGC be denied any economic incentives for building, purchasing, or operating its facilities.

In all, 2013 was another significant year for pro-life legislation—and for the women this legislation seeks to protect.[13] Not only does the passage of life-affirming legislation help to safeguard women from the dangers inherent in abortion, but it also forces the abortion industry to reveal its true colors. Big Abortion seeks not to help women or protect their health; Big Abortion seeks to increase its profits under the guise of mere "access" to abortion—even if that "access" is dangerous or life-threatening.

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[1] See B. Calhoun & M. Smith, *Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women*, in Defending Life 2013: Deconstructing Roe: Abortion's Negative Impact on Women (2012), available at http://www.aul.org/wp-content/uploads/2013/04/RoeAt40-5_PotentialforHarm.pdf (last visited Sept. 21, 2013).

[2] These states included Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Missouri, New Hampshire, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, Texas, Virginia, West Virginia, Wisconsin, and Wyoming.

[3] These states included Arkansas, Illinois, Indiana, Iowa, Kentucky, Maryland, North Dakota, Oregon, South Carolina, Texas, and West Virginia.

[4] *See* E. Swanson & M. Blumenthal, *Abortion Poll Finds Support for 20-Week Ban* (July 11, 2013), available at http://www.huffingtonpost.com/2013/07/11/abortion-poll_n_3575551.html (last visited Sept. 21, 2013).

[5] *See*, e.g., J.V. Last, *America is only 1 of 4 countries to allow abortions post-viability*, Weekly Standard (Sept. 20, 2013), available at http://www.weeklystandard.com/blogs/abortion-nation_756510.html (last visited Sept. 26, 2013).

[6] These states included Colorado, Florida, Indiana, Iowa, Kansas, Massachusetts, Missouri, New York, North Carolina, North Dakota, Oregon, Rhode Island, Texas, Virginia, West Virginia, and Wisconsin.

[7] *See*, e.g., Women's Rights without Frontiers, *WRWF Lodges Complaint at United Nations against Forced Abortion and Gendercide in China* (Aug. 1, 2013), available at http://www.womensrightswithoutfrontiers.org/blog/?p=1254 (last visited Sept. 26, 2013).

[8] These states included Alabama, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Nebraska, New York, North Carolina, North Dakota, Oregon, Texas, Virginia, and West Virginia.

[9] These states included Alabama, Arizona, California, Florida, Illinois, Kentucky, Louisiana, Missouri, New York, North Carolina, North Dakota, South Carolina, Texas, West Virginia, and Wisconsin.

[10] These states included Alabama, Arizona, Arkansas, Indiana, Iowa, Louisiana, Michigan, Mississippi, Missouri, North Carolina, and Texas.

[11] U.S. Food and Drug Administration, *Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011* (July 2011), available at http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf (last visited Sept. 26, 2013).

[12] These states included Alaska, Arizona, Arkansas, Colorado, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Dakota, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington, and West Virginia.

[13] For more complete coverage of the 2013 state legislative session, see"2013 State Legislative Session Report," *available at* http://www.aul.org/wp-content/uploads/2013/09/2013-State-Session-Report.pdf .

Exposing the Pervasiveness of "Back Alley" Abortions

By Denise M. Burke, Vice President of Legal Affairs, Americans United for Life

"[T]here are few surgical procedures given so little attention and so underrated in its potential hazard as abortion."[1]

—Abortionist Warren M. Hern

"Abortion Doctor Kermit Gosnell Convicted of First-Degree Murder,"[2] "Houston Doctor Accused of Illegal Abortions,"[3] and "6,000 Complaints Lodged Against Late-Term Abortionist LeRoy Carhart"[4] – these are just a few of the recent headlines that have Americans concerned and rightly questioning the safety and legitimacy of abortion practice in this country.

For decades, abortion advocates have argued that legalized abortion is beneficial to women's health. When abortion is legal, women are not supposed to be at the mercy of callous and incompetent butchers and unsanitary and unsafe clinics. All too often, however, today's abortion clinics have proven to be the true "back alleys" of abortion mythology.

The Growing Problem of Substandard Abortion Facilities

Importantly, the epidemic of substandard abortion facilitiesis not just a recent phenomenon. Rather, it is a persistent, decades-long problem. Just a few examples illustrate the poor – and often deadly – treatment women are receiving from Big Abortion and aptly demonstrate the pervasiveness of "back alley" abortion practice in America today.

In April 1998, Lou Anne Herron, a mother with two young children at home, visited a downtown Phoenix abortion clinic seeking a late-term abortion. Arizona law prohibits an abortion after 24-weeks of pregnancy unless the abortion is necessary to preserve the woman's life or health. A medical assistant performed an ultrasound examination and determined that the unborn child was at 26-weeks development. Moreover, there were no legitimate medical indications that an abortion was necessary to preserve Lou Anne's life or health.

However, rather than comply with Arizona law, the abortionist, John Biskind, ordered multiple ultrasound examinations until a single, manipulated examination purported to show a 23-week-old unborn child. Biskind then performed the abortion and, in doing so, tore a 2-inch laceration in Lou Anne's uterus.

Two medical assistants later recalled that Lou Anne was very frightened about her condition as she lay in the recovery room. She begged to know what was wrong with her. She cried out in pain as she lay in a "puddle of blood" that soaked the sheets and ran down her legs. After multiple requests to check Lou Anne's condition, Biskind adjusted her IV (complaining that there was no qualified nurse on site who could do this), reassured Lou Anne, and left the facility to visit his tailor.

When paged 25 minutes later and informed of Lou Anne's deteriorating condition, Biskind refused to return to the clinic and instead instructed the staff to call 911. Paramedics were eventually called, but it was too late. Lou Anne was already dead.

Later, at Biskind's 2001 criminal trial, Phoenix fire captain Brian Tobin testified that, when

responding to the abortion clinic that day, he "very quickly" recognized "that there wasn't a lot of competent medical care going on." Biskind was subsequently convicted of manslaughter and sentenced to five years in prison.[5]

In 2005, the Kansas Board of Healing Arts sanctioned abortion provider Krishna Rajanna for substandard conditions and practices at his Kansas City abortion clinic. Among the health and safety violations discovered at the clinic were fetal remains being stored in the same refrigerator as food, a dead rodent in the hallway, overflowing and uncovered disposal bins containing medical waste, improperly labeled and expired medicines, and visible dirt and general disarray throughout the clinic.[6]

In September 2007, 22-year-old Laura Smith died at a Massachusetts abortion clinic. She suffered cardiac pulmonary arrest while undergoing an abortion. A criminal investigation later determined that the facility did not have the necessary equipment to monitor Laura's vital signs, did not have oxygen or a functioning blood pressure cuff, failed to adhere to a basic cardiac life support protocol, and refused to call 911 in a timely fashion. The abortion provider, Rapin Osathanondh, was convicted of manslaughter in September 2010.[7]

"The medical practice by which [Kermit Gosnell] 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."[8] So begins the graphic and heart-wrenching January 2011 grand jury report into notorious Philadelphia late-term abortionist Kermit Gosnell, who is currently serving a life sentence following convictions for murder, manslaughter, and hundreds of violations of Pennsylvania abortion laws, at the Women's Medical Society, his West Philadelphia "house of horrors" abortion clinic where he killed infants who survived attempted abortions by "snipping" their spinal cords with scissors after their birth.

On February 7, 2013, Jennifer Morbelli, a 29-year-old kindergarten teacher from New York, died from massive internal bleeding following an abortion at 33-weeks of pregnancy. The abortion was performed by late-term abortion provider, Leroy Carhart, at his Germantown, Maryland abortion clinic. The Maryland medical examiner's office later determined that Jennifer suffered from an "amniotic fluid embolism following a medical termination of pregnancy"—a life-threatening condition where amniotic fluid or other material from the baby, such as cells or hair, enters the mother's bloodstream and causes a severe allergic reaction. That, in turn, led to a "disseminated intravascular coagulation," where blood stops clotting properly and causes widespread bleeding.[9]

Sadly, these incidences are just the tip of the proverbial iceberg. Cases of substandard abortion practice have arisen in states from coast to coast, and each year brings new outrages over appalling patient care.

The Response to a Growing National Tragedy

So, what is being done about this persistent problem? Surely, given their self-touted concern for women's health and safety, one would expect abortion advocates to be leading the charge to ensure that abortion clinics are properly regulated and inspected and that all necessary steps are being taken to better protect women.

If this is what you think and hope, you are wrong. Rather, Americans United for Life (AUL), other pro-life advocates, and state officials are the ones who are working to remedy the persistent substandard conditions at the nation's abortion clinics and promoting medically appropriate and comprehensive health and safety regulations for these facilities. Pro-life advocates also defend these regulations when they are challenged –

in legal courtrooms and the "court of public opinion" – by abortion providers more concerned with plying their trade without legitimate oversight and protecting their "bottom-lines" than with safeguarding women's health and safety.

While virtually every state regulates the provision of veterinary services, only 29 states currently regulate (to widely varying degrees) facilities performing abortions.[10] Importantly, only five states require that abortion clinics meet the same health and safety standards as other facilities performing other invasive, outpatient surgeries.

Beginning in the late 1990s, in response to well-publicized cases of substandard abortion treatment, a handful of states including Arizona, South Carolina, and Texas began enacting comprehensive abortion clinic regulations based, in large part, on the abortion industry's own standards. Legislators in these states used practice guidelines obtained from Planned Parenthood and the National Abortion Federation (NAF) to craft rules and regulations designed to help ensure that women receive quality, medically appropriate care at abortion clinics.[11] While these early efforts have shielded many women from some of the dangers inherent in the all-too-often substandard treatment being provided by the abortion industry, they were only the opening salvo in a campaign to protect women from Big Abortion's callous indifference to women's health and safety.

In recent years, AUL has led the nationwide effort to require abortion clinics to meet the same medical standards as facilities performing other outpatient surgeries. Missouri was the first state to adopt these patient treatment standards and, over the last three years, Alabama, Pennsylvania, Texas, and Virginia have followed suit.

Big Abortion's Response to Efforts to Protect Women

How have states been rewarded for their laudable efforts on behalf of American women? Abortion advocates have vigorously opposed protective legislation and, when unsuccessful in derailing legislation providing meaningful regulations of abortionists and abortion facilities, immediately filed federal and state lawsuits vociferously complaining about the costs of complying with the new laws and arguing that they should not be required to comply with medically accepted standards of patient care.

Clearly, abortion advocates are neither the protectors of women's health that they so publicly hold themselves out to be, nor can they be trusted to police themselves.

Disturbingly, the impact of existing abortion clinic regulations has, thus far, been somewhat muted. Concerted campaigns by abortion advocates to undercut legislative efforts to enact new regulations or strengthen existing clinic regulations, "delaying tactics" once a law has been enacted including federal and state lawsuits to block the enforcement of these laws, and a lack of enforcement by some state officials have impeded the positive and protective impact of these life-affirming laws.

Misinformation Campaigns to Block Protective Legislation

Abortion advocates vigorously fight the adoption of mandatory health and safety standards for abortion clinics. They refer to them as "TRAP laws" (the "targeted regulation of abortion providers") and, blithely ignoring the demonstrated need for medically appropriate health and safety standards in any facility providing invasive surgical procedures and the wide-spread use of their own internal standards in crafting some states' abortion clinic regulations, illogically claim that the only purpose of such laws are to make abortions more difficult to obtain and more expensive.

Implicit in their arguments is the politically calculated, but medically unsupportable belief, that *mere* access to abortion promotes and protects women's health. Clearly, it does not.

Cynical "Delaying" Tactics

When abortion advocates fail to derail legislative efforts to regulate abortion clinics, they then typically launch multi-year court battles to prevent these protective standards from being enforced. For example, Arizona's law – also known as "Lou Anne's Law" in honor of Biskind's victim – was enacted in 1998, was supplemented in 1999, but did not go into effect until November 2010, after more than a decade of willful obstruction by abortion advocates.

More recently, abortion advocates have filed a federal lawsuit against a 2011 Kansas law mandating minimum health and safety standards for abortion clinics – standards drawn from Planned Parenthood's own treatment protocols and current abortion clinic regulations from Arizona and South Carolina. Notably, the Arizona and South Carolina laws, upon which the Kansas law is clearly predicated, have already survived multiple legal challenges – challenges nearly identical to those now being made in the Kansas case. Additional lawsuits have been filed or are being contemplated against Alabama, Texas, and Virginia's patient treatment standards.

Dereliction of Duty by State Officials

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 arrive at the clinic until 6:00pm 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 on his clinic, 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 (despite a Pennsylvania law mandating inspections).[12] Similar failures have been reported in other states.

The All-Too-Predictable Results: Pervasive "Back Alley" Abortion Clinics and Practitioners

Years of obstruction by abortion advocates and their allies and neglect by some state officials have continued to expose untold numbers of women to substandard conditions in abortion clinics, increased risk of death, and serious complications.

Since 2009, at least 86 abortion providers in at least 29 states have faced investigations, criminal charges, administrative complaints, and/or civil lawsuits related to their provision of abortion care or been cited for violating state laws governing the operation of abortion clinics.

Conclusion

Tragically, these investigations into and the adverse findings from numerous state inspections of abortion providers are indicative of the substandard treatment that increasingly appears to be the norm for Big Abortion. They are also likely only the tip of the proverbial iceberg of the threats women face from today's "back alley" abortion clinics. For the sake of American women, it is a reality that must be confronted and transformed by implementing stringent and medically appropriate standards for abortion patient treatment – standards that are the centerpiece of AUL's *Women's Protection Project*.[13]

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[1] Warren M. Hern, Abortion Practice 101 (1990).

[2] *Available at* http://usnews.nbcnews.com/_news/2013/05/13/18232657-abortion-doctor-kermit-gosnell-convicted-of-first-degree-murder?lite (last visited Sept. 4, 2013).

[3] *Available at* http://www.chron.com/news/houston-texas/houston/article/Houston-doctor-accused-of-illegal-abortions-4519565.php (last visited, Sept. 5, 2013).

[4] *Available at* http://www.breitbart.com/Big-Government/2013/04/28/Citizens-Lodge-Complaints-Against-Abortionist-Carhart-In-Late-Term-Abortion-Death (last visited Sept. 5, 2013).

[5] For a summary of the events surrounding Lou Anne Herron's death, see "Safe and Legal Anniversary: Lou Ann Herron," *available at* http://realchoice.blogspot.com/2006/04/safe-and-legal-anniversary-lou-ann.html (last visited Sept. 5, 2013).

[6] 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.

[7] *See* "Practitioner Heads to Jail for Manslaughter, Killed Woman in Failed Abortion," *available at* http://www.lifenews.com/2009/01/01/state-5453/ (last visited Sept. 5, 2013).

[8] *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 Sept. 5, 2013).

[9] *See* "Cause of Death: Maryland officials say a 29-year-old woman died of massive bleeding following a late-term abortion performed by LeRoy Carhart," *available at* http://www.worldmag.com/2013/02/cause_of_death (last visited Sept. 5, 2013).

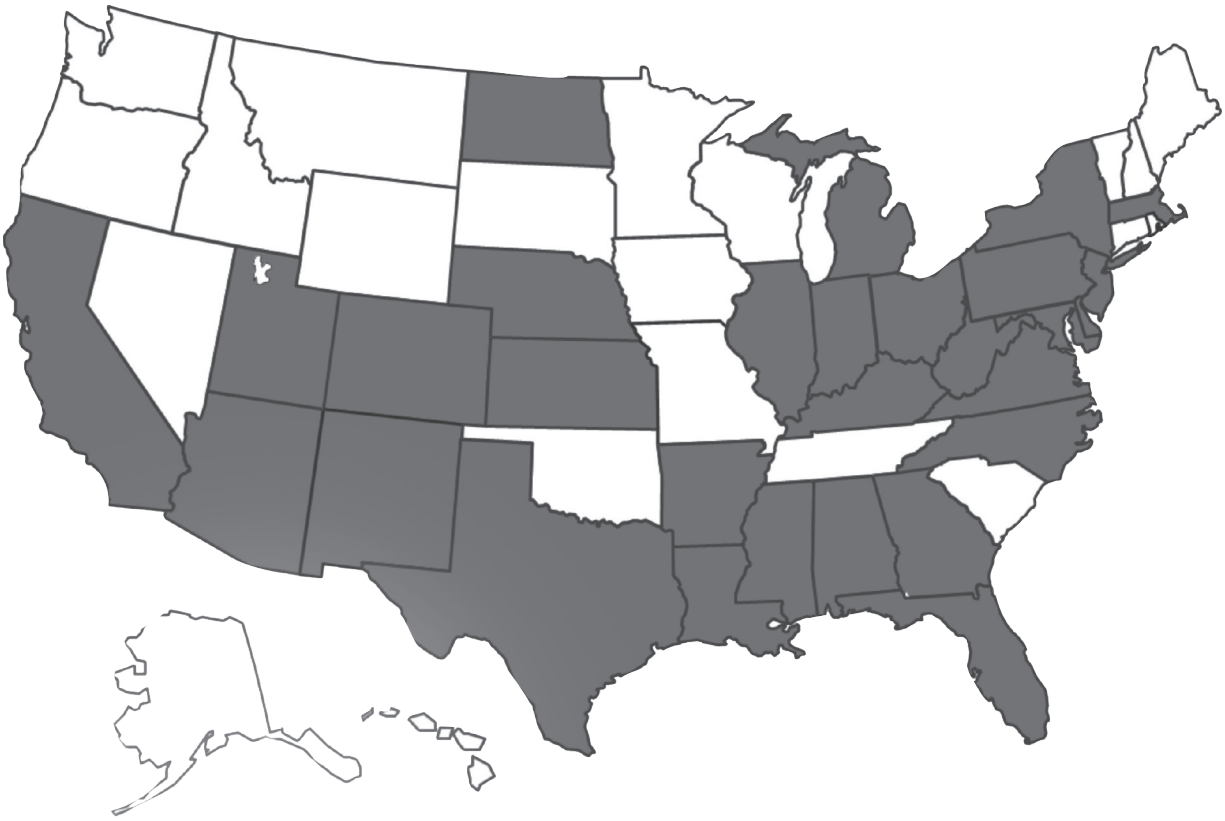
[10] *Id*.

[11] For more information about state efforts to regulate abortion clinics and providers, see Denise Burke, "Regulating Abortion Facilities and Providers: Combating the True Back Alley," Defending Life 2013, Deconstructing Roe: Abortion's Negative Impact on Women, *available at* http://www.aul.org/2013/02/the-defending-life-report/ (last visited Sept. 5, 2013).

[12] *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 Sept. 5, 2013).

[13] For model legislation regulating abortion clinics, see AUL's *Abortion Patients' Enhanced Safety Act and the Women's Health Defense Act*, both contained in this volume.

“Back Alley” Abortions in America



Since 2009, at least 86 abortion providers in at least 29 states have faced investigations, criminal charges, administrative complaints, and/or civil lawsuits related to the provision of abortion care or been cited for violating state laws governing the operation of abortion clinics: AL, AZ, AR, CA, CO, DE, FL, GA, IL, IN, KS, KY, LA, MD, MA, MI, MS, NE, NJ, NM, NY, NC, ND, OH, PA, TX, UT, VA, and WV.

Warning Label Needed: Abortion's Risk to Women

By Anna Franzonello, Staff Counsel, Americans United for Life

"The body is that of an adult Black female…appearing the reported age of 24 years. The body is cold to the touch. Rigor mortis is present to an equal extent in all joints. Postmortem lividity is present on the posterior dependent portions of the body.

The cause of death of this 24-year-old, Black female, TONYA REAVES, is due to hemorrhage resulting from cervical dilation and evacuation due to an intrauterine pregnancy."[1]

—Cook County Medical Examiner Report

The autopsy report for Tonya Reaves confirmed that she bled to death after her uterus was lacerated during an abortion. The young African-American mother was not a victim of a clandestine procedure performed in the years before *Roe v. Wade*. Her future was not cut short by now-convicted murderer Dr. Kermit Gosnell in his Philadelphia clinic dubbed the "house of horrors." The injury, which ultimately led to Tonya's death, was inflicted by an abortion provider at a flagship Planned Parenthood clinic on Chicago's upscale Michigan Avenue.

Tonya's tragic death underscores that making abortion legal has not made abortion safe. Whether accomplished by an invasive surgical procedure or by taking a combination of potent drugs, an abortion carries inherent physical risks for women. Unlike any other procedure, abortion involves the intentional termination of a human life—giving abortion a moral dimension with potential emotional consequences that a patient undergoing a tonsillectomy, for example, would never incur.

Yet, in an increasingly health-conscious society that mandates fast-food restaurants post calorie counts, and where the U.S. Surgeon General routinely warns Americans about the health risks of smoking or being overweight, abortion continues to lack the "warning label" it clearly deserves. Why? Because the health risks of abortion undermine the false narrative pushed by Big Abortion, namely that the debate surrounding abortion requires choosing sides between mothers and their unborn children. The truth is that abortion harms mothers and children – even their children in future pregnancies.[2]

WARNING: Abortion Has Undisputed Immediate Health Risks

Numerous, well-documented studies in peer-reviewed medical journals demonstrate that abortion poses significant medical risks for women. The undisputed risks of immediate complications from abortion include blood clots, hemorrhage, incomplete abortions, infection, and injury to the cervix and other organs.[3] Abortion can also cause missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, or shock.

Immediate complications affect approximately ten percent of women undergoing abortions, and approximately one-fifth of these complications are life threatening.[4]

WARNING: Abortion Poses Risks to Long-term Physical and Emotional Health

Peer-reviewed medical journals consistently document that the long-term physical and psychological consequences of abortion include an increased risk of:

- Subsequent preterm birth;
- Placenta previa (a complication during pregnancy where the placenta partially or totally covers the mother's cervix and which can cause severe bleeding before or during delivery);
- Subsequent suicide or suicidal ideation;
- Major depression;
- Substance abuse;
- Anxiety;
- Eating and sleeping disorders;
- Breast cancer as a result of the loss of the protective effect of a first full-term pregnancy;
- Miscarriage; and
- Death.[5]

WARNING: Abortion Increases the Risk of Pre-term Birth in Future Pregnancies—the Leading Cause of Infant Death

The impact on her reproductive future and the health of subsequently born children is vital information to a woman considering abortion, as up to 75 percent of women who have an induced abortion will become pregnant again.[6]

A preterm birth (PTB) is a birth occurring three or more weeks before the due date of the baby.[7] The link between having an induced abortion and PTB has been recognized in over 130 peer-reviewed scientific studies, as well as being listed as an "immutable medical risk factor" by the Institute of Medicine.[8]

Some of the reasons given for abortion increasing a woman's risk for PTB in later pregnancies commonly include: "mechanical trauma to the cervix, infection, and scarring of the endometrium."[9] A recent study found that 31.5 percent of preterm births may be the result of a woman having an abortion earlier in her life.[10]

PTB is the leading cause of infant death both globally and in the United States.[11] Worldwide PTB causes over three million deaths every year.[12]

Another major concern with PTB is the baby being underweight when it is born ("very low birth weight" or VLBW). Babies born with a VLBW face many health consequences and have an increased risk for developmental problems. Some of the potential long term complications include: cerebral palsy, cognitive impairment, vision problems, hearing problems, dental problems, behavioral problems, psychological problems, and chronic health issues.[13] These complications may not be realized immediately, and can surface later in childhood or even into adulthood.[14]

There are also high financial costs associated with PTB. Hospital costs alone arising out of abortion-related PTB are estimated to be $1.2 billion per year.[15] That figure does not include any long term costs to the families providing care for the prematurely born babies who suffer from conditions requiring long-term treatment.

WARNING: Induced Abortion is A Risk Factor For A Woman Developing Placenta Previa In Future Pregnancies

Placenta previa, a complication during pregnancy where the placenta partially or totally covers the mother's cervix and which can cause severe bleeding before or during delivery, can be dangerous for both the mother and the baby. One of the greatest risks to the mother is hemorrhaging, [16] which is extremely serious as the amount of blood lost in 15 minutes is enough to be potentially life threatening.[17] The placement of the placenta over the cervical canal may also require that an emergency cesarean section be performed to deliver the baby early (often prior

to full term) so as to not cause severe maternal bleeding.[18]

Induced abortion is a risk factor for a woman developing placenta previa in future pregnancies.[19] The risk of placenta previa after a dilation and curettage (D&C) abortion holds a relative risk ("odds ratio" or "OR") of 1.9 compared with women who do not have an abortion.[20] The risk of placenta previa is also greater for women who get infections following their abortion procedures.[21] After an infection from her abortion, a woman's risk of placenta previa is 3.6 (OR) compared with women who do not have an abortion history.[22]

WARNING: Decades of Medical Evidence Reveals that Abortion Carries Significant Psychological Risks Including Increased Risks of Depression, Anxiety, and Suicide

Meta-analysis of the data surrounding abortion and the increased risk of mental health problems demonstrates an association between abortion and an increased risk of mental health problems.[23] There are over 100 studies that demonstrate the connection between abortion and subsequent mental health problems.[24] It has been estimated that ten percent of mental health problems suffered by women are directly attributable to abortion.[25]

Studies demonstrate a link between induced abortion and depression and anxiety. For example, one study found that women whose first pregnancies ended in abortion were 65 percent more likely to score in the "high risk" range for clinical depression than women whose first pregnancies resulted in a birth—even after controlling for age, race, marital status, divorce history, education, income, and pre-pregnancy psychological state.[26]

Studies also demonstrate an increased risk of suicide ideation and suicide following induced abortion. One of the leading studies, led by a pro-abortion researcher and controlling for all relevant factors (including prior history of depression, anxiety, and suicide ideation), found that 27 percent of women who obtained an abortion reported experiencing suicidal ideation, with as many as 50 percent of minors experiencing suicide or suicidal ideation.[27] The risk of suicide was three times greater for women who aborted than for women who delivered. The study also found that 42 percent of women who obtained an abortion reported major depression by age 25, and 39 percent of post-abortive women suffered from anxiety disorders by age 25.

Studies have linked a history of abortion to sleeping disorders and eating disorders.[28] Adolescents who had abortions were three times more likely to experience trouble sleeping.

WARNING: Abortion is Associated With an Increased Risk of Breast Cancer.

As with every topic touching on the issue of abortion, the abortion-breast cancer link has been hotly disputed. However, it is scientifically undisputed that a woman's first full-term pregnancy reduces her risk of breast cancer. Aborting a first pregnancy before 32 weeks eliminates the protective affect against breast cancer for that woman.[29] It is also undisputed that the earlier a woman has a first full-term pregnancy, the lower her risk of breast cancer becomes.[30]

The association between having an induced abortion and a subsequent increased risk of breast cancer has been examined in 70 studies.[31] Of these studies, 33 showed a positive association between having an abortion and developing breast cancer, 19 of which were statistically significant. None of the studies showing a negative association were statistically significant.

WARNING: The Known, Substantial Health Risks of Chemical Abortions May Be Significantly Underreported

The use of the mifepristone and misoprostol chemical abortion drug regimen (also commonly referred to as "RU-486" or the "Mifeprex

regimen") has been strictly regulated by the U.S. Food and Drug Administration (FDA), because of its known dangers. On its website, the FDA notes, "Since its approval in September 2000, the [FDA] has received reports of serious adverse events, including several deaths, in the United States following medical abortion with mifepristone and misoprostol." A 2011 FDA report[32] accounts for at least 2,207 cases of severe adverse events, including hemorrhaging, blood loss requiring transfusions, serious infection, and death.

Thousands of reported instances of serious adverse events, including death, already raises concern. The concern for women's health and safety is heightened when considering the known inadequacies of what is being reported to the FDA about chemical abortions and that FDA reports capture "only a small proportion of events that actually occur."[33]

Additionally, abortion providers are openly flouting the FDA protocol and state laws designed to protect women against the dangers of these drugs. Planned Parenthood's own studies acknowledge that off-label use of chemical abortions (i.e. use that violates FDA protocols) has come at the cost of women's lives and "higher-than-expected" consequences to health. According to a 2009 study produced by Planned Parenthood, "Prompted by the deaths that occurred after medical abortion and internal data that show a higher-than-expected rate of serious infection, [Planned Parenthood Federation of America] changed its medical abortion protocol at the end of March 2006."[34]

Only after women died and suffered serious infections did Planned Parenthood stop the vaginal use of misoprostol, an off-label use never approved by the FDA.

In her "whistleblower" lawsuit filed against Planned Parenthood of the Heartland, Sue Thayer alleges that, lacking the ability to care for these women at their own facilities, Planned Parenthood's "telemed" chemical abortion patients who later experienced significant bleeding were told "to go to an emergency room and report that they were experiencing a spontaneous miscarriage."[35] On top of being unethical, encouraging a woman to be dishonest jeopardizes her health. Lying to a healthcare provider about the cause of the patient's condition leads to a host of obvious problems including inappropriate care and inaccurate reporting of abortion complications.

Studies have also found chemical abortions can carry even more risk to women than surgical abortions. For example, a major review of nearly 7,000 abortions performed in Australia in 2009 and 2010 found that 3.3 percent of patients who used mifepristone in the first trimester required emergency hospital treatment, in contrast to 2.2 percent of patients who underwent surgical abortions.[36] Women receiving chemical abortions were admitted to hospitals at a rate of 5.7 percent following the abortion, as compared with 0.4 percent for patients undergoing surgical abortion. Another study revealed that the overall incidence of immediate adverse events is fourfold higher for chemical abortions than for surgical abortions.[37]

WARNING: It is Undisputed that the Later in Pregnancy an Abortion Occurs, the Riskier it is and the Greater the Chance for Significant Complications

As a well-respected peer-reviewed journal—one which is also frequently cited by abortion advocates—admits, "Abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to abortion at eight weeks of gestation or earlier, the relative risk increases exponentially at higher gestations."[38]

Gestational age is the strongest risk factor for abortion-related mortality.[39] Compared to abortion at eight weeks gestation, the relative risk of mortality increases significantly (by 38 percent for each additional week) at higher gestations.[40] In other words, a woman seeking an abortion at 20 weeks (five months) 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.

Moreover, researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."[41] This is because later-term abortions require a greater degree of cervical dilation, with an increased blood flow in a later-term abortion which predisposes the woman to hemorrhage, and because the myometrium is relaxed, more subject to perforation.[42]

At least two studies have concluded that second-trimester abortions (13-24 weeks) and third-trimester abortions (25-26 weeks) pose more serious risks to women's physical health than first-trimester abortions.[43]

Researchers have also found that women who undergo abortions at 13 weeks or beyond report "more disturbing dreams, more frequent reliving of the abortion, and more trouble falling asleep."[44]

Even Planned Parenthood, the largest abortion provider in the United States, agrees that abortion becomes riskier later in pregnancy. Planned Parenthood states on its national website, "The risks [of surgical abortion] increase the longer you are pregnant. They also increase if you have sedation or general anesthesia [which would be necessary at or after 20 weeks gestation]."[45]

WARNING: The Abortion Industry Promotes a Myth that "Abortion is Safer than Childbirth."

When the U.S. Supreme Court decided Roe v. Wade in 1973, despite the fact that there was no evidence in the record related to medical data, the majority rested its opinion, in part, on the premise that abortion was safer than childbirth. The "abortion is safer than childbirth" mantra of 1973 continues to be repeated by today's abortion advocates. However, it has been undermined by the plethora of peer-reviewed studies published over the last 40 years. Specifically, recent studies demonstrate that childbirth is safer than abortion especially at later gestations.[46]

The risks to women's health posed by abortion were certainly exacerbated by the public health vacuum the Roe decision created 40 years ago. Roe and its companion case, Doe v. Bolton, struck down the abortion laws of all 50 states. Hamstringing the ability of states to regulate abortion providers, Roe and Doe invited back-alley conditions of abortion clinics like that of Kermit Gosnell to operate right on Main Street. However, the evidence is overwhelming that even regulated abortion poses serious medical risks. Women and girls deserve to know the facts. True "choice" depends on full and accurate information, and that information proves that abortion deserves a conspicuous "warning label."

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[1] *See Report of Postmortem Examination*, Off. of the Med. Examiner, Cook County, Ill. (July 26, 2012), obtained by Oper ation Rescue, available at http://operationrescue.org/pdfs/Reaves%20 Autopsy%20Report.pdf (last visited Oct. 8, 2013).

[2] For more information on the growing body of evidence of abortion's harm to women see Mailee R. Smith and Dr. Byron Calhoun, *Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women*, Defending Life 2013.

[3] While they downplay their significance, the websites for abortion organizations such as Planned Parenthood and the National Abortion Federation acknowledge these risks of abortion. See, e.g., Planned Parenthood, *In-Clinic Abortion Procedures* (2010), available at http://www.plannedparenthood.org/health-topics/abortion/abortion-procedures-4359.htm (last visited Oct. 8, 2013); Planned Parenthood, The Abortion Pill (Medical Abortion), available at http://www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.asp (last visited Oct. 8, 2013); and National Abortion Federation, Abortion Facts, available at http://www.prochoice.org/about_abortion/fac ts/safety_of_abortion.html (last visited Oct. 8, 2013).

[4] Elizabeth Shadigian, "Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion", testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota September 21, 2005.

[5] For more information see AUL' s "Summary of Known Health Risks to Abortion: How Abortion Harms Women and Why Concerns for Women's Health must be part of Abortion-related Policies and Media Debate." , *available at* http://www.aul.org/wp-content/uploads/2013/08/Summary-of-Known-Health-Risks-of-Abortion.pdf / (last visited November 11, 2013).

[6] John M. Thorp, Jr., *Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later*, Scientifica 2013 at 5.

[7] Mayo Clinic Staff, Premature Birth, *available at* http://mayoclinic.com/health/premature-birth/DS00137 (last visited Oct. 8, 2013).

[8] Inst. of Med. of the Academies, Preterm Birth: Causes, Consequences, and Prevention, 625 (Richard E. Behrman and Adrienne Stith Butler, eds., 2007) *available at* http://books.nap.edu/openbook.php?record_id=11622&page=625 (last visited Oct. 8, 2013).

[9] Thorp supra at 5.

[10] Byron C. Calhoun, et.al., *Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent*, 52 The Journal of Reproductive Medicine 929-937, 931 (2007).

[11] World Health Organization, Preterm Birth, November 2012, *available at* http://www.who.int/mediacentre/factsheets/fs363/en (last visited Oct. 8, 2013).

[12] Byron C. Calhoun, *Preterm Birth Update*, 79 The Linacre Quarterly, 231, 231(2012).

[13] Mayo Clinic Staff supra.

[14] *Id.*

[15] Byron C. Calhoun, et.al., *Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent*, 52 The Journal of Reproductive Medicine 929-937, 932 (2007).

[16] Medline, Placenta Previa,"Symptoms," *available at* http://www.nlm.nih.gov/medlineplus/ency/article/000900.htm. (last visited Oct. 8, 2013).

[17] L.G. Johnson, et al., *The Relationship of Placenta Previa and History of Induced Abortion*, 81 Int'l J. Gynecology & Obstetrics 191, 191 (2002).

[18] Medline, *supra* at "Treatment."

[19] John M. Thorp, et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 Obstetrical & Gynecological Survey 67, 70 (2002); and Cande V. Anath, et al., *The Association of Placenta Previa with History of Cesarean Delivery and Abortion: A Metaanalysis*, 177 Am. J. Obstetrics & Gynecology 1072, 1075 (1997).

[20] Johnson, *supra* at 194.

[21] *Id*. at 193.

[22] *Id*.

[23] John M. Thorp, Jr., *Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later*, Scientifica 2013.

[24] Priscilla K. Coleman, *Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 The Brit. J. of Psychiatry 180, 180.

[25] *Id*. at 183.

[26] J.R. Cougle et al., *Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort,* Med. Sci.Monitor 9(4):CR157 (2003).

[27] D.M. Fergusson et al., *Abortion in young women and subsequent mental health*, J. Child Psychology & Psychiatry 47:16 (2006).

[28] D.C. Reardon & P.C. Coleman, *Relative Treatment Rates for Sleep Disorders and Sleep Disturbances Following Abortion and Childbirth: A Prospective Record-Based Study*, J. Sleep 29:105-06 (2006).

[29] American Association of Prolife Obstetricians and Gynecologists (AAPLOG), *Induced Abortion and Subsequent Breast Cancer Risk: An Overview* (2008), *available at* http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-breast-cancer/induced-abortion-and-subsequent-breast-cancer-risk-an-overview/ (last visited Oct. 8, 2013).

[30] Scientists define an "early first full-term pregnancy" as one that takes place before the age of 24. Coalition on Abortion/Breast Cancer: *ABC Link: Two Ways that Abortion Raises Breast Cancer Risk* (2007), available at http://www.abortionbreastcancer.com/The_Link.htm (last visited Oct. 8, 2013).

[31] Breast Cancer Prevention Institute, *Epidemiologic Studies: Induced Abortion & Breast Cancer Risk*, (September 2012), available at http://www.bcpinstitute.org/FactSheets/BCPI-FactSheet-Epidemiol-studies_7_2013.pdf. (last accessed Oct. 8, 2013).

[32] The FDA report, "Mifepristone U.S. Postmarketing Adverse Events Summary through 04/30/2011," *available at* http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf (last visited Oct. 8, 2013).

[33] A 2006 review of Adverse Event Reports (AERs) related to the use of the RU-486 drug regimen conducted by Dr. Margaret M. Gary, M.D. and Dr. Donna J. Harrison, M.D. found "AERs relied upon by the FDA to monitor mifepristone's postmarketing safety are grossly deficient due to extremely poor quality." Margaret M. Gary, M.D. and Donna J. Harrison, M.D., *Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient*, 40(2) Annals of Pharmacology 191 (2006). What is perhaps even more disturbing than the lack of essential facts in what is reported to the FDA about chemical abortions—precluding accurate, or even any, analysis—is what is not being reported to the FDA about the dangerous drug regimen. The limitation of the AER system was detailed by Michael F. Mangano, Principal Deputy Inspector General of the Department of Health and Human Services, in his testimony before the U.S. Senate committee, "Adverse Event Reporting systems typically detect only a small proportion of events that actually occur. They are passive systems that depend on someone linking an adverse event with the use of a product, then reporting the event … .Adverse Event Reports in and of themselves typically cannot generate conclusive evidence about the safety of a product or ingredient. Rather the system generates signals that FDA must assess to confirm if, in fact, a public health problem exists… With limited information to draw upon to generate signals, it is not surprising that FDA rarely reaches the point of knowing whether a safety action is warranted to protect consumers." Hearing on consumer safety and weight-loss supplements. *Before the Subcomm. on Oversight of Gov't Mgmt, Restructuring, and the District of Columbia, S. Comm on Gov't Affairs*. 107th Cong. (2002) (statement of Michael F Mangano, Principal Deputy Inspector General, Office of Inspector Gen., U.S. Dep't of Health & Human Servs.).

[34] Mary Fjerstad, N.P., M.H.S., et al, *Rates of Serious Infection after Changes in Regimens for Medical Abortion*, 361 New. Eng. J. Med. 145 (2009). Mrs. Fjerstad and Dr. Cullins report having been employed by Planned Parenthood Federation of America (PPFA) at the time of the study. Drs. Lichtensberg and Trussell report serving on the PPFA National Committee, as follows: "No other conflict of interest relevant to this article was reported."

[35] Second Amended Complaint at 45, *United States and Iowa ex rel Thayer v. Planned Parenthood of the Heartland*, No. CV00129 (S.D. Iowa July 26, 2012).

[36] E. Mulligan & H. Messenger, *Mifepristone in South Australia: The First 1343 Tablets*, Australian Family Physician 40(5):342-45 (May 2011).

[37] M. Niinimaki et al., *Immediate Complications after Medical compared with Surgical Termination of Pregnancy*, Obstet. Gynecol. 114:795 (Oct. 2009).

[38] L.A. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States, Obstetrics & Gynecology* 103(4):729-37 (2004). "The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks gestation to one per 29,000 abortions at sixteen to twenty weeks and one per 11,000 abortions at twenty-one or more weeks."

[39] *Id.* at 731.

[40] See id. at 729, 731.

[41] *Id*. at 735.

[42] *Id*.

[43] P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, J. Pregnancy 2010:1, 7 (2010) (citing S.V. Gaufberg & P.L Dyne, Abortion Complications (2012), available at http://emedicine.medscape.com/article/795001-overview (last visited May 20, 2013); L.A. Bartlett et al., supra).

[44] P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, supra, at 7.

[45] See Planned Parenthood Federation of America, In-Clinic Abortion Procedures (2012), *available at* http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp (last visited Oct. 8, 2013).

[46] See, e.g., D.C. Reardon & P.K. Coleman, *Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark* 1980-2004, Med. Sci. Monit. 18(9):71-76 (Aug. 2012). "Compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years." This study is particularly striking in the range studied—even up to 10 years after birth or abortion, more women die after abortion than after childbirth. See also E. Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, PLoS ONE 7(5):e36613 (May 4, 2012), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3344918/ (last visited May 20, 2013). The May 2012 study out of Chile is particularly significant because it examined trends in maternal death both when abortion was legal in Chile and after abortion was prohibited. The study found that death rates did not increase after abortion was made illegal. In fact, the maternal mortality ratio decreased from 41.3 deaths per 100,000 live births when abortion was legal, to just 12.7 maternal deaths per 100,000 live births after abortion was made illegal. Today, Chile has a lower maternal mortality ratio than the United States and it has the lowest maternal mortality ratio in all of Latin America. Moreover, the leading cause of death for a pregnant woman between 1957 and 1989 (the time in which abortion was legal) was abortion. This data convincingly demonstrates that the 1989 law prohibiting abortion has not put women's lives at risk, effectively refuting the claims that abortion advocates routinely employ against most abortion restrictions. See also Carroll, Ireland's Gain: The Demographic Impact and Consequences for the Health of Women of the Abortion Laws in Ireland and Northern Ireland since 1968, at Figure 8 (Dec. 2011), available at http://papriresearch.org/ESW/Files/Irelands_Gain.pdf (last visited May 20, 2013). The study compared maternal mortality rates in Ireland (where abortion is illegal) to England and Scotland (where abortion is legal). Researchers found that maternal mortality rates were much lower in Ireland than in England or Scotland. Specifically, in Ireland, there are 1-2 maternal deaths per 100,000 live births, whereas in England/Wales there are 10 deaths per 100,000 live births, and in Scotland there are 10-12 deaths per 100,000 live births. If abortion is safer than childbirth, then the data should confirm that assumption in countries where abortion is illegal; however, studies prove exactly the opposite: where abortion is restricted, maternal mortality rates decrease.

Consent Denied: The Need for Informed Consent and Parental Involvement

By Mary E. Harned, Staff Counsel, Americans United for Life

"Trust Women." This phrase has become the mantra of abortion advocates. They falsely insinuate that and *only they* believe women considering abortion will make the best choices for themselves, and that pro-life Americans do not have this confidence. In reality, abortion advocates are so blinded by their ideology and greed that *they* are the ones who do not trust women. They do not trust women with all of the facts necessary to make informed choices. Instead, they aggressively oppose – through legislative action and litigation – laws requiring that women considering terminating pregnancy be provided complete and accurate information about abortion, its consequences, and its alternatives and parental involvement requirements designed to safeguard minors.[1] The consequences of their politically and financially motivated activism are often tragic for mothers and their unborn children.

Informed Consent is Critical for Women's Health

"I was 15, afraid, ashamed and I felt like I had no choice. . . .The abortion caused me emotional, physical and spiritual harm that I was never told could or would result. I was never given a pregnancy test, told about the procedure or told the real truth about abortion: risks such as death, breast cancer, endometriosis, and infertility. . . . No one was there to hold my hand. . . . They took my money and my baby! . . .I was distant and empty and contemplated suicide. . . . We never told our parents. . . . I could not forgive myself. I was NEVER able to conceive a child after my abortion and I am 50 years old now. The pain is still there. Abortion scarred me!" - Nicole, Connecticut.[2]

Unfortunately, this testimony is not unique. Abortion providers perform abortions everyday without adequately and accurately informing women about the short-term and long-term risks of the procedure. The undisputed[3] short-term physical risks of surgical abortion include 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 infections caused by incomplete abortions; and injury to the cervix and other organs which includes cervical lacerations and incompetent cervix—a condition that affects subsequent pregnancies. Long-term risks include subsequent miscarriage, pre-term birth, infertility, hysterectomy, and other serious complications.[4]

Abortion also poses significant risks to women's emotional and psychological health. Women who have had abortions are more likely to suffer from depression and anxiety and are at an increased risk for suicide. One of the leading studies examined a sample group of over 500 women from birth to age 25.[5] That study, led by pro-abortion researcher D.M. Fergusson, was controlled for all relevant factors, including prior history of depression and anxiety and prior history of suicide ideation.[6] The Fergusson study found that 42 percent of young women experience major depression after abortion.[7] Yet another study stated that "anxiety and depression have long been associated with induced abortion," and that anxiety is the most common adverse mental effect of abortion.[8] Further, the Fergusson study found that 27 percent of women who aborted reported experiencing suicide ideation, with as many as 50 percent of minors experiencing suicide or suicide ideation.[9]

It is indefensible for abortion providers to withhold this critical information from women. Ultimately, however, abortion providers know that "trusting women" with these facts could lead them to walk out of clinics—a risk that many abortion providers are not willing to take.

Undisputed Benefits of Parental Involvement

It is particularly dangerous for abortion providers to presume that minors understand the risks posed by abortion. Yet, in states that do not require parental notification or consent prior to an abortion, minors are treated virtually the same as adult women. Even in states with parental involvement requirements, abortion providers often brazenly violate the law.[10]

Medical Risks to Minors

Parental guidance is imperative when a minor is considering an abortion, given that the medical, emotional, and psychological consequences of abortion are often serious and can be long-lasting, particularly when the patient is immature.[11] Parents usually possess information essential to a physician's exercise of his or her best medical judgment concerning a minor. Further, parents who are aware that their daughter has had an abortion may better ensure she obtains the best post-abortion medical attention.

Minors are even more susceptible to abortion's medical risks than are older women. For example, minors are up to twice as likely to experience cervical lacerations during abortions.[12] Researchers believe that smaller cervixes make them more difficult to dilate or grasp with instruments. Minors are also at greater risk for post-abortion infections, such as pelvic inflammatory disease and endometritis.[13] Again, researchers believe that minors are more susceptible because their bodies are not yet fully developed and do not yet produce the protective pathogens found in the cervical mucus of older women.

While these risks apply to surgical abortion, it is important to note that drugs producing a chemical abortion have never been tested on minors. For example, the common abortion drug RU-486 has only been tested on women aged 18 to 46.[14]

Minors are also more susceptible to the long-term risks of abortion. In fact, the Guttmacher Institute—Planned Parenthood's former research wing—has acknowledged that because minors are less likely than adults to take prescribed antibiotics or follow other regimens of treatment, they are at greater risk for serious long-term complications.[15]

Included in these long-term risks are the harmful effects on future pregnancies—yet most women who abort do so early in their reproductive lives while desiring to have children at a later time.[16] However, induced abortion increases the risk of pre-term birth (premature birth) and very low birth weight in subsequent pregnancies. Induced abortion has been associated with an increased risk of the premature rupture of membranes, hemorrhage, and cervical and uterine abnormalities which are responsible for the increased risk of pre-term birth.[17]

The psychological risks of abortion inflict minors with particular force. In studying teens aged 15 to 18, researchers have found that minors who became pregnant and carried the pregnancy to term had a 35.7 percent chance of experiencing major depression, but minors who aborted had an astonishing 78.6 percent chance of experiencing major depression.[18]

In teens, the chance of experiencing anxiety after abortion was 64.3 percent, and the chance of suicidal ideation was 50 percent.[19] Likewise, a 2003 study showed that women who abort their first pregnancies were 65 percent more likely to be at "high risk" for depression than women who did not abort.[20]

The Fergusson study found as many as 50 percent of minors experience suicide or suicide

ideation after abortion.[21] The risk of suicide was three times greater for women who aborted than for women who delivered.

Minors and Sexual Predators

Minors face dangers beyond physical and psychological complications of abortion. When they obtain "secret" abortions, minors often do so at the behest of the older men who impregnated them and then return to abusive situations.[22] News stories frequently reveal yet another teen that has been sexually abused by a person in authority—a coach, teacher, or other authority figure. Every day, teens are taken to abortion clinics without the consent or even the knowledge of their parents. Minors are at risk in every state in which parental involvement laws have not been enacted or are easily circumvented.

Abortion advocates do not trust women—if they did, they would support laws mandating the provision of adequate and accurate information to women considering abortion. Instead, women, including minors, are often not told about the physical and psychological risks of abortion, with devastating consequences.

Perhaps abortion advocates cannot face these truths themselves. They ultimately know that trusting women with accurate information can empower them to make life-affirming choices—choices that do not bankroll the abortion industry while unnaturally pitting women against their unborn children.

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[1] Planned Parenthood, the nation's largest abortion provider, brought legal actions against laws or regulations requiring parental involvement in a minor's abortion decision at least 28 times between 1975 and 2010. They also brought numerous actions against informed consent requirements. The Case for Investigating Planned Parenthood, Appendix XII (Americans United for Life 2011), *available at* http://www.aul.org/aul-special-report-the-case-for-investigating-planned-parenthood (last visited Oct. 10, 2013). The Center for Reproductive Rights and other abortion advocacy groups often challenge these laws as well. See Center for Reproductive Rights, The Center's Cases, *available at* http://reproductiverights.org/en/archive/cases?issue=9&region=50 (last visited Oct. 11, 2013).

[2] Silent No More Awareness, Testimonies, *available at* http://www.silentnomoreawareness.org/testimonies/testimony.aspx?ID=2915 (last visited Oct. 11, 2013).

[3] These risks are openly acknowledged by abortion providers. See, e.g., Planned Parenthood, *In-Clinic Abortion Procedures* (2010), *available at* http://www.plannedparenthood.org/health-topics/abortion/abortion-procedures-4359.htm (last visited Oct. 11, 2013).

[4] Guttmacher Institute, *Teenage Pregnancy: Overall Trends and State-by-State Information* (Feb. 19, 2004); C. Moreau et al., Previous Induced Abortions and the Risk of Very Preterm Delivery: Results of the EPIPAGE Study, Brit. J. Obstet. & Gyn. 112:430, 431 (2005).

[5] D.M. Fergusson et al., *Abortion in Young Women and Subsequent Mental Health*, J. Child Psychol. & Psychiat. 41(1):16 (2006).

[6] *Id.*

[7] *Id.*

[8] V.M. Rue et al., *Induced Abortion and Traumatic Stress: A Preliminary Comparison of American and Russian Women*, Med. Sci. Monitor 10(10):SR5, SR6 (2004).

[9] D.M. Fergusson et al., *supra*, at 19, Table 1.

[10] *See* The Case for Investigating Planned Parenthood, supra p. 18.

[11] *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).

[12] *See*, *e.g.*, K.F. Schultz et al., *Measures to prevent cervical injury during suction curettage abortion*, Lancet 1(8335):1182 (1993); R.T. Burkman et al., Morbidity risk among young adolescents undergoing elective abortion, Contraception 30(2):99 (1984).

[13] *See, e.g.*, R.T. Burkman et al., *Culture and treatment results in endometritis following elective abortion*, Am. J. Obstet. Gynecol. 128(5):556 (1997); W. Cates, Jr., *Teenagers and sexual risk-taking: The best of times and the worst of times*, J. Adolesc. Health 12(2):84 (1991); D. Avonts & P. Piot, *Genital infections in women undergoing therapeutic abortion*, Euro. J. Obstet. Gynecol. & Reprod. Bio. 20(1):53 (1985).

[14] *See* Mifeprex Label, available at http://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.htm (last visited Oct. 11, 2013).

[15] Guttmacher Institute, *Teenage Pregnancy: Overall Trends and State-by-State Information* (Feb. 19, 2004).

[16] C. Moreau et al., *Previous Induced Abortions and the Risk of Very Preterm Delivery: Results of the EPIPAGE Study*, Brit. J. Obstet. & Gyn. 112:430, 431 (2005).

[17] *Id.*

[18] D.M. Fergusson et al., *supra*, at 19.

[19] *Id.*

[20] J.R. Cougle et al., *Depression Associated with Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort*, Med. Sci. Monitor 9(4):CR157, CR 162 (2003).

[21] D.M. Fergusson et al., *supra*, at 19, Table 1.

[22] Unfortunately, sexual abuse is "vastly underreported." In fact, nearly 88 percent of sexual abuse is never reported—let alone prosecuted. Many experts refer to sexual violence and date/acquaintance rape as a "hidden" or "silent" epidemic because of the high rates of occurrence and its infrequent disclosure. Yet studies reveal that at least one in five girls is sexually abused before the age of 18. Some researchers estimate even higher numbers. See National Association of Children's Hospitals and Related Institutions ["NACHRI"], *Child Sexual Abuse Fact Sheet* (2004); E.M. Saewyc et al., *Teenage Pregnancy and Associated Risk Behaviors Among Sexually Abused Adolescents*, Persp. on Sexual & Reprod. Health 936(3):8, 99 (May/June 2004); Stop It Now, *Commonly Asked Questions: Answers to Commonly Asked Questions About Child Sexual Abuse* (2005) (citing R.F. Hanson et al., F*actors Related to the Reporting of Childhood Sexual Assault*, Child Abuse & Neglect 23:559, 559-69 (1999)); C.E. Irwin & V.I. Rickert, Editorial: Coercive Sexual Experiences During Adolescence and Young Adulthood: A Public Health Problem, 36 J. Adoles. Health 359 (2005); V.I. Rickert et al., *Disclosure of Date/Acquaintance Rape: Who Reports and When*, 18 J. Ped. Adoles. Gyn. 17 (2005).

Implementation of the Women's Protection Project: How Do the States Measure Up?

What progress has each of the 50 states made in implementing the component laws and the underlying goals of the *Women's Protection Project*? AUL attorneys have prepared the enclosed chart to track each state's progress and to show where urgent action is needed.

The chart summarizes state laws enacted on or before September 1, 2013 that are in substantial compliance with the requirements of AUL's expertly crafted model legislation. Specifically, the columns list legislative elements of the *Women's Protection Project* or, where appropriate, critical features of the component legislation:

- "Ambulatory Surgical Center Standards for Abortion Clinics": States displaying an "X" in this column have enacted laws requiring abortion clinics to meet the same patient care standards as facilities performing other outpatient surgeries. States without notations have less protective clinic regulations laws or, in some cases, no clinic regulations at all.
- "Informed Consent": An "X" in this column denotes the existence of a basic informed consent law requiring women considering abortion to be given information about the abortion procedure, its risks and consequences, and, in some cases, its alternatives.
- "Reflection Period": States displaying an "X" in this column provide women with a period of time (typically 24 hours) to review and consider the informed consent information they are provided. An abortion cannot be performed until this period has expired. Reflection periods are crucial in ensuring that women's choices are fully informed and that, in many cases, their choices are for life.
- "Parental Involvement Law": In this column, AUL has noted whether a state has an enforceable parental consent or parental notice law. A principal component of the *Women's Protection Project* is our *Parental Involvement Enhancement Act* which is designed to strengthen existing parental consent and notice laws. Clearly, it is important to know what type of parental involvement law a state has in place before considering how to strategically improve that law.
- "Parental Involvement Enhancements": AUL's *Parental Involvement Enhancement Act* provides states with 10 different options for strengthening their existing parental consent or notice laws including requirements for notarized documents, requirements for identification and proof of relationship for the person consenting to or receiving notice of the abortion, and specific evidentiary and other standards for a judicial bypass hearing when a minor is seeking the waiver of her state's parental involvement requirement. In this column, we note which of these enhancements each state already maintains.
- "*Child Protection Act*: Abortion Clinic Staff Are Mandatory Reporters": AUL's *Child Protection Act* has three major components. The first component is a requirement that all those working in an abortion clinic – including administrative staff and volunteers, not just licensed medical personnel – are mandatory reporters of suspected child sexual abuse. An "X" is this column denotes a state law or laws designating abortion clinic, "reproductive health center," and/or family planning clinic staff as mandatory reporters of suspected abuse.

- "*Child Protection Act*: Requirement to Retain Evidence": The second major component of the *Child Protection Act* is a requirement that, when an abortion is performed on a girl under the age of 14, the abortion provider retain forensic evidence from the abortion that can be used in any subsequent investigation and/or prosecution. States with an "X" in this column have already enacted this or substantially similar requirements.
- "*Child Protection Act*: Prohibits/Penalizes Efforts to Circumvent Parental Involvement Laws": The final component of AUL's *Child Protection Act* provides legal remedies for parents or guardians when a third-party such as an abortion clinic employee or a teacher attempts to aid a child in obtaining an abortion without involving her parents as required by the laws of her home state. States with an "X" in this column provide some legal remedy for parents whose legal rights have been violated.
- "Comprehensive Regulation of Abortion-Inducing Drugs and/or Prohibition of 'Telemed Abortions'": AUL's *Abortion-Inducing Drugs Safety Act* includes provisions strictly regulating the administration of abortion-inducing drugs such as RU-486 and effectively prohibiting the practice of "telemed abortions," where these dangerous drugs are provided without an in-person consultation with and examination by a physician. An "X" in this column denotes that a state has one or both of these provisions.
- "Five-Month Abortion Limitation": AUL's *Women's Health Defense Act* proscribes abortions at or after 5-months of pregnancy (*i.e.,* 20 weeks gestation) based on concerns for women's health and the pain experienced by an unborn child. In 2012, Arizona became the first state to enact this protective and innovative law. In this column, we note whether a state has an abortion prohibition beginning at 5-months and the basis for the prohibition: maternal health concerns, fetal pain, or both.

State-By-State Implementation of Women's Protection Project

(As of September 1, 2013)

State	Ambulatory Surgical Center Standards for Abortion Clinics	Informed Consent Law	Reflection Period	Parental Involvement Law	Parental Involvement Enhancements	Child Protection Act: Abortion Clinic Staff Are Mandatory Reporters	Child Protection Act: Requirement to Retain Evidence	Child Protection Act: Prohibits/ Penalizes Efforts to Circumvent Parental Involvement	ComprehensiveRegulation of Abortion-Inducing Drugs and/or Prohibition of "Telemed" Abortions	Five-Month Abortion Limitation
Alabama	X	X	X	Consent	Venue requirements	X			X	Five-month limitation based on fetal pain
Alaska		X		Notice(in litigation)	Evidentiary standards		X			
Arizona		X	X	Consent	Notarized consent; evidentiary standards; judicial bypass standards		X(limited applicability)		X	Five-month limitation based on maternal health concerns and fetal pain(in litigation)
Arkansas		X	X	Consent	Notarized consent; identification (in lieu of notarized consent)	X	X	X		Five-month limitation based on fetal pain
California		X								
Colorado				Notice	Evidentiary standards					
Connecticut		X								
Delaware				Notice						Five-month limitation
District of Columbia										
State	Ambulatory Surgical Center Standards for Abortion Clinics	Informed Consent Law	Reflection Period	Parental Involvement Law	Parental Involvement Enhancements	Child Protection Act: Abortion Clinic Staff Are Mandatory Reporters	Child Protection Act: Requirement to Retain Evidence	Child Protection Act: Prohibits/ Penalizes Efforts to Circumvent Parental Involvement	ComprehensiveRegulation of Abortion-Inducing Drugs and/or Prohibition of "Telemed" Abortions	Five-Month Abortion Limitation

State	Ambulatory Surgical Center Standards for Abortion Clinics	Informed Consent Law	Reflection Period	Parental Involvement Law	Parental Involvement Enhancements	Child Protection Act: Abortion Clinic Staff Are Mandatory Reporters	Child Protection Act: Requirement to Retain Evidence	Child Protection Act: Prohibits/ Penalizes Efforts to Circumvent Parental Involvement	ComprehensiveRegulation of Abortion-Inducing Drugs and/or Prohibition of "Telemed" Abortions	Five-Month Abortion Limitation
Florida		X		Notice	Notarized waiver of notice; venue requirements; notice post-emergency; evidentiary standards; judicial bypass standards					
Georgia		X	X	Notice	Identification (to waive notice)	X				Five-month limitation based on fetal pain (in litigation)
Hawaii										
Idaho		X	X	Consent	Evidentiary standards					Five-month limitation based on fetal pain (in litigation)
Indiana		X	X	Consent	Venue requirements	X			X	Five-month limitation based on fetal pain
Iowa				Notice		X				
Kansas		X	X	Consent	Notarized consent; evidentiary standards; judicial bypass standards; mental health evaluations		X		X	Five-month limitation based on fetal pain
Kentucky		X	X	Consent	Judicial bypass standards					
Louisiana		X	X	Consent	Notarized consent; venue requirements; evidentiary standards; judicial bypass standards; mental health evaluations				X	Five-month limitation based on fetal pain
Maine		X		Consent	Judicial bypass standards					

State	Ambulatory Surgical Center Standards for Abortion Clinics	Informed Consent Law	Reflection Period	Parental Involvement Law	Parental Involvement Enhancements	Child Protection Act: Abortion Clinic Staff Are Mandatory Reporters	Child Protection Act: Requirement to Retain Evidence	Child Protection Act: Prohibits/ Penalizes Efforts to Circumvent Parental Involvement	ComprehensiveRegulation of Abortion-Inducing Drugs and/or Prohibition of "Telemed" Abortions	Five-Month Abortion Limitation
Maryland				Notice						
Massachusetts				Consent						
Michigan		X	X	Consent	Venue requirements				X	
Minnesota		X	X	Notice						
Mississippi		X	X	Consent	Venue requirements; evidentiary standards	X	X		X	
Missouri	X	X	X	Consent	Judicial bypass standards	X		X	X	
Montana				Consent(in litigation)	Notarized consent; identification and proof of relationship; specific consent forms					
Nebraska		X	X	Consent	Notarized consent; evidentiary standards; judicial bypass standards				X	Five-month limitation based on fetal pain
Nevada		X								
New Hampshire				Notice						
New Jersey						X				
New Mexico										
New York										
North Carolina	TBD; awaiting implementing regulations for 2013 law	X(in litigation)	X(in litigation)	Consent	Venue requirements; judicial bypass standards	X				Five-month limitation
North Dakota		X	X	Consent	Venue requirements; evidentiary standards; judicial bypass standards				X(in litigation)	Five-month limitation based on fetal pain
Ohio		X	X	Consent	Venue requirements; evidentiary standards; evidentiary standards; judicial bypass standards				X(enforceable during litigation)	Five-month limitation based on fetal pain

State	Ambulatory Surgical Center Standards for Abortion Clinics	Informed Consent Law	Reflection Period	Parental Involvement Law	Parental Involvement Enhancements	Child Protection Act: Abortion Clinic Staff Are Mandatory Reporters	Child Protection Act: Requirement to Retain Evidence	Child Protection Act: Prohibits/ Penalizes Efforts to Circumvent Parental Involvement	ComprehensiveRegulation of Abortion-Inducing Drugs and/or Prohibition of "Telemed" Abortions	Five-Month Abortion Limitation
Oklahoma		X	X	Consent	Notarized consent; identification and proof of relationship; venue requirements; notice post- emergency; evidentiary standards; judicial bypass requirements; specific consent forms	X			X (part of law in litigation)	Five-month limitation based on fetal pain
Oregon										
Pennsylvania	X	X	X	Consent	Venue requirements; judicial bypass standards					
Rhode Island		X		Consent						
South Carolina		X	X	Consent	Judicial bypass standards					
South Dakota		X	X	Notice	Notarized waiver of notice; notice post-emergency; evidentiary standards				X	
Tennessee				Consent	Proof of relationship		X		X	
Texas	X	X	X	Consent	Notarized consent; verification of relationship; specific consent forms	X			X	Five-month limitation based on fetal pain
Utah		X	X	Consent						
Vermont										
Virginia	X	X	X	Consent						
Washington										
West Virginia		X	X	Notice	Venue requirements					
Wisconsin		X	X	Consent	Judicial bypass standards				X	
Wyoming		X		Consent	Evidentiary standards; judicial bypass standards	X				