# WOMEN'S PROTECTION PROJECT

AMERICANS UNITED FOR LIFE

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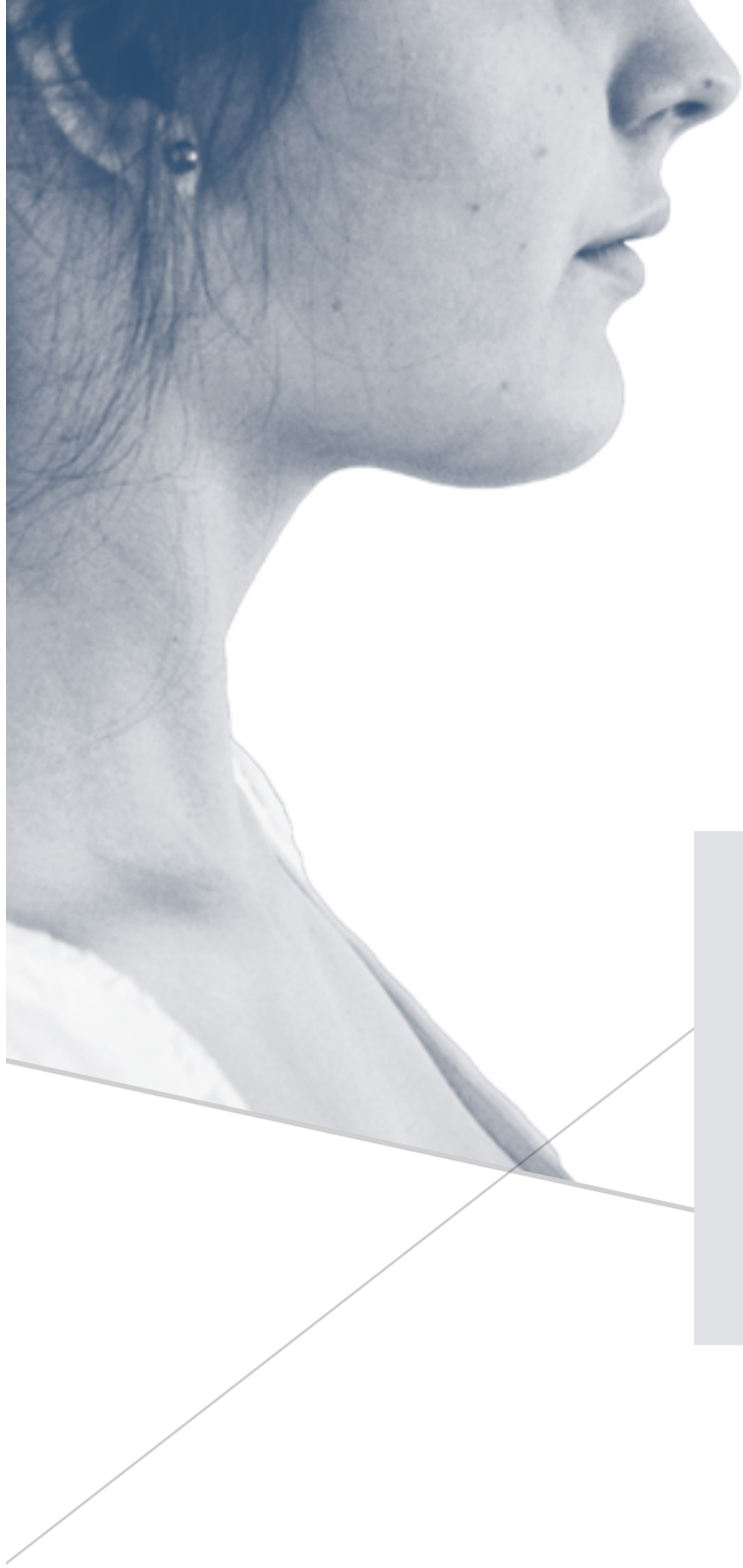

# *Introduction*

## Introduction

Charmaine Yoest, Ph.D., President and CEO, Americans United for Life

As we begin preparations for the 2014 state legislative sessions, Americans United for Life (AUL), the legal architect of the pro-life movement, has launched the *Women's Protection Project* to highlight abortion's negative impact on women and to recommend specific legislative solutions to the growing concerns regarding the health risks to women from abortion.

The U.S. Supreme Court has repeatedly made clear that the states have a legitimate interest in protecting maternal health from the onset of pregnancy. *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992). Moreover, the Court has held that legislative bodies enjoy wide discretion to enact regulations where there is medical uncertainty as to the safety of abortion procedures, both surgical and chemical. *Gonzalez v. Carhart*, 550 U.S. 124, 163 (2007). Whether it involves regulating abortion clinics or establishing the standard of care under which abortions are to be performed, laws predicated on the state's interest in safeguarding maternal health have the strongest potential both to protect women and to withstand potential judicial review.

As the first article in this volume, "Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women," explains, the evidence of abortion's devastating harms to women is overwhelming and growing. Consider this partial list of the short-term and long-term physical and psychological risks associated with abortion:

- **Short-term risks** include blood loss, blood clots, incomplete abortion, infections such as pelvic inflammatory disease, and cervical lacerations and other injuries to organs.

- **Premature birth:** At least 130 studies have shown an increased risk of subsequent premature birth and low birth weight infants following abortion. The increased risk of these serious complications is estimated to be approximately 37 percent after one abortion, 90 percent after two abortions, and further increased risk for each additional abortion.

- **Placenta previa** is the condition during pregnancy in which the placenta covers the cervix, increasing the risks of life-threatening maternal hemorrhage, premature birth, and perinatal child death. Abortion increases the risk of placenta previa in subsequent pregnancies by 30 to 50 percent, and much more so for women who have had multiple abortions.

- **Breast cancer:** It is undisputed that a woman's first full-term pregnancy reduces her risk of breast cancer. Moreover, numerous studies have shown that abortion may increase a woman's lifetime risk of breast cancer. For example, in one study funded by the National Cancer Institute, pro-choice researcher Dr. Janet Daling found that "among women who had been pregnant at least once, the risk of breast cancer in those who had experienced an induced abortion was 50 percent higher than among other women."

- **Mental health:** A 2011 study in the *British Journal of Psychiatry* examined 22 studies conducted from 1995 to 2009 and found that women face an 81 percent increased risk of mental health problems following abortion. There were increased risks of 34 percent for anxiety, 37 percent for depression, 110 percent for alcohol abuse, and 155 percent for suicide.



- **Maternal mortality:** Abortion advocates have long incorrectly asserted that abortion is safer than childbirth. Many studies show the opposite, including one that found maternal death to be three times more likely from abortion than from childbirth.

- **Risks of later-term abortions:** Abortion's risks increase the further into pregnancy it is performed. Beginning at five months of pregnancy, the risk of complications from abortion rises dramatically.

Despite growing evidence to the contrary, abortion advocates have long assured judges, legislators, and the American public that legalized abortion is beneficial to the health and well-being of American women. In support of these arguments, they have devised a litany of purported "advantages" including increased medical safety.

Abortion advocates continue to argue that, as long as abortion remains legal and readily available, the procedure will be safer for women, proper surgical procedures will be followed, and only skilled and reputable gynecologists and surgeons will perform the procedure. Legalized abortion is supposed to ensure that women receive proper care before, during, and after abortion procedures.

However, abortion advocates' lofty promises have proven false, and American women have instead confronted a different and far more dangerous reality. Today, abortion clinics across the nation have become the true "back-alleys" of abortion mythology. Legalized abortion has not eliminated substandard medical care or kept people without medical licenses from performing abortions. Because abortion is largely unregulated, women who seek legalized abortion continue to witness the use of dirty, unsanitary procedure rooms and unsterile, inadequate instrumentation, and experience the lack of competent post-abortion care. Moreover, legalized abortion has not prevented women from dying from unsafe abortions.

Importantly, there is abundant evidence to support the contention that abortion clinics are the true "back-alleys" that abortion advocates warned us about. AUL has documented that, since 2009, at least 86 abortion providers in at least 29 states have faced investigations, criminal charges, administrative complaints, and/or civil lawsuits or been cited for violating state laws governing the operation of abortion clinics.

In response to the well-documented risks of abortion and the epidemic of substandard abortion care, the *Women's Protection Project* features seven pieces of expertly crafted AUL model legislation:

- ***Abortion Patients' Enhanced Safety Act*** requiring abortion providers to meet the same patient care standards as other facilities performing outpatient surgeries.

- ***Women's Right to Know Act*** providing a woman, at least 24 hours before an abortion, with detailed information regarding her medical and psychological risks; her child's gestational age, development, and pain capability; and the abortion procedure itself.

- ***Parental Involvement Enhancement Act*** strengthening parental involvement laws with requirements for notarized consent forms; identification and proof of relationship for a parent or guardian; and more stringent standards for judicial bypass proceedings.

■ ***Child Protection Act*** strengthening requirements that family planning and abortion clinics report all cases of suspected statutory rape and sexual abuse and imposing strict penalties on those who circumvent these laws.

■ ***Abortion-Inducing Drugs Safety Act*** protecting women from unsafe "telemed" abortions (where abortion-inducing drugs are administered without a face-to-face examination by a physician) and the growing practice within the abortion industry not to follow FDA-approved protocols for the administration of these dangerous drugs.

■ ***Women's Health Defense Act*** limiting abortions at or after five months of pregnancy based on the substantial risks these abortions pose to women's health and the pain felt by unborn children.

■ An ***enforcement module*** providing options for the criminal, civil, and administrative enforcement of all abortion-related statutes including the component legislation of the *Women's Protection Project*.

There is much that can be done in 2014 to protect women from the harms inherent in abortion. In that regard, AUL's *Women's Protection Project* provides an excellent blueprint for medically appropriate and protective abortion regulations and limitations.

The legal and policy experts at Americans United for Life look forward to assisting state legislators and policymakers in implementing the legislative and policy goals of the *Women's Protection Project* and Defending Life!

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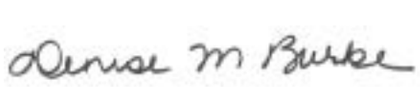

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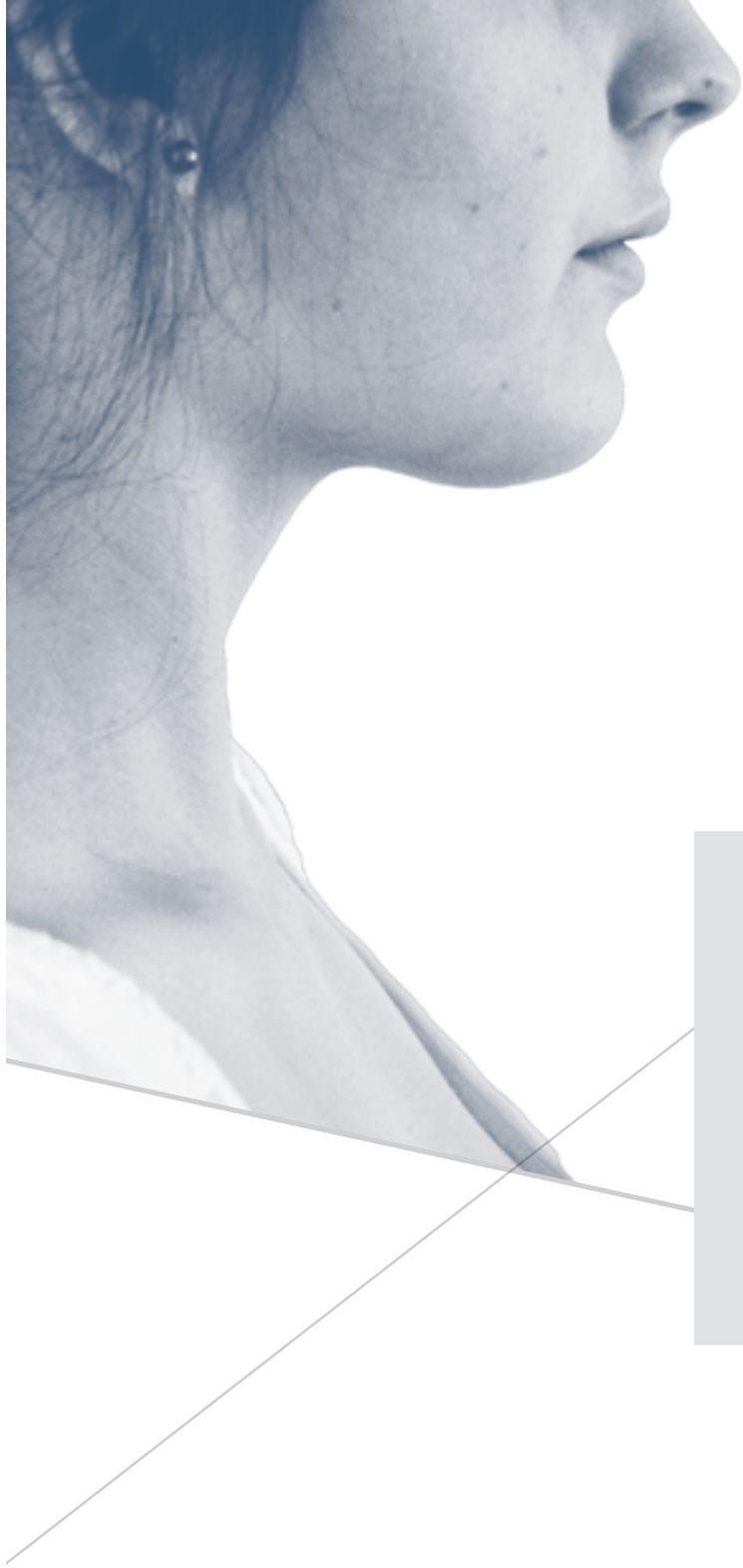


# *Significant Potential for Harm*

*Growing Medical Evidence of Abortion's Negative Impact on Women*

*"[I]f courts were to delve into the facts underlying Roe's balancing scheme with present-day knowledge, they might conclude that the woman's 'choice' is far more risky and less beneficial… than the Roe Court knew."*[2]

—Justice Edith Jones





## Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women

By Dr. Byron C. Calhoun, M.D.[1] and
Mailee R. Smith, J.D., Staff Counsel, Americans United for Life

In 1973, abortion was enshrined as a constitutional "right" by the U.S. Supreme Court without any real consideration of the impact of abortion on maternal health. No medical data was entered into the legal record. In fact, when *Roe v. Wade* was decided four decades ago, there were few, if any, peer-reviewed studies related to the long-term risks of abortion.[3]

In 2013, the medical landscape paints a different picture than that before the Supreme Court in 1973. We now know what the Justices did not know (or refused to consider) then—abortion harms women.

Since *Roe*, there have been more than 50 million abortions in the United States; estimates are that one out of three American women will have an abortion by the age of 45. As one peer-reviewed study has proclaimed, "[T]he high prevalence of a history of induced abortion means that even small positive or negative effects on long-term health could influence the lives of many women and their families."[4]

In other words, given the vast number of women who have had or will have an abortion, even a "small" increase in the risk of potential complications will affect a large number of women. However, medical evidence proves that there are much more than "small" risks involved in abortion; abortion carries significant short and long-term physical risks, as well as serious psychological risks. In fact, medical evidence now reveals that the risk of mortality is higher following abortion than it is following childbirth and that these risks increase substantially later in pregnancy.

### Short-Term Physical Risks of Abortion

The short-term risks of abortion are undisputed—even Planned Parenthood, the nation's largest abortion provider, acknowledges many of these risks.[5] Potential short-term risks include blood loss; blood clots; incomplete abortions, which occur when part of the unborn child or other products of pregnancy are not completely emptied from the uterus; infection, which includes pelvic inflammatory disease and infection caused by an incomplete abortion; and injury to the cervix and other organs, which includes cervical lacerations and incompetent cervix—a condition that affects subsequent pregnancies (and, therefore, is also a long-term risk of abortion).

More specifically, bleeding or hemorrhage occur in up to one percent of first-trimester abortions and in up to 2.5 percent of second trimester abortions and are caused by cervical laceration, uterine perforation, atony (loss of tone in uterine musculature), and retained pregnancy (incomplete abortion).[6] While this may appear to be a small percentage, it involves, as already stated, a significant number of American women. For example, the pro-abortion Guttmacher Institute estimates that there were 1.21 million abortions performed in 2008, with approximately 90 percent (or 1,089,000 abortions) occurring during the first trimester.[7] This translates to at least 10,890 women (1 percent of the first trimester abortions) who suffered from excessive blood loss following abortions in just 2008 alone.

Likewise, infection—the most common short-term complication—occurs in one to five percent of abortions.[8] Again, according to Guttmacher Institute's statistics, that means between 10,890 and 54,450 women who had first trimester abortions in 2008 suffered from infections following their abortions. Short-term risks such as hemorrhage, incomplete abortion, and infection are even more

common following medical abortions (*e.g.,* abortions using RU-486 or other drugs) than surgical abortions.[9]

Moreover, minors are even more susceptible to these short-term risks than are older women. For example, minors are up to twice as likely to experience cervical lacerations during abortion.[10] Researchers believe that smaller cervixes make it 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.[11] 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.

Medical abortions caused by abortion-inducing drugs (such as RU-486) also carry particular short-term risks. The drug's label acknowledges that "[n]early all of the women who receive Mifeprex and misoprostol will report adverse reactions, and many can be expected to report more than one such reaction."[12] These risks include, but are not limited to, abdominal pain, cramping, vomiting, headache, fatigue, uterine hemorrhage, viral infections, and pelvic inflammatory disease.[13]

Notably, even Planned Parenthood acknowledges that "safety is a concern" and that possible risks of medical abortions include allergic reactions to the drugs, incomplete abortions, infection, blood clots in the uterus, very heavy bleeding, and undetected ectopic pregnancies (which, if left undetected, can result in fallopian tube ruptures and fatal bleeding).[14]

Furthermore, RU-486 (also known as the Mifeprex regimen) has only been tested on women aged 18 to 46.[15] We simply do not yet know how the use of the Mifeprex regimen has impacted young women; however, we do know that, as of April 30, 2011, the FDA knew of 2,207 adverse events in the U.S. related to the use of RU-486, including hemorrhaging, blood loss requiring transfusions, serious infections, and women's deaths.[16] Among the 2,207 adverse events were 14 deaths, 612 hospitalizations, 339 blood transfusions, and 256 infections (including 48 "severe" infections).[17]

**Long-Term Physical Risks of Abortion**

While there were few, if any, studies on the long-term physical effects of abortion in 1973, today there is substantial medical data demonstrating that abortion can have a significant long-term physical impact. Three of the best documented areas are 1) an increased risk of pre-term birth in subsequent pregnancies, 2) an increased risk of placenta previa in subsequent pregnancies, and 3) an increased risk of breast cancer.

*Pre-Term Birth (Premature Birth)*

Pre-term birth occurs prior to the 37th week of pregnancy and is very dangerous to the child. According to the U.S. Centers for Disease Control, premature birth is the leading cause of infant mortality in the United States.[18] It is also a risk factor for later disabilities for the child, such as cerebral palsy and behavioral problems.[19]

Most women who abort do so early in their reproductive lives while desiring to have children at a later time.[20] However, induced abortion increases the risk of pre-term 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, in turn, responsible for an increased risk of pre-term birth.[21]

There are currently over 130 published studies showing a statistically significant association between induced abortion and subsequent pre-term birth or low birth weight. In 2009 alone, three different systematic studies demonstrated the risk of pre-term birth following abortion. P. Shah et al. reported that induced abortion increases the risk of pre-term birth in a subsequent pregnancy by 37 percent, with two or more abortions increasing the risk by 93 percent.[22] Similarly, R.H. van Oppenraaij et al. found that a single induced abortion raises the risk of subsequent pre-term birth by 20 percent, with two or more abortions increasing the risk by 90 percent.[23] Those researchers also found that a woman who has two or more abortions doubles her risk of subsequently having a "very" premature baby (before 34 weeks gestation).[24] Likewise, Swingle et al. reported an odds-ratio of a statistically significant 64 percent higher risk of "very pre-term birth" (before 32 weeks gestation) for a woman with one prior induced abortion.[25]

Then in 2012, a study found that two or more abortions increases the risk for very pre-term delivery (less than 28 weeks). In fact, the researchers demonstrated that two or more abortions increases the risk of delivering before 28 weeks by 69 percent, and with three or more abortions the risk for delivering before 28 weeks rises by a staggering 178 percent. Further, they found that after more than three abortions the risk for preterm delivery before 37 weeks increases by 35 percent. The risk for low birth weight of less than 2,500 grams (5.5 pounds) increased by 43 percent, while the risk for low birth weight of less than 1,500 grams (3.3 pounds) increased by over 125 percent.[26]

These recent studies simply confirmed what was already evident in the medical literature. For example, a 2005 study demonstrated that a woman who has an abortion is 50 percent more likely to deliver before 33 weeks, and 70 percent more likely to deliver before 28 weeks in subsequent pregnancies.[27] An earlier study demonstrated that a woman who has two abortions doubles her future risk of pre-term birth, and a woman who has four or more abortions increases the risk of pre-term birth by 800 percent.[28] Thus, not only does an abortion increase the risk of pre-term birth, but each additional abortion magnifies that risk.

The Institute of Medicine (IOM), which is part of the National Academy of Science, lists first-trimester abortion as a risk factor associated with subsequent pre-term birth.[29] Likewise, a renowned pregnancy resource book states, "[i]f you have had one or more induced abortions, your risk of prematurity with this pregnancy increases by about 30 percent."[30] The resource also states that birth before 32 weeks is 10 times more likely when a woman has an incompetent cervix—which has already been discussed as a common complication following abortion.[31]

Given the significant increased risk of pre-term birth following abortion, the millions of women who have had or will have abortions, and the fact that up to 75 percent of women who abort will have a subsequent pregnancy,[32] the potential impact of women's abortions on subsequent pregnancies is overwhelming.

*Placenta Previa*

Placenta previa occurs when the placenta covers all or part of the cervix during pregnancy; if it persists until labor, it carries substantial risks for both the mother and the unborn child. For the mother, the risks of placenta previa include life-threatening hemorrhage and post-partum hemorrhage. Risks to the child include pre-term birth and perinatal death. As one study has noted, placenta previa is the leading cause of uterine bleeding in the third trimester and of medically indicated pre-term birth.[33]

Abortion increases the risk of placenta previa in subsequent pregnancies. One study found an increased risk of 30 percent,[34] while three studies conducted before 2003 showed a 50 percent increased of placenta previa following abortion.[35] Another study indicated that two or more abortions more than doubles the risk of placenta previa in subsequent pregnancies.[36]

Thus, as with pre-term birth, the more abortions a woman has, the higher her risk of placenta previa in subsequent pregnancies. And again, because the vast majority of women who have had or will have abortions will have a subsequent pregnancy, this risk is substantial and affects hundreds of thousands of American women and their children.

*Breast Cancer*

An estimated 226,870 new cases of breast cancer were diagnosed in the United States in 2012.[37] It is also estimated that 39,510 women will die from breast cancer.[38]

As with every topic touching on the issue of abortion, the link between abortion and breast cancer (commonly known as the "ABC link") has been hotly disputed. However, it is scientifically undisputed that a woman's first full-term pregnancy reduces her risk of breast cancer.[39] Aborting a first pregnancy before 32 weeks eliminates this protective affect against breast cancer.[40] It is also undisputed that the earlier a woman has a first full-term pregnancy, the lower her lifetime risk of breast cancer.[41]

The science behind this reality is not hard to understand. Lifetime exposure to estrogen plays a role in the development of breast cancer.[42] While genetics also play a role, 90 percent of breast cancer cases are actually linked to lifetime exposure to estrogen and issues related to breast cancer maturation.[43]

A woman's level of estrogen increases at the time of her menstrual cycle; the more menstrual cycles a woman has in her lifetime, the greater her exposure to estrogen and potential risk of breast cancer development.[44] Thus, if a woman is very young at the age of first menstruation (menarche) and has late menopause, then her risk of breast cancer is greater than a woman with later menarche and earlier menopause.[45]

Further, during pregnancy, a woman's breast cells go through a transition and maturing process called differentiation:

> [W]hen a woman becomes pregnant she experiences a dramatic increase in her hormone levels of estradiol, progesterone, and hCG. The initial increase in hormone levels induces breast cells to divide and undergo a maturing process called differentiation, which lasts throughout a woman's pregnancy and is completed only after her first term baby is delivered.[46]

More specifically, during the first and second trimesters of pregnancy, the breasts develop merely by duplicating immature tissues. But once a woman passes the 32nd week of pregnancy, the immature cells develop into mature, cancer-resistant cells.[47]

It is also acknowledged by mainstream medical science that premature deliveries that occur before 32 weeks increase a woman's risk of breast cancer because she has more immature breast tissue and her level of estrogen is much higher.[48] In fact, by the end of the first trimester, a woman has 2,000 percent more estrogen in her body than before pregnancy.[49]

Thus, researchers agree that the maturation of breast cells in a woman's first full-term pregnancy offers a protective effect against future breast cancer development. More controversial is the data showing that there is a direct causal link between abortion and breast cancer. However, this data builds upon the same undisputed foundation.

As previously explained, hormone levels increase dramatically during pregnancy, with breast cells maturing only after the 32nd week of pregnancy. However, when a woman has an induced abortion, hormone levels fall rapidly, leaving her breast cells in a transitional state where they have increased in number but not completely matured (differentiated) and are vulnerable to carcinogens such as estrogen.[50]

Currently, at least 53 out of 68 worldwide studies demonstrate an association between abortion and subsequent breast cancer.[51] One of the most prominent of these studies was conducted by pro-choice researcher Dr. Janet Daling and specifically funded by the U.S. National Cancer Institute.[52]



Daling found that "among women who had been pregnant at least once, the risk of breast cancer in those who had experienced an induced abortion was 50 percent higher than among other women."[53] Rather than the typical 12 percent lifetime chance of developing breast cancer, a woman who aborted was found to have an 18 percent lifetime chance. Among women with a family history of breast cancer, Daling found an increased risk of 80 percent. Tragically, Daling found an increase in risk of 100 percent (a doubled risk) for women who obtained an abortion before the age of 18. For women who had a family history of breast cancer and obtained an abortion before the age of 18, the risk of subsequent breast cancer development was incalculably high. All 12 women in the study that fit into this category developed breast cancer by the age of 45.[54]

Two years later, in 1996, Dr. Joel Brind conducted a meta-analysis[55] of all existing studies that included specific data on induced abortion and breast cancer incidence.[56] After examining those studies, Dr. Brind calculated a 30 percent increased risk of breast cancer among women who obtained an abortion after their first full-term pregnancy, and a 50 percent increased risk of breast cancer among women who obtained an abortion before their first full-term pregnancy.[57] In 2000, Britain's Royal College of Obstetricians and Gynecologists (RCOG) reviewed the Brind study and concluded that the study had no methodological shortcomings and could not be disregarded.[58]

Indeed, the link between abortion and subsequent breast cancer similarly cannot be disregarded.

**Psychological Risks of Abortion**

Numerous peer-reviewed studies have examined the effect abortion has on the mental state of women and confirm that abortion poses significant risks, including increased risk of depression, anxiety, and even suicide. Importantly, in 2011, a landmark study published in the British Journal of Psychiatry (a publication of the Royal College of Psychiatrists) found that women face an 81 percent increased risk of mental health problems following abortion.[59] Specifically, women with a history of abortion had a 34 percent increased risk of anxiety, a 37 percent increased risk of depression, a 110 percent increased risk of alcohol use, and a 155 percent increased risk of suicide following abortion.[60]

Significantly, the study examined the results of 22 studies published between 1995 and 2009, included 877,181 women (163,831 who had aborted) from six countries, and utilized very stringent criteria. This study effectively confirmed what many medical researchers and physicians already knew: abortion puts women at risk for serious psychological harm.

For example, one leading study examined a sample group of over 500 women from birth to the age of 25.[61] The study, led by a pro-choice researcher D. Fergusson, was controlled for all relevant factors including prior history of depression, anxiety, and suicide ideation.[62]

Significantly, the Fergusson study found that 27 percent of women who aborted reported experiencing suicidal ideation, with as many as 50 percent of minors experiencing suicide or suicidal ideation.[63] The risk of suicide was three times greater for women who aborted than for women who delivered. Likewise, the researchers found that 42 percent of women who aborted reported major depression by age 25, and 39 percent of post-abortive women suffered from anxiety disorders by age 25.[64]

The Fergusson Study was not the first (nor the last) to demonstrate a connection between abortion and anxiety, depression, and suicide. Twice a team led by M. Gissler found that the suicide rate was nearly six times greater among women who aborted compared to women who gave birth.[65] Gilchrist et al. reported that, among women with no history of psychiatric illness, the rate of

deliberate self-harm was 70 percent higher after abortion than after childbirth.[66] In a comparison study of American women and Russian women, V.M. Rue et al. reported that 36.4 percent of the American women and 2.8 percent of the Russian women reported suicide ideation.[67] And in a study reported by D.C. Reardon et al., which controlled for prior mental illness, the suicide mortality rate was 3.1 times higher among women who aborted compared to those who delivered.[68]

The Reardon study, as well as others, also noted that a record-based measurement of suicide attempts before and after abortion has shown that the increase in suicide rates among aborting women is not related to previous suicidal behavior but is most likely related to adverse reactions to the abortion procedure.[69]

The statistics related to depression and anxiety are just as staggering. For example, a study performed by J.R. Cougle et al. 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.[70] The study noted that most previous studies had employed only short-term follow-up interviews at a small number of abortion clinics. Thus, data on post-abortion reactions was collected within hours or weeks of the event. Conversely, J.R. Cougle et al. examined the long-term psychological effects of abortion on women, looking at depression scores an average of eight years after the women's first pregnancy, adding validity to the study's conclusions.

Yet another study stated that "anxiety and depression have long been associated with induced abortion," and that anxiety is the most common adverse mental health complication of abortion.[71] Up to 30 percent of women experience extremely high levels of anxiety and stress one month after their abortions.[72]

These studies represent just a sampling of research demonstrating an increased risk of mental health problems following abortion. Numerous studies also link abortion with other mental health problems, such as sleep and eating disorders and an increased use of alcohol or other harmful substances—which, obviously, carry further health risks not immediately related to abortion, but stemming from the harmful effects of the initial abortion.

One further factor bears consideration here: women experiencing the greatest psychological harm are the least likely to report their psychological distress. For example, the study by J.R. Cougle et al. reported that women who conceal their abortions from others are more likely to suppress thoughts of the abortion, experience more intrusive abortion-related thoughts, and feel greater psychological distress.[73] In other words, women who admit having abortions may be less likely to experience psychological distress than those who conceal their abortions—meaning that the studies listed here likely reflect a smaller number of women who *admit* negative mental health effects as opposed to the larger number of women who actually *experience* them.

**Risk of Maternal Mortality**

When *Roe* was decided in 1973, it was assumed (without merit) that abortion is safer than childbirth, at least to a certain point in pregnancy. However, 40 years of medical research has undermined this unfounded assumption.

For example, in 2004, Gissler and colleagues compared the various pregnancy-associated outcomes—including live births, stillbirths, spontaneous abortions, ectopic pregnancies, and induced abortions—for all childbearing Finnish women.[74] The researchers reported:

> The pregnancy associated mortality ratio per 100,000 pregnancies increased only slightly for live births and stillbirths, but became sevenfold for spontaneous abortions and ectopic pregnancies, and 5.5-fold for induced abortions ... The outcome-specific denominator also revealed that the crude risk of a pregnancy-associated death was more than twice as high after a spontaneous abortion or an ectopic pregnancy and more than three times as high after an induced abortion than after a live birth or stillbirth."[75]

Pregnancy-associated deaths have usually been calculated using the number of live births as the denominator. But the Gissler study demonstrated that calculating pregnancy-associated deaths per 100,000 pregnancies with a specific pregnancy outcome gives a very different and more accurate picture of maternal mortality rates.

In 2011, a study using 42 years of national health data from the United Kingdom, Ireland, and Northern Ireland found that countries with legal abortion actually have a higher maternal mortality rate.[76] Researchers found that maternal mortality rates were much lower in Ireland (where elective abortion is illegal) than in England or Scotland (where elective abortion is legal). Specifically, in Ireland, there are 1-2 maternal deaths per 100,000 live births, whereas in England/Wales there are ten 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, as abortion advocates claim, then the data should confirm that maternal death rates are higher in countries where abortion is illegal. However, the data proves exactly the opposite: where abortion is restricted, maternal mortality rates decrease. Moreover, this landmark study was based upon real data from a national database, and not estimates as have been used in other studies on the maternal mortality rate following abortion.

In August 2012, a study out of Denmark reviewed medical records for almost a half million women who had their first pregnancies between 1980 and 2004, and compared these records with the death register and the abortion register. The results were significant: "Compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years."[77] This study is particularly striking for the range studied—even up to ten years after birth or abortion, more women die after abortion than after childbirth. Specifically, the study found that one abortion increased the risk of death by 45 percent (compared to no abortions and controlled for other reproductive outcomes). Two abortions increased the risk of death by 114 percent, and three abortions increased the risk of death by 191 percent. On the other hand, giving birth was associated with a *decreased* mortality risk for women who had experienced two, three, or more births.

A May 2012 Chilean study is particularly significant because it utilized national birth registry statistics and examined trends in maternal death both when abortion was legal in Chile (1957-1988) and after abortion was prohibited (1989-2007). The study found that death rates did not increase after abortion was made illegal, as abortion advocates averred it would. 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.[78] 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.[79] 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.

**Risks of Later-Term Abortions**

The likelihood of maternal harm from abortion depends upon the gestational age at the time of the abortion. The vast majority of abortions occur in the first trimester (up to 12 weeks gestation),

and the above-discussed risks certainly apply to those abortions.

But abortion carries even higher medical risk when performed later in pregnancy. Gestational age is the strongest risk factor for abortion-related mortality.[80] At least two studies have concluded that second-trimester abortions (at 13 to 24 weeks gestation) and third-trimester abortions (at or after 25 to 26 weeks gestation) pose more serious risks to women's physical health compared to first-trimester abortions.[81] Moreover, the incidence of major complications is highest after 20 weeks gestation.[82]

The incidence of death following abortion clearly illustrates the danger of later-term abortions. Compared to an abortion at eight weeks gestation, the relative risk of mortality increases exponentially (by 38 percent for each additional week) at higher gestations.[83] The risk of death at eight weeks gestation is one death per one million abortions; at 16 to 20 weeks, that risk rises to one death per 29,000 abortions; and at 21 weeks gestation or later, the risk of death is one per every 11,000 abortions.[84]

In other words, a woman seeking an abortion ***at 20 weeks is 35 times more likely to die from abortion*** than she was in the first trimester. ***At 21 weeks or more, she is 91 times more likely to die*** from abortion than she was in the first trimester.

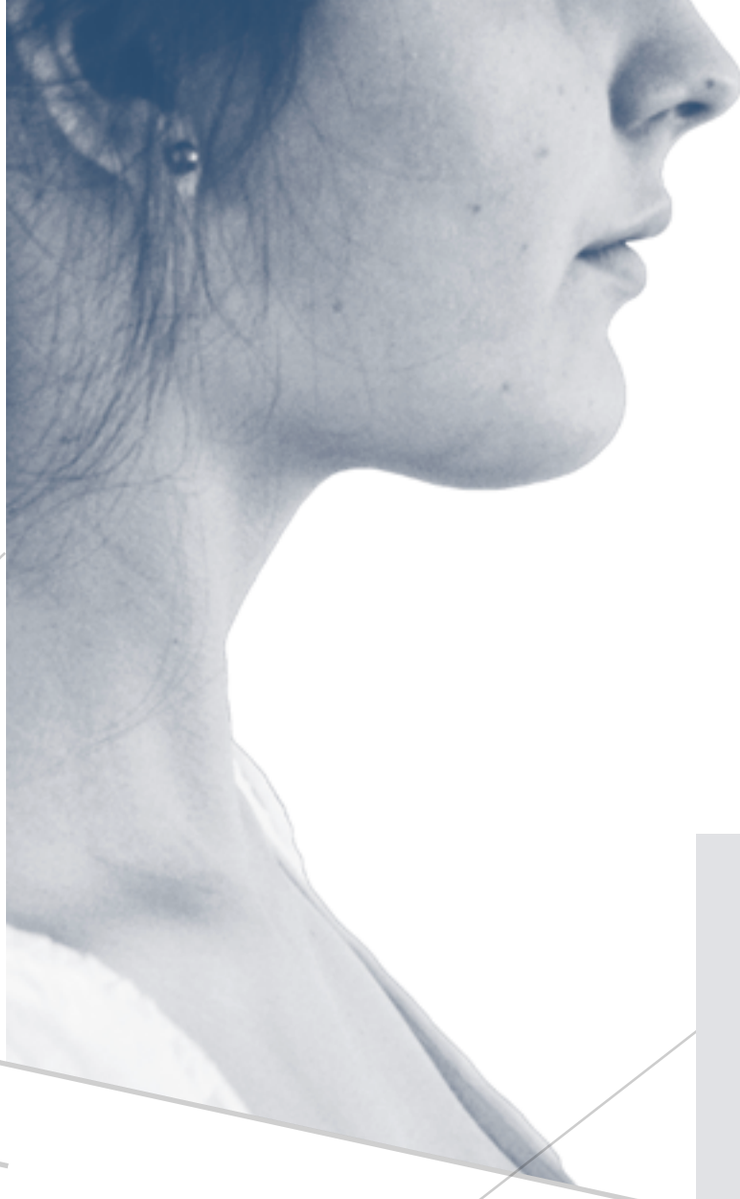
Researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."[85] This is because a later-term abortion requires a greater degree of cervical dilation, the increased blood flow in a later-term abortion predisposes the woman to hemorrhage, and the myometrium (middle layer of the uterine wall) is relaxed and more subject to perforation.[86]

Researchers have also found that women who undergo abortions at 13 weeks gestation or later report "more disturbing dreams, more frequent reliving of the abortion, and more trouble falling asleep."[87]

While the majority of abortions occur in the first trimester and not after 20 weeks gestation, the vast number of women having abortions in the United States means that the number of women affected by these later-term complications is not insignificant. Later-term abortions account for approximately 51,000 abortions annually—with 36,000 taking place between 16 and 20 weeks gestation, and 15,600 occurring after 20 weeks gestation.[88] This means that at least two or three women die each year from later-term abortions. Moreover, many women suffer from non-fatal complications every year following a later-term abortion.

## *Conclusion*

Abortion advocates claim that abortion is a safe procedure and is, in fact, "safer" than childbirth. These claims are false and ignore the medical data. Abortion causes harm—both physical and psychological—and this harm impacts large numbers of American women every year. Given that over 50 million abortions have been performed since 1973, the number of women harmed by abortion is considerable and growing.



# *Exposing the Pervasiveness of "Back Alley" Abortions*

By Denise M. Burke, J.D.
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]

—Late-term Abortionist Warren Hern





## Exposing the Pervasiveness of "Back Alley" Abortions

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

"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 concerned Americans rightly questioning the safety and legitimacy of abortion practice in this country.

For decades, abortion advocates have resolutely 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 Care**

Importantly, the epidemic of substandard abortion care is not just a recent phenomenon. Rather, it is a persistent, decades-long problem. Just a few illustrative examples of the poor – and often deadly – care women are receiving from Big Abortion 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 two-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 abortionist 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 abortionist, 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 abortionist Kermit Gosnell, currently serving a life sentence following convictions for murder, manslaughter, and hundreds of violations of Pennsylvania abortion laws, and 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.

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 abortionist, 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, abortion advocates must be leading the charge to ensure that abortion clinics are properly regulated and inspected and that all necessary steps are being taken to protect women.

If this is what you think and hope, you would be wrong. Rather, Americans United for Life, other pro-life advocates, and state officials are the ones who are working tirelessly to remedy the epidemic of substandard conditions at the nation's abortion clinics and promoting medically appropriate and comprehensive health and safety regulations for these facilities. They 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 care, 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 basic care at abortion clinics.[11] While these early efforts better regulated 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, Americans United for Life 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 high-quality patient care 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 for abortion care, 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 not the protectors of women's health that they so publicly hold themselves out to be. Nor can they be counted on 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 Ann'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.

*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, 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 abortion care and increased risk of death and serious complications.

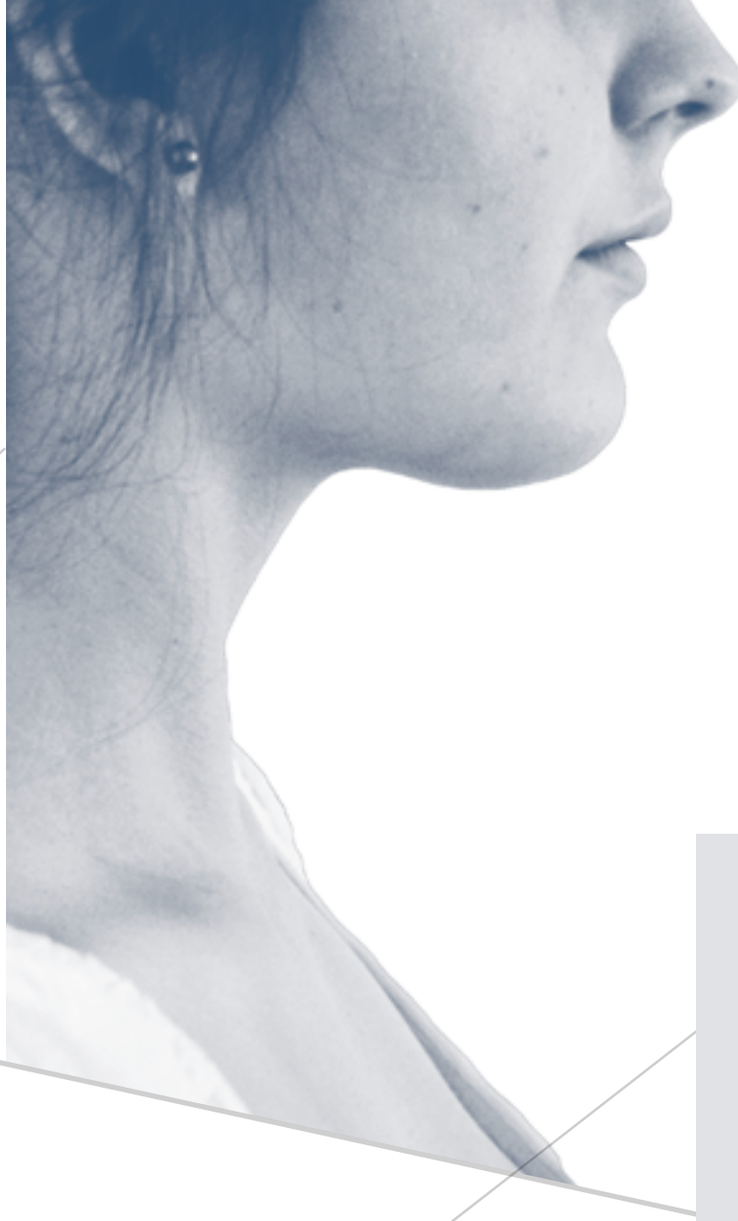
Since 2009, at least 86 abortion providers in at least 29 states have faced investigations, criminal charges, administrative complaints, and/or civil lawsuits or been cited for violating state laws governing the operation of abortion clinics. Abortion providers implicated in these actions over the past four years have included:

- The Beacon Women's Center in Montgomery, Alabama;[13]
- New Woman All Women Health Care in Birmingham, Alabama;[14]
- David Child in Arizona;[15]
- Little Rock Family Planning Services, PA in Arkansas;[16]
- Jesse James Joplin in California;[17]
- Feliciano Rios in California;[18]
- Andrew Rutland in California;[19]
- Planned Parenthood of the Rocky Mountains in Colorado;[20]
- The Atlantic Women's Medical Services abortion clinics in Dover and Wilmington, Delaware;[21]
- A Planned Parenthood clinic in Wilmington, Delaware;[22]
- Arturo Apolinario in Delaware; [23]
- Albert Dworkin in Delaware;[24] Both Dworkin and Apolinario had their medical licenses suspended for not reporting Kermit Gosnell for performing illegal late-term abortions at the Atlantic Women's Medical Services clinic in Wilmington;[25] Apolinario was also investigated for prescribing drugs illegally;[26]
- Timothy Liveright in Delaware.27 Liveright worked at Planned Parenthood's Wilmington clinic.
- James Pendergraft in Florida;[28]
- Randall Whitney in Florida;[29]
- Atlanta Women's Medical Center in Georgia;[30]
- Tyrone Malloy in Atlanta, Georgia;[31]
- Lawrence Miller in Savannah, Georgia;[32]
- A Planned Parenthood clinic on Chicago's (Illinois) Michigan Avenue following the death of Tonya Reaves;[33]
- Ulrich Klopher in Indiana;[34]
- Ann Kristin Neuhaus in Kansas;[35]
- EMW Women's Surgical Center in Louisville, Kentucky;[36]
- Delta Women's Clinic in Baton Rouge, Louisiana;[37]
- The Gentilly Medical Clinic for Women in New Orleans, Louisiana;[38]
- The Hope Medical Group for Women in Shreveport, Louisiana;[39]
- Associates in OB/GYN Care in Baltimore, Cheverly, Frederick, and Silver Spring, Maryland;[40]
- Germantown Reproductive Health Services (owned by Leroy Carhart) in Maryland;[41]
- Harold Alexander in Maryland;[42]
- Michael Basco in Maryland;[43]
- Steven Brigham in Maryland;[44] Brigham has also faced adverse actions in New Jersey and Pennsylvania.
- Leroy Carhart in Maryland;[45]
- Iris Dominy in Maryland;[46]
- Abolghassem Gohari in Maryland;[47]
- Mansour Panah in Maryland;[48]
- Nicola Riley in Maryland;[49] Riley has also faced adverse action in Utah.
- George Sheppard in Maryland;[50]
- Rapin Osathanondh in Massachusetts;[51]
- WomanCare of Southfield in Lathrup Village, Michigan;[52]
- Women's Medical Services in Muskegon, Michigan;[53]
- Robert Alexander in Michigan;[54]
- Alberto Hodari in Michigan;[55]
- Jackson Women's Health Organization, the only abortion clinic in Mississippi;[56]
- Lindsey Creekmore, a registered nurse in Leroy Carhart's Bellevue, Nebraska abortion clinic;[57]
- Steven Brigham in New Jersey;[58]
- A-1 Medicine Clinic in New York City;[59]
- Salomon Epstein in New York;[60]
- Southwestern Women's Options in New Mexico;[61]
- Curtis Boyd in New Mexico;[62]
- Shelley Sella in New Mexico;[63]
- A Preferred Women's Health Center in Charlotte, North Carolina;[64]
- Tami Lynn Holst Thorndike in North Dakota;[65]
- Capital Care Network abortion clinic in Cuyahoga Falls, Ohio;[66]
- Lebanon Road Surgery Center in Cincinnati, Ohio;[67]
- Martin Haskell, the abortionist credited with creating the partial-birth abortion technique, in Ohio;[68]
- Abortion as an Alternative, Inc. clinics in Philadelphia;[69]
- Allentown Medical Services in Allentown, Pennsylvania;[70]
- Steven Brigham in Pennsylvania;[71]
- Kermit Gosnell and the Women's Medical Society in West Philadelphia, Pennsylvania;[72]
- Soleiman Soli in Pennsylvania;[73]
- AAA Concerned Women's Center, Inc. in Houston, Texas;[74]
- Abortion Advantage in Dallas, Texas;[75]
- Routh Street Women's Clinic in Dallas, Texas;[76]
- The Reproductive Services Abortion Facility in El Paso, Texas;[77]
- Suburban Women's Medical Center in Houston, Texas;[78]
- West-Side Clinic Inc. in Fort Worth, Texas;[79]

- Whole Women's Health in Austin, Beaumont, and McAllen, Texas80
- Douglas Karpen in Texas;[81] Karpen is cur-rently under criminal investigation for allegations that he murdered born-alive infants and performed illegal late-term abortions.
- Robert E. Hanson Jr. in Texas;[82]
- Margaret Kini in Texas;[83]
- Pedro J. Kowalyszyn in Texas;[84]
- Sherwood C. Lynn Jr. in Texas;[85]
- Alan Molson in Texas;[86]
- Robert L. Prince in Texas;[87]
- H. Brook Randal in Texas;[88]
- Franz Theard in Texas;[89]
- William W. West Jr. in Texas;[90]
- Nicola Riley in Utah;[91]
- A Tidewater Women's Health Clinic in Norfolk, Virginia;[92]
- Planned Parenthood of Southeastern Virginia in Virginia Beach, Virginia;[93]
- Roanoke Medical Center for Women in Roanoke, Virginia;[94]
- Rodney Lee Stephens of Charleston, West Virginia;[95]
- Women's Health Center of West Virginia;[96]

# *Conclusion*

Tragically, these investigations into and the adverse findings from numerous state inspections of abortion providers are indicative of the substandard care that increasingly appears to be the norm in 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. And for the sake of American women, it is a reality that must be confronted and transformed through the implementation of stringent and medically appropriate standards for abortion patient care.[97]



## MAP

*"Back Alley Abortions in America"*

## CHARTS

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

# 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.

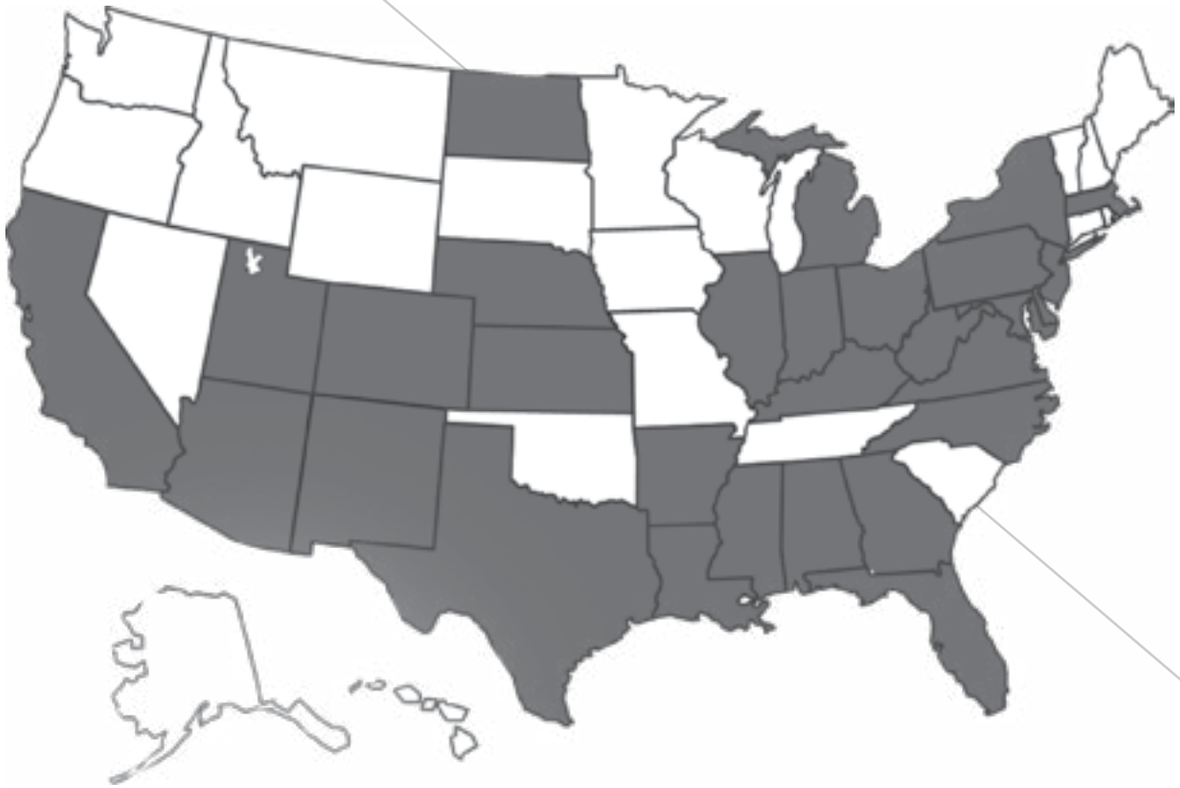
- "Child Protection Act": Requirement to Retain Evidence": The second major component of the "Child Protection Act" is a requirement that, when an abortion is performed on a girl under the age of 14, the abortion provider retain forensic evidence from the abortion that can be used in any subsequent investigation 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.

# "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.

# 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 |



Americans United for Life

| 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 | | | | |

AUL
Model Legislation:

*Women's Protection Project*

## *Drafter's note:*

The *Women's Protection Project* is comprised of six pieces of AUL model legislation, along with a new enforcement module. This legislative package is intended to be introduced and debated as a single, omnibus measure. However, some states maintain a "single subject" or similar rule for legislation, precluding the possibility of an omnibus measure. In those states, each component piece of legislation should be introduced separately. AUL legal and policy experts are available to provide advice and drafting assistance.

# Abortion Patients' Enhanced Safety Act

Drawing on decades of leadership and experience with regulating abortion facilities and providers, AUL's "Abortion Patients' Enhanced Safety Act" mandates that abortion clinics meet exacting and medically appropriate standards of patient care and requires regular inspections by state health officials. In light of the tragedy of Kermit Gosnell's "house of horrors" abortion clinic in Philadelphia and the fact that, since 2010, at least 15 states have launched investigations into abortion clinics and individual abortion providers, AUL's language provides the best means for protecting women from the all-too-often substandard conditions at today's "back alley" abortion clinics.

[**Drafter's Note:** *The best candidates for this legislation have an established record of enacting protective legislation such as comprehensive informed consent requirements, parental consent, ultrasound requirements, and comprehensive and specifically targeted abortion clinic regulations. Moreover, several issues will need to be carefully considered before introducing this legislation including whether or not the administration of abortion-inducing drugs such as RU-486 will be specifically covered or excluded. Moreover, states that have abortion clinic regulations already on the books may also want to consider enacting specific ambulatory surgical center standards to remedy noted deficiencies in the existing regulations. Please contact AUL for assistance in this regard.*]

**HOUSE/SENATE BILL No. _____**

**By Representatives/Senators _____**

**Section 1. Title.**

This Act may be known and cited as the "Abortion Patients' Enhanced Safety Act."

**Section 2. Legislative Findings and Purposes.**

(a) The Legislature of the State of [*Insert name of State*] finds that:

(1) The [*vast majority*] of all abortions in this State are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion either before or after the procedure and they do not return to the facility for post-surgical care. In most instances, the woman's only actual contact with the abortion provider occurs simultaneously with the abortion procedure, with little opportunity to ask questions about the procedure, potential complications, and proper follow-up care.

(2) For most abortions, the woman arrives at the clinic on the day of the procedure, has the procedure in a room within the clinic, and recovers under the care of clinic staff, all without a hospital admission.

(3) "The medical, emotional, and psychological consequences of an abortion are serious and can be lasting …." *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).

(4) Abortion is an invasive surgical procedure that can lead to numerous and serious medical complications. Potential complications for first trimester abortions include, among others, bleeding, hemorrhage, infection, uterine perforation, blood clots, cervical tears, incomplete abortion (retained tissue), failure to actually terminate the pregnancy, free fluid in the abdomen,

acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, reactions to anesthesia, fertility problems, emotional problems, and even death.

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

(6) The State of [*Insert name of State*] has a legitimate concern for the public's health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1985).

(7) The State of [*Insert name of State*] "has legitimate interests from the outset of pregnancy in protecting the health of women." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992). More specifically, the State of [*Insert name of State*] "has a legitimate concern with the health of women who undergo abortions." *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983)

(8) Moreover, the State of [*Insert name of State*] has "a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient." *Roe v. Wade*, 410 U.S. 113, 150 (1973).

(9) Since the Supreme Court's decision in *Roe v. Wade*, courts have repeatedly recognized that for the purposes of regulation, abortion services are rationally distinct from other routine medical services, because of the "particular gravitas of the moral, psychological, and familial aspects of the abortion decision." *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001).

(10) An ambulatory surgical center (ASC) [*or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)*] is a healthcare facility that specializes in providing surgery services in an outpatient setting. ASCs generally provide a cost-effective and convenient environment that may be less stressful than what many hospitals offer. Particular ASCs may perform surgeries in a variety of specialties or dedicate their services to one specialty.

(11) Patients who elect to have surgery in an ASC arrive on the day of the procedure, have the surgery in an operating room, and recover under the care of the nursing staff, all without a hospital admission.

(b) Based on the findings in subsection (a) of this Act, it is the purpose of this Act to:

(1) to define certain abortion clinics as "ambulatory surgical centers" [*or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)*] under the laws of this State and to subject them to licensing and regulation as such;

(2) to promote and enforce the highest standard for care and safety in facilities performing abortions in this State;

(3) to provide for the protection of public health through the establishment and enforcement of rigorous and medically appropriate standard of care and safety in abortion clinics; and

(4) to regulate the provision of abortion consistent with and to the extent permitted by the decisions of the Supreme Court of the United States.



**Section 3. Definitions.**

As used in this Act only:

(a) "**Abortion**" means the act of using or prescribing any instrument [*, medicine, drug, or any other substance, device, or means*][1] with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use [*, prescription, or means*] is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

(3) Remove an ectopic pregnancy.

(b) "**Abortion clinic**" means a facility, other than an accredited hospital, in which five (5) or more first trimester abortions in any month or any second or third trimester abortions are performed.

(c) "**Department**" means the [*Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities*] of the State of [*Insert name of State*].

**Section 4. Statutory Definition of "Ambulatory Surgical Center" [*Or Other Appropriate Term*] Modified to Include Certain Facilities Performing Abortions.**

(a) The term "**ambulatory surgical center**" [*or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)*] as used in [*Insert specific reference(s) to state statute(s), administrative rules, or other regulatory material(s) governing ambulatory surgical centers or similar state-regulated entities*] shall include abortion clinics which do not provide services or other accommodations for abortion patients to stay more than twenty-three (23) hours within the clinic.

(b) All ambulatory surgical centers [*or other appropriate term as used in existing state statutes, administrative rules, or other regulatory material(s)*] operating in this State including abortion clinics must meet the licensing and regulatory standards prescribed in [*Insert specific reference(s) to state statute(s), administrative rules, or other regulatory material(s) providing licensing and regulatory standards for ambulatory surgical centers or similar state-regulated entities*].

**Section 5. Criminal Penalties.**

Whoever operates an abortion clinic as defined in this Act without a valid ambulatory surgical center [*or other appropriate term as used in existing state statute(s), administrative rules, or other regulatory material(s)*] license issued by the Department is guilty of a [*Insert proper penalty/offense classification*].

**Section 6. Civil Penalties and Fines.**

(a) Any violation of this Act may be subject to a civil penalty or fine up to *[Insert appropriate amount*] imposed by the Department.

(b) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

[1] This language is used when state officials intend the regulations prescribed herein to apply to the provision of abortion-inducing drugs (such as the use of RU-486).

(c) In deciding whether and to what extent to impose fines, the Department shall consider the following factors:

(1) Gravity of the violation including the probability that death or serious physical harm to a patient or individual will result or has resulted;

(2) Size of the population at risk as a consequence of the violation;

(3) Severity and scope of the actual or potential harm;

(4) Extent to which the provisions of the applicable statutes or regulations were violated;

(5) Any indications of good faith exercised by licensee;

(6) The duration, frequency, and relevance of any previous violations committed by the licensee; and

(7) Financial benefit to the licensee of committing or continuing the violation.

(d) Both the Office of the Attorney General and the Office of the District Attorney [*or other appropriate classification such as "County Attorney"*] for the county in which the violation occurred may institute a legal action to enforce collection of civil penalties or fines.

**Section 7. Injunctive Remedies.**

In addition to any other penalty provided by law, whenever in the judgment of the Director of the [*Insert name of state department or agency that licenses and regulates ambulatory surgical centers or similar state-regulated entities*], any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this Act, the Director shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the Director that such person has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

**Section 8. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

**Section 9. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged.

**Section 10. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 11. Effective Date.**

This Act takes effect on [*Insert date*].

# Women's Right to Know Act

**Abortion clinics all too often fail to provide adequate and accurate information to women considering abortion. As a result, many women are physically and psychologically harmed by the abortion process. AUL's "The Woman's Right to Know Act" is designed to equip women with the knowledge they need before making an abortion decision and to ensure that their consent is valid. This Act would require basic information about the abortion procedure, its risks and alternatives, to be provided to women at least twenty-four (24) hours before an abortion.**

**HOUSE/SENATE BILL No. _____**

**By Representatives/Senators _____**

**Section 1. Title.**

This Act may be known and cited as the "Women's Right to Know Act." [*Or, alternatively, as the "Women's Health Information Act" or the "Informed Consent for Abortion Act"*]

**Section 2. Legislative Findings and Purposes.**

(a) The [*Legislature*] of the State of [*Insert name of State*] finds that:

(1) It is essential to the psychological and physical well-being of a woman considering an abortion that she receive complete and accurate information on abortion and its alternatives.

(2) The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two alternatives: giving birth or having an abortion.

(3) Adequate and legitimate informed consent includes information which "relat[es] to the consequences to the fetus." *Planned Parenthood v. Casey,* 505 U.S. 833, 882-883 (1992).

(4) [*Insert percentage*] of all abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision.

(5) The decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood v. Danforth,* 428 U.S. 52, 67 (1976).

(6) "The medical, emotional, and psychological consequences of an abortion are serious and can be lasting. . . ." *H.L. v. Matheson,* 450 U.S. 398, 411 (1981).

(7) Abortion facilities or providers often offer only limited or impersonal counseling opportunities.

(8) Many abortion facilities or providers hire untrained and unprofessional "counselors" to provide pre-abortion counseling, but whose primary goal is actually to "sell' or promote abortion services.

(b) Based on the findings in Subsection (a) of this Section, the purposes of this Act are to:

(1) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives and that every woman submitting to an abortion does so only after giving her voluntary and fully-informed consent to the abortion procedure;

(2) Protect unborn children from a woman's uninformed decision to have an abortion;

(3) Reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." *Planned Parenthood v. Casey,* 505 U.S. 833, 882 (1992); and

(4) Adopt the construction of the term "medical emergency" accepted by the U.S. Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

**Section 3. Definitions.**

For purposes of this Act only:

(a) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

(3) Remove an ectopic pregnancy.

(b) "**Complication**" means any adverse physical or psychological condition arising from the performance of an abortion, which includes but is not limited to: uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs; any psychological or emotional complications such as depression, anxiety, and sleeping disorders; and any other "adverse event" as defined by the Food and Drug Administration (FDA) criteria provided in the Medwatch Reporting System. The Department may further define "complication."

(c) "**Conception**" means the fusion of a human spermatozoon with a human ovum.

(d) "**Department**" means the Department of [*Insert appropriate title*] of the State of [*Insert name of State*].

(e) "**Facility**" or "**medical facility**" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(f) "**First trimester**" means the first twelve (12) weeks of gestation.

(g) "**Gestational age**" means the time that has elapsed since the first day of the woman's last menstrual period.

(h) "**Hospital**" means an institution licensed pursuant to the provisions of the law of this State.

(i) "**Medical emergency**" means that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(j) "**Physician**" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(k) "**Pregnant**" or "**pregnancy**" means that female reproductive condition of having an unborn child in the [*woman's*] uterus.

(l) "**Qualified person**" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.

(m) "**Unborn child**" means the offspring of human beings from conception until birth.

(n) "**Viability**" means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of his or her mother, with or without artificial support.

**Section 4. Informed Consent Requirement.**

No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(a) At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

(1) The name of the physician who will perform the abortion;

(2) Medically-accurate information that a reasonable patient would consider material to the decision of whether or not to undergo the abortion, including (a) a description of the proposed abortion method; (b) the immediate and long-term medical risks associated with the proposed abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or uterine perforation, danger to subsequent pregnancies, and increased risk of breast cancer; and (c) alternatives to the abortion;



(3) The probable gestational age of the unborn child at the time the abortion is to be performed;

(4) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(5) The medical risks associated with carrying her child to term; and

(6) Any need for anti-Rh immune globulin therapy if she is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy.

(b) At least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has informed the woman, orally and in person, that:

(1) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her and described in Section 5.

(2) The printed materials and informational DVD in Section 5 describe the unborn child and list agencies that offer alternatives to abortion.

(3) The father of the unborn child is liable to assist in the support of this child, even in instances where he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted.

(4) She is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally-funded benefits to which she might otherwise be entitled.

(5) The information contained in the printed materials and informational DVD given to her, as described in Section 5, are also available on a State-maintained website.

(c) The information required in Subsections 4(a) and 4(b) is provided to the woman individually and in a private room to protect her privacy, to maintain the confidentiality of her decision, and to ensure that the information focuses on her individual circumstances and that she has an adequate opportunity to ask questions.

(d) At least twenty-four (24) hours before the abortion, the woman is given a copy of the printed materials and permitted to view or given a copy of the informational DVD described in Section 5. If the woman is unable to read the materials, they shall be read to her. If the woman asks questions concerning any of the information or materials, answers shall be provided to her in a language she can understand.

[*Optional – Information on Fetal Pain: (e) At least twenty-four (24) hours prior to an abortion being performed or induced on an unborn child who is twenty (20) weeks gestation or more, the physician performing the abortion on the pregnant woman, the referring physician, or a qualified person assisting the physician shall, orally and in person, offer information on fetal pain to the pregnant woman. This information and counseling shall include, but shall not be limited to, the following:*

*(1) That, by twenty (20) weeks, the unborn child possesses all anatomical links in its nervous system (including spinal cord, nerve tracts, thalamus, and cortex) that are necessary in order to feel pain;*

*(2) That an unborn child who is twenty (20) weeks gestation or more is fully capable of experiencing pain;*

*(3) A description of the actual steps in the abortion procedure to be performed or induced, and at which steps in the abortion procedure the unborn child is capable of feeling pain;*

*(4) That maternal anesthesia typically offers little pain prevention for the unborn child; and*

*(5) That an anesthetic or analgesic is available in order to minimize and/or alleviate pain to the fetus*.]

[*(f)*] Prior to the abortion, the woman certifies in writing on a checklist form provided or approved by the Department that the information required to be provided under Subsections 5(a), 5(b), 5(c), and 5(d) have been provided. All physicians who perform abortions shall report the total number of certifications received monthly to the Department. The Department shall make the number of certifications received available to the public on an annual basis.

[*(g)*] Except in the case of a medical emergency, the physician who is to perform the abortion shall receive and sign a copy of the written certification prescribed in Subsection [*(f)*] of this Section prior to performing the abortion. The physician shall retain a copy of the checklist certification form in the woman's medical record.

[*(h)*] In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion shall clearly certify in writing the nature of the medical emergency and the circumstances which necessitated the waiving of the informed consent requirements of this Act. This certification shall be signed by the physician who performed the emergency abortion, and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion takes place.

[*(i)*] A physician shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 24-hour reflection period required in Subsections 4(a), 4(b), [*and*] 4(d)[*, and 4(e)*].

**Section 5. Publication of Materials.**

The Department shall cause to be published printed materials and an informational DVD in English and [*Spanish and other appropriate language(s)*] within [*Insert appropriate number*] days after this Act becomes law. The Department shall develop and maintain a secure internet website, which may be part of an existing website, to provide the information described in this Section. No information regarding persons using the website shall be collected or maintained. The Department shall monitor the website on a weekly basis to prevent and correct tampering.

On an annual basis, the Department shall review and update, if necessary, the following easily comprehensible printed materials and informational DVD:



(a) Geographically indexed materials that inform the woman of public and private agencies and services available to assist a woman through pregnancy, upon childbirth, and while her child is dependent, including but not limited to adoption agencies.

The materials shall include a comprehensive list of the agencies, a description of the services they offer, and the telephone numbers and addresses of the agencies, and shall inform the woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care.

The Department shall ensure that the materials described in this Section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any agency or service described in this Section. The materials shall also contain a toll-free, 24-hour-a-day telephone number which may be called to obtain information about the agencies in the locality of the caller and of the services they offer.

The materials shall state that it is unlawful for any individual to coerce a woman to undergo an abortion [*Insert reference to State's anti-coercion statute(s), if any*] and that if a minor is denied financial support by the minor's parents, guardian, or custodian due to the minor's refusal to have an abortion performed, the minor shall be deemed emancipated for the purposes of eligibility for public-assistance benefits, except that such benefits may not be used to obtain an abortion. The materials shall also state that any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action at law and that the law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care. The materials shall also include the following statement:

"There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of [*Insert name of State*] strongly urges you to contact one or more of these agencies before making a final decision about abortion. The law requires that your physician or his agent give you the opportunity to call agencies like these before you undergo an abortion."

(b) Materials that include information on the support obligations of the father of a child who is born alive, including but not limited to the father's legal duty to support his child, which may include child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate, by a statement of paternity, or by court action. The printed material shall also state that more information concerning establishment of paternity and child support services and enforcement may be obtained by calling State or county public assistance agencies.

(c) Materials that inform the pregnant woman of the probable anatomical and physiological characteristics of the unborn child at two (2) week gestational increments from fertilization to full term, including color photographs of the developing unborn child at two (2) week gestational increments. The descriptions shall include information about brain and heart functions, the presence of external members and internal organs during the applicable stages of development, and any relevant information on the possibility of the unborn child's survival. If a photograph is not available, a picture must contain the dimensions of the unborn child and must be realistic. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

(d) Materials which contain objective information describing the various surgical and drug-induced methods of abortion, as well as the immediate and long-term medical risks commonly associated with each abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or

uterine perforation or rupture, danger to subsequent pregnancies, increased risk of breast cancer, the possible adverse psychological effects associated with an abortion, and the medical risks associated with carrying a child to term.

(e)A uniform resource locator (URL) for the State-maintained website where the materials described in Subsections 5(a), 5(b), 5(c), and 5(d) can be found.

(f) A checklist certification form to be used by the physician or a qualified person under Subsection 4[*(f)*] of this Act, which will list all the items of information which are to be given to the woman by a physician or the agent under this Act.

(g) The materials shall be printed in a typeface large enough to be clearly legible.

(h) The Department shall produce a standardized DVD that may be used statewide, presenting the information described in Subsections 5(a), 5(b), 5(c), 5(d), and 5(e), in accordance with the requirements of those Subsections. In preparing the DVD, the Department may summarize and make reference to the printed comprehensive list of geographically indexed names and services described in Subsection 5(a). The DVD shall, in addition to the information described in Subsections 5(a), 5(b), 5(c), 5(d), and 5(e), show an ultrasound of the heartbeat of an unborn child at four (4) to five (5) weeks gestational age, at six (6) to eight (8) weeks gestational age, and each month thereafter, until viability. That information shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

(i) The materials required under this Section and the DVD described in Subsection 5(h) shall be available at no cost from the Department upon request and in appropriate number to any person, facility, or hospital.

**Section 6. Medical Emergencies.**

When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a 24-hour delay will cause substantial and irreversible impairment of a major bodily function.

**Section 7. Criminal Penalties.**

Any person who intentionally, knowingly, or recklessly violates this Act is guilty of a [*Insert appropriate penalty/offense classification*].

**Section 8. Civil Penalties.**

(a) In addition to any and all remedies available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

(1) Provide a basis for a civil malpractice action for actual and punitive damages.

(2) Provide a basis for a professional disciplinary action under [*Medical Malpractice Act*].

(b) No civil liability may be assessed against the female upon whom the abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.



(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

(e) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fee in favor of the defendant against the plaintiff.

**Section 9. Reporting.**

(a) For the purpose of promoting maternal health and life by adding to the sum of medical and public health knowledge through the compilation of relevant data, and to promote the State's interest in protecting the unborn child, a report of each abortion performed shall be made to the Department on forms prescribed by it. The reports shall be completed by the hospital or other licensed facility in which the abortion occurred, signed by the physician who performed the abortion, and transmitted to the Department within fifteen (15) days after each reporting month. The report forms shall not identify the individual patient by name and shall include the following information:

(1) Identification of the physician who performed the abortion, the facility where the abortion was performed, and the referring physician, agency, or service, if any. Notwithstanding any provision of law to the contrary, the Department shall ensure that the identification of any physician or other health care provider reporting under this Section shall not be released or otherwise made available to the general public.

(2) The county and state in which the woman resides.

(3) The woman's age.

(4) The number of prior pregnancies and prior abortions of the woman.

(5) The probable gestational age of the unborn child.

(6) The type of procedure performed or prescribed and the date of the abortion.

(7) Preexisting medical condition(s) of the woman which would complicate pregnancy, if any.

(8) Medical complication(s) which resulted from the abortion, if known.

[***Drafter's Note:*** *Please refer to AUL's "Abortion Complication Reporting Act" for more detail regarding reporting of abortion complications.*]

(9) The length and weight of the aborted child for any abortion performed pursuant to a medical emergency as defined in Section 6 of this Act.

(10) Basis for any medical judgment that a medical emergency existed which excused the physician from compliance with any provision of this Act.

(b) When an abortion is performed during the first (1st) trimester of pregnancy, the tissue that is removed shall be subjected to a gross or microscopic examination, as needed, by the physician or a qualified person designated by the physician to determine if a pregnancy existed and was terminated. If the examination indicates no fetal remains, that information shall immediately be made known to the physician and sent to the Department within fifteen (15) days of the analysis.

(c) When an abortion is performed after the first (1st) trimester of pregnancy, the physician must certify whether or not the child was viable, and the dead unborn child and all tissue removed at the time of the abortion shall be submitted for tissue analysis to a board-eligible or certified pathologist. If the report reveals evidence of viability or live birth, the pathologist shall report such findings to the Department within fifteen (15) days, and a copy of the report shall also be sent to the physician performing the abortion. The Department shall prescribe a form on which pathologists may report any evidence of live birth, viability, or absence of pregnancy.

(d) Every facility in which an abortion is performed within this State during any quarter year shall file with the Department a report showing the total number of abortions performed within the hospital or other facility during that quarter year. This report shall also show the total abortions performed in each trimester of pregnancy. These reports shall be submitted on a form prescribed by the Department that will enable a facility to indicate whether or not it is receiving any State-appropriated funds. The reports shall be available for public inspection and copying only if the facility receives State-appropriated funds within the twelve (12)-calendar-month period immediately preceding the filing of the report. If the facility indicates on the form that it is not receiving State-appropriated funds, the Department shall regard that facility's report as confidential unless it receives other evidence that causes it to conclude that the facility receives State-appropriated funds.

(e) After thirty (30) days public notice following the law's enactment, the Department shall require that all reports of maternal deaths occurring within the State arising from pregnancy, childbirth, or intentional abortion state the cause of death, the duration of the woman's pregnancy, when her death occurred, and whether or not the woman was under the care of a physician during her pregnancy prior to her death. The Department shall issue any necessary regulations to assure that information is reported, and conduct its own investigation, if necessary, to ascertain such data.

Known incidents of maternal mortality of nonresident women arising from induced abortion performed in this State shall be included in the report as incidents of maternal mortality arising from induced abortions.

Incidents of maternal mortality arising from continued pregnancy or childbirth and occurring after induced abortion has been attempted but not completed, including deaths occurring after induced abortion has been attempted but not completed as a result of ectopic pregnancy, shall be included as incidents of maternal mortality arising from induced abortion.

(f) Every physician who is called upon to provide medical care or treatment to a woman who is in need of medical care because of a complication or complications resulting, in the good faith judgment of the physician, from having undergone an abortion or attempted abortion, shall prepare a report. The report must be filed with the Department within thirty (30) days of the date of the physician's first examination of the woman. The report shall be on forms prescribed by the Department. The forms shall contain the following information, as received, and such other information except the name of the patient, as the Department may from time to time require:

(1) Age of the patient;

(2) Number of pregnancies patient may have had prior to the abortion;

(3) Number and type of abortions patient may have had prior to this abortion;

(4) Name and address of the facility where the abortion was performed;



(5) Gestational age of the unborn child at the time of the abortion, if known;

(6) Type of abortion performed, if known;

(7) Nature of complication or complications;

(8) Medical treatment given; and

(9) The nature and extent, if known, of any permanent condition caused by the complication.

(g) Reports filed pursuant to Subsections 9(a) or 9(f) shall not be deemed public records and shall remain confidential, except that disclosure may be made to law enforcement officials upon an order of a court after application showing good cause. The court may condition disclosure of the information upon any appropriate safeguards it may impose.

(h) The Department shall prepare a comprehensive annual statistical report for the Legislature based upon the data gathered from reports under Subsections 9(a) and 9(f). The statistical report shall not lead to the disclosure of the identity of any physician or person filing a report under Subsections 9(a) or 9(f), nor of any patient about whom a report is filed. The statistical report shall be available for public inspection and copying.

(i) Original copies of all reports filed under Subsections 9(a), 9(d), and 9(f) shall be available to the [*State Medical Board*] for use in the performance of its official duties.

(j) The following penalties shall attach to any failure to comply with the requirements of this Section:

(1) Any person required under this Section to file a report, keep any records, or supply any information, who willfully fails to file such report, keep such records, or supply such information at the time or times required by law or regulation, is guilty of "unprofessional conduct," and his or her license for the practice of medicine and surgery shall be subject to suspension or revocation in accordance with procedures provided under the [*Medical Practice Act*].

(2) Any person who willfully delivers or discloses to the Department any report, record, or information known by him or her to be false is guilty of a [*Insert appropriate penalty/offense classification*].

(3) Any person who willfully discloses any information obtained from reports filed pursuant to Subsection 9(a) or 9(f), other than that disclosure authorized under Subsection 9(g), or as otherwise authorized by law, is guilty of a [*Insert appropriate penalty/offense classification*].

(4) Intentional, knowing, reckless, or negligent failure of the physician to examine an unborn child or tissue remains or submit an unborn child or tissue remains to a pathologist as required by Subsections 9(b) or 9(c), or intentional, knowing, or reckless failure of the pathologist to report any evidence of live birth or viability to the Department in the manner and within the time prescribed in Subsection 9(c) is a [*Insert appropriate penalty/offense classification*].

(5) In addition to the above penalties, any person, organization, or facility who willfully violates any of the provisions of this Section requiring reporting shall upon conviction:

a. For the first time, have his, her, or its license suspended for a period of six (6) months.

b. For a second time, have his, her, or its license suspended for a period of one (1) year.

c. For the third time, have his, her, or its license revoked.

(k) The Department shall create the forms required by this Act within sixty (60) days after the effective date of this Act and shall cause to be published, within ninety (90) days after the effective date of this Act, the printed materials described in this Act. No provision of this Act requiring the reporting of information on forms published by the Department, or requiring the distribution of printed materials published by the Department pursuant to this Act, shall be applicable until ten (10) days after the requisite forms are first created and printed materials are first published by the Department or until the effective date of this Act, whichever is later

**Section 10. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

**Section 11. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

**Section 12. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 13. Effective Date.**

This Act takes effect on [*Insert date*].





# Parental Involvement Enhancement Act

**Americans, by a wide majority, support laws requiring parental consent or notice prior to a chemical or surgical abortion procedure being performed on a minor. Specifically, these laws boast a 71 % nationwide approval rating, protect the health and wellbeing of minors, respect parental rights, and save the lives of unborn babies.**

**AUL's "Parental Involvement Enhancement Act" provides a variety of legally sound options to enhance the protections already available in existing parental involvement laws including notarization requirements, requirements for identification and proof of relationship, more stringent standards for judicial bypass proceedings, and mandates that abortion providers fully disclose and discuss abortion's risks and alternatives with both the minor and her parents or guardians.**

**HOUSE/SENATE BILL No. _____**

**By Representatives/Senators _____**

[***Drafter's Note:*** *The Sections in this model may be enacted individually or in groups, depending on the needs of an individual state. Each substantive Section contains a drafter's note indicating when enactment of the enhancement would be appropriate, and provides language that may be tailored to fit a state's particular law. For assistance in drafting a complete overhaul of a state's parental notice or consent law, please see also AUL's "Parental Consent for Abortion Act" or "Parental Notification of Abortion Act."*]

**Section 1. Short Title.**

This Act may be cited as the "Parental Involvement Enhancement Act."

**Section 2. Legislative Findings and Purposes.**

(a) The Legislature of the State of [*Insert name of State*] finds that:

(1) Immature minors often lack the ability to make fully informed choices that take into account both immediate and long-range consequences.

(2) The medical, emotional, and psychological consequences of abortion are sometimes serious and can be lasting, particularly when the patient is immature.

(3) The capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.

(4) Parents ordinarily possess information essential to a physician's exercise of his or her best medical judgment concerning the child.

(5) Parents who are aware that their minor daughter has had an abortion may better ensure that she receives adequate medical attention after her abortion.

(6) Parental consultation is usually desirable and in the best interests of the minor.

(b) The [*Legislature*]'s purposes in enacting this enhancement to the State of [*Insert name of State*]'s parental [*consent or notice*] law are to further the important and compelling State interests of:

(1) Protecting minors against their own immaturity;

(2) Fostering family unity and preserving the family as a viable social unit;

(3) Protecting the constitutional rights of parents to rear children who are members of their household;

(4) Reducing teenage pregnancy and abortion; and

(5) In light of the foregoing statements of purpose, allowing for judicial bypasses of the parental [*consent or notice*] requirement to be made only in exceptional or rare circumstances.

**Section 3. Definitions.**

[***Drafter's Note:*** *These are recommended definitions, but some may not be compatible with a state's existing parental involvement law. In drafting a specific bill, care should be taken to select only those definitions that are compatible with existing state law or with the intent of the new bill.*]

For purposes of this Act only:

(a) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

(3) Remove an ectopic pregnancy.

(b) "**Actual notice**" means the giving of notice directly, in person or by telephone.

(c) "**Constructive notice**" means notice by certified mail to the last known address of the parent or guardian with delivery deemed to have occurred forty-eight (48) hours after the certified notice is mailed.

(d) "**Coercion**" means restraining or dominating the choice of a pregnant woman by force, threat of force, or deprivation of food and shelter.

(e) "**Consent**" means, in the case of a pregnant woman who is less than eighteen (18) years of age, a notarized written statement signed by the pregnant woman and her mother, father, or legal guardian declaring that the pregnant woman intends to seek an abortion and that her mother, father, or legal guardian consents to the abortion; or, in the case of a pregnant woman who is an incompetent person, a notarized written statement signed by the pregnant woman's guardian declaring that the guardian consents to the performance of an abortion upon the pregnant woman.



(f) "**Department**" means the Department of [*Insert appropriate title*] of the State of [*Insert name of State*].

(g) "**Emancipated minor**" means any person under eighteen (18) years of age who is or has been married or who has been legally emancipated.

(h) "**Incompetent**" means any person who has been adjudged a disabled person and has had a guardian appointed for her under the [*State Probate Act or other appropriate state law*].

(i) "**Medical emergency**" means a condition that, on the basis of the physician's good-faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

(j) "**Neglect**" means the failure of a parent or legal guardian to supply a minor with necessary food, clothing, shelter, or medical care when reasonably able to do so or the failure to protect a minor from conditions or actions that imminently and seriously endanger the minor's physical or mental health when reasonably able to do so.

(k) "**Physical abuse**" means any physical injury intentionally inflicted by a parent or legal guardian on a minor.

(l) "**Physician**," "**attending physician**," or "**referring physician**" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(m) **"Pregnant woman"** means a woman who is pregnant and is less than eighteen (18) years of age and not emancipated, or who has been adjudged an incompetent person under [*Insert citation(s) or other reference(s) to state statute(s) relating to petition and hearing; independent evaluation, etc.*].

(n) "**Sexual abuse**" means any sexual conduct or sexual penetration as defined in [*Insert citation(s) or other reference(s) to appropriate section(s) of the state criminal code or other appropriate law(s)*] and committed against a minor by a parent or legal guardian.

**Section [*4*]. Notarized Consent.**

[***Drafter's Note:*** *This enhancement is appropriate for a state with a parental consent law that does not already require notarized consent*.]

(a) No person shall perform an abortion upon a pregnant woman unless, in the case of a woman who is less than eighteen (18) years of age, he or she first obtains the notarized written consent of both the pregnant woman and one of her parents or her legal guardian; or, in the case of a woman who is an incompetent person, he or she first obtains the notarized written consent of her guardian.

(b) The physician shall keep the notarized written consent of the parent or legal guardian in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

**Section [*5*]. Notarized Waiver of Notice Requirement.**

[***Drafter's Note****: This enhancement is appropriate for a state with a parental notice law that permits the person(s) entitled to notice to waive the requirement*.]

(a) Notice is not required if the physician obtains a notarized written statement by the pregnant woman's parent or legal guardian, dated not more than 30 days before the abortion, waiving the right of the parent or legal guardian to notice of the pregnant woman's abortion.

(b) The physician shall keep a copy of the notarized written statement of the parent or legal guardian waiving their right to notice in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

**Section [*6*]. Proof of Identification and Relationship to Pregnant Woman – Consent.**

[***Drafter's Note:*** *This enhancement is appropriate for a state with a parental consent law that does not require the consenting parent or guardian to provide identification or proof of the parent or guardian's relationship to the pregnant woman.*]

(a) The physician shall obtain from the parent or legal guardian entitled to consent:

(1) Government-issued proof of the identity of the parent or legal guardian; and

(2) Written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the pregnant woman.

(b) The physician shall keep a copy of the proof of identification of the parent or legal guardian and the written documentation that establishes the relationship of the parent or legal guardian to the pregnant woman in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

(c) A physician receiving parental consent under this section shall execute for inclusion in the medical record of the pregnant woman an affidavit stating: "I, (Insert name of physician), certify that according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the pregnant woman and her parent or legal guardian as sufficient evidence of identity and relationship."

**Section [*7*]. Proof of Identification and Relationship to Pregnant Woman – Waiver of Notice Requirement.**

[***Drafter's Note:*** *This enhancement is appropriate for a state with a parental notice law that permits the person(s) entitled to notice to waive the requirement.*]

(a) In lieu of the notice required by this section, the physician shall obtain from the parent or legal guardian entitled to notice:

(1) Government-issued proof of the identity of the parent or legal guardian;

(2) Written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the pregnant woman; and

(3) A signed statement by the parent or legal guardian that the parent or legal guardian has been notified that an abortion is to be performed on the pregnant woman.

(b) The physician shall keep a copy of the proof of identification of the parent or legal guardian and the written documentation that establishes the relationship of the parent or legal guardian to the pregnant woman in the medical file of the pregnant woman for five (5) years past the majority of the pregnant woman, but in no event less than seven (7) years.

(c) A physician receiving parental notice under this section shall execute for inclusion in the medical record of the pregnant woman an affidavit stating: "I, (Insert name of physician), certify that according to my best information and belief, a reasonable person under similar circumstances would rely on the information presented by both the pregnant woman and her parent or legal guardian as sufficient evidence of identity and relationship."

**Section [*8*]. Notice of Post-Emergency.**

[***Drafter's Note:*** *This enhancement is appropriate for states with parental consent or parental notification laws. This suggested language is based on laws in Oklahoma, Florida, and South Dakota.*]

(a) [*Consent or Notice*] shall not be required under section [*Insert section number*] of this Act if the attending physician certifies in the minor or incompetent woman's medical record that a medical emergency exists and there is insufficient time to [*obtain the required consent or provide the required notice*]. However, the attending physician shall, within twenty-four (24) hours after completion of the abortion, notify one of the parents or the legal guardian of the minor or incompetent woman in the manner provided in this section that a medical emergency abortion was performed on the minor or incompetent woman and of the circumstances that warranted invocation of this section.

(b) Unless the minor or incompetent woman gives notice of her intent to seek a judicial waiver pursuant to section [*Insert number for judicial waiver section*] of this [*Act*], the attending physician shall verbally inform the parent or legal guardian of the minor or incompetent woman within twenty-four (24) hours after the performance of a medical emergency abortion that an abortion was performed on the minor or incompetent woman. The attending physician shall also inform the parent or legal guardian of the basis for the certification of the physician required under paragraph (a) of this section, and provide details regarding any additional risks to the minor or incompetent woman. The attending physician shall also send a written notice of the performed abortion by certified mail to the last known address of the parent or legal guardian, restricted delivery, return receipt requested.

(c) If the minor or incompetent woman gives notice to the attending physician of her intent to seek a judicial waiver pursuant to section [*Insert number for judicial waiver section*] of this title, the physician shall file a notice with any judge of a court of competent jurisdiction that the minor has given such notice and shall provide the information the physician would have been required to provide the parent under paragraph (b) of this section if the minor or incompetent woman had not given notice of her intent to seek a judicial waiver.

(d) The court shall expeditiously schedule a confidential conference with notice to the minor or incompetent woman and the physician. If the minor or incompetent woman is able to participate in the proceedings, the court shall advise the minor or incompetent woman that she has the right to court-appointed counsel and shall, upon her request, provide the minor or incompetent woman with such counsel. If the minor or incompetent woman is unable to participate, the court shall appoint counsel on behalf of the minor or incompetent woman.

(e) After an appropriate hearing, the court, taking into account the medical condition of the minor or incompetent woman, shall set a deadline by which the minor or incompetent woman must file a petition or motion pursuant to section [*Insert number for judicial waiver section*] of this [*Act*]. The court may subsequently extend the deadline in light of the medical condition of the minor or incompetent woman or other equitable considerations. If the minor or incompetent woman does not file a petition or motion by the deadline, either in that court or in another court of competent jurisdiction

with a copy filed in that court, the court shall direct that the court clerk provide the notice to a parent or legal guardian.

**Section [*9*]. Venue.**

[***Drafter's Note:*** *This enhancement is for any state that does not restrict the venue in which a minor may file a petition for judicial waiver of the state's consent or notice requirement.*]

The pregnant woman may petition a [*circuit*] court in the county in which the pregnant woman resides for a waiver of the [*consent or notice*] requirement.

**Section [*10*]. Burden of Evidence for Bypass.**

[***Drafter's Note:*** *This enhancement is for a state that wishes to define or to provide a heightened evidentiary requirement in judicial waiver proceedings.*]

(a) If the court finds, by clear and convincing evidence, that the pregnant woman is both sufficiently mature and well-informed to decide whether to have an abortion, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the [*consent or notification*] of a parent or guardian and the court shall execute the required forms. If the court does not make the finding specified in this subsection or subsection (b) of this section, it shall dismiss the petition.

(b) If the court finds, by clear and convincing evidence, that the pregnant woman is the victim of physical or sexual abuse by one or both of her parents or her legal guardian, or that [*obtaining the consent or the notification*] of a parent or legal guardian is not in the best interest of the pregnant woman, the court shall issue an order authorizing the pregnant woman to consent to the performance or inducement of an abortion without the [*consent or notification*] of a parent or guardian. If the court does not make the finding specified in this subsection or subsection (a) of this section, it shall dismiss the petition.

**Section [*11*]. Judicial Bypass Standards.**

[***Drafter's Note:*** *This enhancement is for states that want to enact specific standards for courts to use when evaluating judicial waiver petitions*.]

(a) If the pregnant woman claims to be mature and well-informed at a proceeding held pursuant to [*Insert section number*], the pregnant woman must prove by clear and convincing evidence that she is sufficiently mature and capable of giving informed consent without [*obtaining consent from or giving notice to*] her parent or legal guardian based on her experience level, perspective, and judgment.

(b) In assessing the pregnant woman's experience level, the court may consider, among other relevant factors, the pregnant woman's age and experiences working outside the home, living away from home, traveling on her own, handling personal finances, and making other significant decisions. In assessing the pregnant woman's perspective, the court may consider, among other relevant factors, what steps the pregnant woman took to explore her options and the extent to which she considered and weighed the potential consequences of each option. In assessing the pregnant woman's judgment, the court may consider, among other relevant factors, the pregnant woman's conduct since learning of her pregnancy and her intellectual ability to understand her options and to make an informed decision.

(c) In assessing whether, by clear and convincing evidence, [*obtaining the consent or notification*] of a pregnant woman's parent or guardian is not in her best interest, a court may not consider the potential financial impact on the pregnant woman or the pregnant woman's family if the pregnant woman does not have an abortion.



**Section [*12*]. Mental Health Evaluation.**

[***Drafter's Note:*** *This enhancement is for any state that wants to better protect minors from their own immaturity or coercion or abuse by others, and is based on Louisiana law.*]

(a) Prior to court proceedings addressing a petition for judicial waiver, the court may require the pregnant woman to participate in an evaluation and counseling session with a mental health professional from the [*State Health Department*] or a staff member from the [*State Departmetn of Social Services*], or both. Such evaluation shall be confidential and scheduled expeditiously.

(b) Such evaluation and counseling session shall be for the purpose of developing trustworthy and reliable expert opinion concerning the pregnant woman's sufficiency of knowledge, insight, judgment, and maturity with regard to her abortion decision in order to aid the court in its decision and to make the state's resources available to the court for this purpose. Persons conducting such sessions may employ the information and printed materials referred to in [*Insert citation(s) to state informed consent law, if applicable*] in examining how well the pregnant woman is informed about pregnancy, fetal development, abortion risks and consequences, and abortion alternatives, and should also endeavor to verify that the pregnant woman is seeking an abortion of her own free will and is not acting under coercion, intimidation, threats, abuse, undue pressure, or extortion by any other persons.

(c) The results of such evaluation and counseling shall be reported to the court by the most expeditious means, commensurate with security and confidentiality, to assure receipt by the court prior to a hearing on the pregnant woman's petition.

**Section [*13*]. Disclosure and Consent Form.**

[***Drafter's Note:*** *This enhancement is appropriate for states with parental consent laws. It is based on the consent form developed by the Texas Medical Board.*]

(a) A form created by the [*Insert appropriate department*] shall be used by physicians to obtain the consent required prior to performing an abortion on a minor who is not emancipated.

(b) A form is not valid, and therefore consent is not sufficient, unless:

(1) A parent or legal guardian initials each page of the form, indicating that he or she has read and understands the information included on that page;

(2) A parent or legal guardian signs the last page of the form in front of a person who is a notary public;

(3) The minor initials each list of risks and hazards, detailed in sections (c)(4)(i)-(iv) below;

(4) The minor signs a "consent statement," described in section (c)(6) below; and

(5) The physician signs the declaration described in section (c)(7) below.

(c) The form shall include, but is not limited to, the following:

(1) A description of the minor's rights, including her right to informed consent;

(2) A description of the parent or legal guardian's rights under [*Insert name of State*] law;

(3) A detailed description of the surgical and/or medical procedures that are planned to be performed on the minor;

(4) A detailed list of the risks and hazards related to the surgical and medical procedures planned for the minor, including, but not limited to, the following:

i. Risks and hazards that may occur in connection with any surgical, medical, and/or diagnostic procedure: potential for infection; blood clots in veins and lungs; hemorrhage (heavy bleeding); allergic reactions; or death.

ii. Risks and hazards that may occur with a surgical abortion: hemorrhage (heavy bleeding); a hole in the uterus (uterine perforation) or other damage to the uterus; sterility; injury to the bowel and/or bladder; a possible hysterectomy as a result of complication or injury during the procedure; and failure to remove all products of conception that may result in an additional procedure.

iii. Risks and hazards that may occur with a medical/non-surgical abortion: hemorrhage (heavy bleeding); failure to remove all products of conception that may result in an additional procedure; sterility; and possible continuation of pregnancy.

iv. Risks and hazards of the particular procedure planned for the minor: cramping of the uterus or pelvic pain; infection of the female organs (uterus, tubes, and ovaries); cervical laceration; incompetent cervix; and emergency treatment for any of the above named complications.

(5) A description of additional information that must be provided by the physician to the minor under [*Insert name of State*] law, including, but not limited to [*Insert information required by the state's informed consent law, if applicable (e.g. the probable gestational age of the unborn baby; the availability of medical assistance benefits; the father's responsibilities, etc.)*]

(6) A "consent statement" which must be signed by the minor. The consent statement must include, but is not limited to, the following points, which must be individually initialed by the minor:

i. That the minor understands that the doctor is going to perform an abortion on her which will end her pregnancy and will result in the death of her unborn child;

ii. That the minor is not being forced to have an abortion and that she has the choice not to have the abortion and may withdraw consent prior to the abortion;

iii. That the minor gives permission for the procedure;

iv. That the minor understands that there are risks and hazards that could affect the minor if she has the surgical or medical procedures planned for her;

v. That the minor has been given the opportunity to ask questions about her condition, alternative forms of treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved;



vi. That the minor has been given information required under [*Insert citation(s) to the state's informed consent law, if applicable*]; and

vii. That the minor has sufficient information to give informed consent.

(7) A "physician declaration," which must be signed by the physician, stating that the physician or his or her assistant has explained the procedure and the contents of this form to the minor and her parent or legal guardian, as required, and has answered all questions. Further, to the best of the physician's knowledge, the patient and her parent or legal guardian have been adequately informed and have consented to the procedure.

(8) A "parental consent statement" stating that the signing parent or legal guardian:

i. Understands that the doctor signing the "physician declaration" is going to perform an abortion on the minor, which will end her pregnancy and result in the death of her unborn child;

ii. That the parent or legal guardian has had the opportunity to read this form or have it read to him or her and has initialed each page;

iii. That the parent or legal guardian had the opportunity to ask questions to the physician or the physician's assistant about the information in this form and the surgical and medical procedures to be performed on the minor;

iv. That the parent or legal guardian believes that he or she has sufficient information to give informed consent; and

v. That by the parent or legal guardian's signature, the parent or legal guardian affirms that he or she is the minor's father, mother, or legal guardian.

(9) A page for the parent or legal guardian's signature that must be notarized by a notary public.

(10) Any additional information that must be provided to a woman under the laws of [*Insert name of State*] in order for a physician to obtain her informed consent prior to performing an abortion.

**Section [*14*]. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this law to make lawful an abortion that is currently unlawful.

**Section [*15*]. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section [*16*]. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members who sponsored or co-sponsored this Act, as a matter of right and in his or her official capacity, to intervene to defend this law in any case in which its constitutionality is challenged.

**Section [*17*]. Effective Date.**

This Act takes effect on [*Insert date*].

# Child Protection Act

**Currently, all 50 states have laws requiring healthcare professionals and others to report the suspected sexual abuse of minors including statutory rape. The federal government also mandates that Title X healthcare facilities comply with state criminal reporting laws. However, there is substantial evidence that many family planning and abortion clinics are not reporting all instances of suspected abuse, and are instead advising minors and their abusers on how to circumvent the law. As a result, sexual predators are free to continue to abuse their victims, scarring them for life.**

**In response, the pro-life movement must champion legislation that requires family planning and abortion clinics, their employees, and their volunteers to report all cases of suspected sexual abuse to state authorities and to impose strict penalties upon anyone who is found to be circumventing these laws or encouraging non-reporting of sexual abuse. To achieve these aims, AUL has drafted the "Child Protection Act." This innovative legislation has three major components – all designed to protect minors from on-going and continued abuse, neglect, and coercion.**

**HOUSE/SENATE BILL No. _____**
**By Representatives/Senators _____**

**Section 1. Short Title.**

This Act may be cited as the "[*Insert name of State*] Child Protection Act."

**Section 2. Legislative Findings and Purposes.**

(a) The [*Legislature*] of the State of [*Insert name of State*] finds that:

(1) Children are increasingly being preyed upon, victimized, and coerced into illegal sexual relationships by adults.

(2) [*Insert name of State*] law requires caretakers, healthcare facilities, healthcare providers, teachers, and other specified individuals to report suspected incidents of sexual crimes against children. [*Insert reference to appropriate state statute(s)*].

(3) However, many of these suspected criminal acts go unreported and perpetrators are not investigated or prosecuted.

(4) [*Insert name of State*] may better prevent future sexual crimes against children by investigating, prosecuting, incarcerating, and treating those who prey upon and victimize children.

(5) To prevent future and continuing sexual crimes against children, all crimes of this nature must be reported to state investigators and state agencies that are specifically trained and equipped to professionally, thoroughly, and compassionately investigate cases of suspected crimes against children, relieving mandatory reporters of this responsibility.

(6) The physical, emotional, developmental, and psychological impact of sexual crimes on child victims can be severe and long-lasting.

(7) The societal costs of these crimes are also significant and affect the entire populace.

(8) The collection, maintenance, and preservation of evidence—including forensic tissue samples—furthers [*Insert name of State*]'s interest in protecting children from sexual crimes and provides the State with the tools necessary for successful investigations and prosecutions.

(9) Parents and guardians have both the right and responsibility to be involved in medical treatment decisions involving their children and no one has the right to knowingly or willfully impede or circumvent this right.

(10) There are documented cases of individuals other than a parent or guardian aiding, abetting, and assisting minor girls to procure abortions without their parents' or guardians' knowledge, consent, or involvement. This includes transporting children across state lines to avoid [*Insert name of State*]'s parental [*involvement or consent or notice*] requirements for abortion.

(11) Such actions violate both the sanctity of the familial relationship and [*Insert name of State*]'s parental [*involvementor consent or notice*] law for abortion.

(b) The [*Legislature*]'s purposes in enacting the [*Child Protection Act*] are to further the important and compelling state interests of:

(1) Protecting children from sexually predatory adults.

(2) Ensuring that adults who are involved in illegal sexual relationships or contact with children are reported, investigated, and, when warranted, prosecuted.

(3) Relieving medical professionals and other mandatory reporters of suspected sexual crimes against children from any responsibility to personally investigate an allegation or suspicion. Mandatory reporters must simply report allegations, suspicions, and pertinent facts. Trained law enforcement or social services personnel will then be responsible for any investigation and for the ultimate disposition of the allegation(s) or case.

(4) Reducing the physical, emotional, developmental, and psychological impact of sexual crimes on child victims.

(5) Reducing the societal and economic burden on the populace that results from sexual crimes against children.

(6) Providing law enforcement officials with the tools and evidence necessary to investigate and prosecute child predators.

(7) Protecting and respecting the right of parents and guardians to be involved in the medical decisions and treatment of their children and preventing anyone from knowingly or willfully subverting or circumventing these rights.



**Section 3. Definitions.**

For the purposes of this Act only:

(a) "**Abuse**" means [*Insert specific language from existing state statutes concerning the reporting of child abuse, child sexual abuse, or similar terms*] [*or, the involvement of a child in any sexual act with a parent or another adult; any sexual activity involving a child under the age of twelve (12); the aiding or toleration of a parent or caretaker of the child's sexual involvement with any other adult; the child's involvement in pornographic displays; or any other involvement of a child in sexual activity constituting a crime under the laws of this State*].

[***Drafter's Note:*** *Depending on the specific provisions and prohibitions of the state's criminal code or other statutes, a more definitive exclusion of sexual acts or conduct between two (consenting) children may be appropriate in light of recent federal court decisions. Please consult AUL for specific drafting assistance.*]

(b) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child.

(2) Remove a dead unborn child caused by spontaneous abortion.

(3) Remove an ectopic pregnancy.

(c) "**Adult**" means one who has attained the age [*of eighteen (18) or the legal age of majority in this State*].

(d) "**Caretaker**" means any person legally obligated to provide or secure adequate care for the child, including a parent, guardian, tutor, legal custodian, foster home parent, or anyone else providing the child with a residence.

(e) "**Child**" or "**children**" means anyone under the age of [*eighteen (18) or, if appropriate, state's age of consent for sexual activity*].

(f) "**Mandatory reporter**" means any of the following individuals performing their occupational duties:

(1) [*Insert specific categories and definitions of mandatory reporters from existing state statutes defining "mandatory reporters" for child abuse, child sexual abuse, or similar terms*].

(2) "**Reproductive healthcare facility**" means any office, clinic, or any other physical location that provides abortions, abortion counseling, abortion referrals, contraceptives, contraceptive counseling, sex education, or gynecological care and services.

i. "**Sexual abuse**" means [*Insert specific language from existing state statutes concerning child sexual abuse or similar terms*] [*or, any sexual conduct, sexual contact, or sexual penetration as defined in [Insert appropriate reference(s) to state criminal code provision(s)] and committed against a child by an adult or involving a child under the age of twelve (12)*].

**Section 4. Mandatory Reporter Requirements.**

A mandatory reporter must report [*in writing*] every instance of alleged or suspected abuse, sexual abuse, or sexual crimes against a child as defined by [*Insert appropriate reference(s) to state criminal code or other statutory provision(s)*]. The mandatory reporter may not use his or her discretion in deciding what cases should or should not be reported to the appropriate law enforcement or state agencies.

**Section 5. Mandatory Reporting Procedure.**

If a mandatory reporter has cause to believe that a child has been abused, sexually abused, or has been the victim of a sexual crime as defined in [*Insert appropriate reference(s) to state criminal code or other statutory provision(s)*], the mandatory reporter shall make a report no later than the forty-eighth (48th) hour after such abuse, sexual abuse, or crime has been brought to his or her attention or he or she suspects such abuse, sexual abuse, or crime. A mandatory reporter may not delegate the responsibility to report such abuse, sexual abuse, or crime to any other person but must personally make the report. The mandatory reporter must make a report to [*designated appropriate local or state law enforcement agency and/or other state agency*].

**Section 6. Contents of the Report.**

The person making the report must identify the name and address of the child as well as the name and address of the person(s) who is responsible for the care or custody of the child. The person making the report must also file any pertinent information he or she may have relating to the alleged or suspected abuse, sexual abuse, or sexual crime.

**Section 7. Failure to Report.**

Any mandatory reporter who has cause to believe that a child has been abused, sexually abused, or has been the victim of a sexual crime as defined in [*Insert appropriate reference(s) to state criminal code or other statutory provision(s)*] and does not report such abuse, sexual abuse, or sexual crime as provided by this Act shall be subject to [*Insert reference(s) to appropriate civil remedy, fine, or other penalty*].

**Section 8. Maintenance of Forensic Samples from Abortions Performed on a Child.**

(a) Any physician who performs an abortion on a child who is less than [*fourteen (14)*] years of age at the time of the abortion procedure shall preserve, in accordance with rules and regulations adopted by the [s*tate Attorney General or other appropriate law enforcement agency charged with the collection and preservation of evidence*] pursuant to this Act, fetal tissue extracted during such abortion. The physician shall submit such tissue to the [*Insert name of proper state agency such as state Department of Public Safety, state Bureau of Investigation, or the state Crime Laboratory*].

(b) The [*state Attorney General or other appropriate law enforcement agency charged or familiar with the forensic collection and preservation of evidence*] shall adopt rules and regulations prescribing:

(1) The amount and type of fetal tissue to be preserved and submitted by a physician pursuant to this Section;

(2) Procedures for the proper preservation of such tissue for the purpose of DNA testing and examination;

(3) Procedures for documenting the chain of custody of such tissue for use as evidence;



(4) Procedures for proper disposal of fetal tissue preserved pursuant to this Section;

(5) A uniform reporting instrument mandated to be utilized by physicians when submitting fetal tissue under this Section which shall include thename and address of the physician submitting the fetal tissue and the name and complete address of residence of the parent or legal guardian of thechild upon whom the abortion was performed; and

(6) Procedures for communication with law enforcement agencies regarding evidence and information obtained pursuant to this Section.

(c) Failure of a physician to comply with any provision of this Section or any rule or regulation adopted thereunder:

(1) Shall constitute unprofessional conduct for the purposes of [*Insert appropriate statutory reference(s)*]; and

(2) Is a [*Insert appropriate criminal offense classification*] and a [*Insert appropriate higher offense classification*] upon a second or subsequent conviction.

**Section 9. Prohibition on Intentionally Causing, Aiding, Abetting, or Assisting Child to Obtain an Abortion Without Parental [*Involvement or Consent or Notification*].**

(a) No person shall intentionally cause, aid, or assist a child to obtain an abortion without the [*consent or notification required by [insert reference(s) to state parental involvement for abortion law]*].

(b) A person who violates subsection (a) of this Section shall be civilly liable to the child and to the person or persons required to [*give the consent/receive notice under [insert reference(s) to state parental involvement for abortion law]*]. A court may award damages to the person or persons adversely affected by a violation of subsection (a) of this Section, including compensation for emotional injury without the need for personal presence at the act or event, and the court may further award attorneys' fees, litigation costs, and punitive damages. Any adult who engages in or consents to another person engaging in a sexual act with a child in violation of the provisions of [*Insert appropriate reference(s) to state criminal code provision(s)*], which results in the child's pregnancy, shall not be awarded damages under this Section.

(c) It shall not be a defense to a claim brought under this Section that the abortion was performed or induced pursuant to consent to the abortion given in a manner that is otherwise lawful in the state or place where the abortion was performed or induced.

(d) An unemancipated child does not have capacity to consent to any action in violation of this Section.

(e) A court of competent jurisdiction may enjoin conduct that would be in violation of this Section upon petition by the Attorney General, a prosecuting or district [*county or city*] attorney, or any person adversely affected or who reasonably may be adversely affected by such conduct, upon a showing that such conduct:

(1) Is reasonably anticipated to occur in the future.

(2) Has occurred in the past, whether with the same child or others, and that it is not unreasonable to expect that such conduct will be repeated.

**Section 10. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

**Section 11. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable here from and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 12. Effective Date.**

This Act takes effect on [*Insert date*].



# Abortion-Inducing Drugs Safety Act

**In response to the abortion industry's expanding promotion of chemical abortion, including dangerous "telemed" abortions (where women are provided abortion-inducing drugs such as RU-486 over telecommunication systems like Skype and without face-to-face consultations with and examinations by physicians), AUL's "Abortion-Inducing Drugs Safety Act" requires that abortion providers follow the protocols approved by the U.S. Food and Drug Administration (FDA) and eliminates opportunities for abortion providers to engage in unsafe and impersonal "telemed" practices or to provide these dangerous drugs according to unproven protocols.**

[**Drafter's Note:** *AUL has drafted detailed talking points to assist those interested in introducing this model in preparing for and countering arguments typically raised by abortion providers. Those talking points are available upon request by contacting AUL's Legislative Coordinator at (202) 741-4907 or Legislation@AUL.org.*]

**HOUSE/SENATE BILL No. _____**

**By Representatives/Senators _____**

**Section 1. Title.**

This Act may be known and cited as the "Abortion-Inducing Drugs Safety Act."

**Section 2. Legislative Findings and Purposes.**

(a) The [*Legislature*] of the State of [*Insert name of State*] finds that:

(1) The Food and Drug Administration (FDA) approved the drug mifepristone (brand name "Mifeprex"), a first-generation [*selective*] progesterone receptor modulator ([S]PRM), as an abortion-inducing drug with a specific gestation, dosage, and administration protocol.

(2) As approved by the FDA, and as outlined in the Mifeprex drug label, an abortion by mifepristone consists of three 200 mg tablets of mifepristone taken orally, followed by two 200 mcg tablets of misoprostol taken orally, through 49 days LMP (a gestational measurement using the first day of the woman's "last menstrual period" as a marker). The patient is to return for a follow-up visit in order to confirm that a complete termination of pregnancy has occurred. This FDA-approved protocol is referred to as the "Mifeprex regimen."

(3) The aforementioned treatment requires three office visits by the patient, and the dosages may only be administered in a clinic, medical office, or hospital and under supervision of a physician.

(4) The Mifeprex final printed labeling (FPL) outlines the FDA-approved dosage and administration of both drugs in the Mifeprex regimen, namely mifepristone and misoprostol.

(5) Court testimony by Planned Parenthood and other abortion providers demonstrates that providers routinely fail to follow the FDA-approved protocol for the Mifeprex regimen, as it is outlined in the Mifeprex FPL. *See*, *e.g.*, *Planned Parenthood Cincinnati Region v. Taft*, 459 F. Supp. 2d 626 (S.D. Oh. 2006).

(6) Specifically, Planned Parenthood and other abortion providers are administering a single oral dose of 200 mg of mifepristone, followed by a single *vaginal* or *buccal* dose of .8 mg misoprostol, through 63 days LMP, without medical supervision, and without follow-up care. *See*, *e.g.*, *Planned Parenthood Cincinnati Region*, 459 F. Supp. 2d at 630n.7.

(7) The use of mifepristone presents significant medical risks to women, including but not limited to abdominal pain, cramping, vomiting, headache, fatigue, uterine hemorrhage, viral infections, pelvic inflammatory disease, severe bacterial infection, and death.

(8) Abortion-inducing drugs are associated with an increased risk of complications relative to surgical abortion. The risk of complications increases with advancing gestational age, and, in the instance of mifepristone, with failure to complete the two-step dosage process.

(9) In July 2011, the FDA reported 2,207 adverse events in the U.S. after women used the Mifeprex regimen for the termination of pregnancy. Among those were 14 deaths, 612 hospitalizations, 339 blood transfusions, and 256 infections (including 48 "severe infections").

(10) "Off-label" or so-called "evidence-based" use of the Mifeprex regimen can be deadly. To date, 14 women have reportedly died after administration of the Mifeprex regimen, with eight deaths attributed to severe bacterial infection. All eight of those women administered the regimen in an "off-label" or "evidence-based" manner advocated by abortion providers.

(11) Medical evidence demonstrates that women who utilize abortion-inducing drugs incur more complications than those who have surgical abortions.

(b) Based on the findings in Subsection (a) of this Section, it is the purpose of this Act to:

(1) Protect women from the dangerous and potentially deadly off-label use of abortion-inducing drugs, such as, but not limited to, the Mifeprex regimen; and

(2) Ensure that physicians abide by the protocol tested and approved by the FDA for such abortion-inducing drugs, as outlined in the drug labels.

**Section 3. Definitions.**

(a) "**Abortion-inducing drug**" means a medicine, drug, or any other substance prescribed or dispensed with the intent of terminating the clinically diagnosable pregnancy of a woman, with knowledge that the termination will with reasonable likelihood cause the death of the unborn child. This includes off-label use of drugs known to have abortion-inducing properties, which are prescribed specifically with the intent of causing an abortion, such as misoprostol (Cytotec), and methotrexate. This definition does not apply to drugs that may be known to cause an abortion, but which are prescribed for other medical indications (*e.g.*, chemotherapeutic agents, diagnostic drugs, etc.).

Use of such drugs to induce abortion is also known as **"medical abortion."**

(b) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;



(2) Remove a dead unborn child caused by spontaneous abortion;

(3) Remove an ectopic pregnancy; or

(4) Treat a maternal disease or illness for which the prescribed drug is indicated.

(c) "**Department**" means the Department of [*Insert appropriate title*] of the State of [*Insert name of State*].

(d) "**Final printed labeling (FPL)**" means the FDA-approved informational document for an abortion-inducing drug which outlines the protocol authorized by the FDA and agreed upon by the drug company applying for FDA authorization of that drug.

(e) "**LMP**" or "**gestational age**" means the time that has elapsed since the first day of the woman's last menstrual period.

(f) **"Mifeprex regimen"** means the abortion-inducing drug regimen that involves administration of mifepristone (brand name "Mifeprex") and misoprostol. It is the only abortion-inducing drug regimen approved by the FDA. It is also known as the "**RU-486 regimen**" or simply **"RU-486."**

(g) "**Mifepristone**" means the first drug used in the Mifeprex regimen.

(h) "**Misoprostol**" means the second drug used in the Mifeprex regimen.

(i) "**Physician**" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(j) "**Pregnant**" or "**pregnancy**" means that female reproductive condition of having an unborn child in the mother's [*woman's*] uterus.

(k) "**Unborn child**" means the offspring of human beings from conception until birth.

**Section 4. Unlawful Distribution of Abortion-Inducing Drug.**

(a) It shall be unlawful to knowingly give, sell, dispense, administer, otherwise provide, or prescribe any abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion in that pregnant woman, or enabling another person to induce an abortion in a pregnant woman, unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the abortion-inducing drug is a physician, and the provision or prescription of the abortion-inducing drug satisfies the protocol authorized by the FDA as outlined in the final printed labeling (FPL) for the drug or drug regimen. In the case of the Mifeprex regimen, the Mifeprex label includes the FDA-approved dosage and administration instructions for both mifepristone (Mifeprex) and misoprostol.

(b) Because the failure and complications rates from medical abortion increase with advancing gestational age, because the physical symptoms of medical abortion can be identical to the symptoms of ectopic pregnancy, and because abortion-inducing drugs do not treat ectopic pregnancies but rather are contraindicated in ectopic pregnancies, the physician giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug must first examine the woman and document, in the woman's medical chart, gestational age and intrauterine location of the pregnancy prior to giving, selling, dispensing, administering, or otherwise providing or prescribing the abortion-inducing drug.

(c) Every pregnant woman to whom a physician gives, sells, dispenses, administers, otherwise provides, or prescribes any abortion-inducing drug shall be provided with a copy of the drug's label.

(d) The physician giving, selling, dispensing, administering, otherwise providing, or prescribing the abortion-inducing drug must have a signed contract with a physician who agrees to handle complications and be able to produce that signed contract on demand by the patient or by the Department. Every pregnant woman to whom a physician gives, sells, dispenses, administers, otherwise provides, or prescribes any abortion-inducing drug shall receive the name and phone number of the physician who will be handling emergencies, and the hospital at which any emergencies will be handled. The physician who contracts to handle emergencies must have active admitting privileges and gynecological/surgical privileges at the hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug.

(e) The physician giving, selling, dispensing, administering, otherwise providing, or prescribing any abortion-inducing drug, or an agent of said physician, must schedule a follow-up visit for the woman at approximately 14 days after administration of the abortion-inducing drug to confirm that the pregnancy is completely terminated and to assess the degree of bleeding. Said physician or agent of physician shall make all reasonable efforts to ensure that the woman returns for the scheduled appointment. A brief description of the efforts made to comply with this subsection, including the date, time, and identification by name of the person making such efforts, shall be included in the woman's medical record.

**Section 5. Reporting.**

If a physician provides an abortion-inducing drug to another for the purpose of inducing an abortion as authorized in Section 4 of this Act, and if the physician knows that the woman who uses the abortion-inducing drug for the purpose of inducing an abortion experiences—during or after the use—an adverse event, the physician shall provide a written report of the adverse event within three (3) days of the event to the FDA via the Medwatch Reporting System [*and to the State Medical Board*].

[*The State Medical Board shall compile and retain all reports it receives under this Section. All reports the Board receives are public records open to inspection under [Insert citation(s) to or appropriate reference(s) to applicable State code section(s) regarding public records]. In no case shall the State Medical Board release to any person or entity the name or any other personal identifying information regarding a person who uses an abortion-inducing drug for the purpose of inducing an abortion and who is the subject of a report the State Medical Board receives under this provision.*]

An "**adverse event**" shall be defined for purposes of this Act according to the FDA criteria given in the Medwatch Reporting System.

[**Drafter's Note:** *Inclusion of the Reporting requirements is optional and may be removed without diminishing the effect of the regulation itself.*]

**Section 6. Criminal Penalties.**

A person who intentionally, knowingly, or recklessly violates any provision of this Act is guilty of a [*Insert appropriate penalty/offense classification*]. In this Section, "**intentionally**" is defined by Section [*Insert section number*] of the [*State Penal Code*].

No criminal penalty may be assessed against the pregnant woman upon whom the drug-induced abortion is performed.



**Section 7. Civil Penalties.**

(a) In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

(1) Provide a basis for a civil malpractice action for actual and punitive damages.

(2) Provide a basis for a professional disciplinary action under [*Medical Malpractice Act*].

(3) Provide a basis for recovery for the woman's survivors for the wrongful death of the woman under the [*Wrongful Death Act*].

(b) No civil liability may be assessed against the pregnant woman upon whom the drug-induced abortion is performed.

(c) When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the drug-induced abortion was performed.

(d) If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

**Section 8. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

**Section 9. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

**Section 10. Severability.**

Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 11. Effective Date.**

This Act takes effect on [*Insert date*].

# Women's Health Defense Act

**AUL's "Women's Health Defense Act" prohibits late-term abortions based on increasing evidence of the negative impact that such abortions have on women's health, as well as concerns about the pain felt by an unborn child. Unlike other available legislative models prohibiting late-term abortions, AUL's model is the only one to directly attack the Supreme Court's primary rationale for affirming *Roe v. Wade* – the "reliance interest." The specific language and animating principles of this model directly undercut the Supreme Court's ill-informed assumption that abortion is good for women and beneficial to woman's health, drastically weakening support for the Court's rationale that *Roe* must be maintained because women rely on abortion for their betterment.**

**HOUSE/SENATE BILL No. _____**

**By Representatives/Senators _____**

**Section 1. Title.**

This Act may be known and cited as the "Women's Health Defense Act" [*or, alternatively, the "Women's Late-Term Pregnancy Health Act."*]

**Section 2. Legislative Findings and Purposes.**

(a) The [*Legislature*] of the State of [*Insert name of State*] finds that:

(1) complications for women, including but not limited to: uterine perforation, uterine scarring, cervical perforation or other injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, psychological or emotional complications such as depression, anxiety, sleeping disorders, and death.

(2) Abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at eight (8) weeks gestation or earlier, the relative risk increases exponentially at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, Obstetrics & Gynecology 103(4):729 (2004).

(3) In fact, the incidence of major complications is highest after 20 weeks of gestation. J. Pregler & A. DeCherney, Women's Health: Principles and Clinical Practice 232 (2002).

(4) According to the Alan Guttmacher Institute, 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 (8) weeks gestation to one per 29,000 abortions at sixteen (16) to twenty (20) weeks and one per 11,000 abortions at twenty-one (21) or more weeks (citing L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, Obstetrics & Gynecology 103(4):729–737 (2004)).



(5) After the first trimester, the risk of hemorrhage from an abortion, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion.

(6) The State of [*Insert name of State*] has a legitimate concern for the public's health and safety. *Williamson v. Lee Optical*, 348 U.S. 483, 486 (1985).

(7) The State of [*Insert name of State*] "has legitimate interests from the outset of pregnancy in protecting the health of women." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992). More specifically, the State of [*Insert name of State*] "has a legitimate concern with the health of women who undergo abortions." *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983).

(8) In addition, there is substantial and well-documented medical evidence that an unborn child by at least 20 weeks gestation has the capacity to feel pain during an abortion. K. Anand, *Pain and its effects in the human neonate and fetus*, N.E.J.M. 317:1321 (1987).

(b) For these reasons, the [*Legislature*]'s purposes in promulgating this Act are to:

(1) Based on the documented risks to women's health, prohibit abortions at or after 20 weeks gestation except in cases of a medical emergency.

(2) Prohibit abortions at or after 20 weeks gestation, in part, because of the pain felt by an unborn child.

(3) Define "medical emergency" to encompass "significant health risks," namely only those circumstances in which a pregnant woman's life or a major bodily function is threatened. *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007).

**Section 3. Definitions.**

For purposes of this Act only:

(a) "**Abortion**" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(1) Save the life or preserve the health of the unborn child;

(2) Remove a dead unborn child caused by spontaneous abortion; or

(3) Remove an ectopic pregnancy.

(b) "**Attempt to perform**" means an act or omission of a statutorily-required act that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion.

(c) "**Conception**" means the fusion of a human spermatozoon with a human ovum.

(d) "**Gestational age**" means the time that has elapsed since the first day of the woman's last menstrual period.

(e) "**Major bodily function**" includes, but is not limited to, functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

(f) "**Medical facility**" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(g) "**Physician**" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy.

(h) "**Pregnant**" or "**pregnancy**" means that female reproductive condition of having an unborn child in the [*woman's*] uterus.

(i) "**Probable gestational age**" means what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child at the time the abortion is considered, performed, or attempted.

(j) "**Reasonable medical judgment**" means that medical judgment that would be made by a reasonably prudent physician [*in the community*], knowledgeable about the case and the treatment possibilities with respect to the medical condition(s) involved.

(k) "**Unborn child**" means the offspring of human beings from conception until birth.

**Section 4. Prohibition.**

(a) Except in the case of a medical emergency as specifically defined in Subsection 4(c) of this Act, no abortion shall be performed, induced, or attempted unless the physician [*or the referring physician*] has first made a determination of the probable gestational age of the unborn child. In making such a determination, the physician [*or referring physician*] shall make such inquiries of the pregnant woman and perform or cause to be performed all such medical examinations, imaging studies, and tests as a reasonably prudent physician [*in the community*], knowledgeable about the medical facts and conditions of both the woman and the unborn child involved, would consider necessary to perform and consider in making an accurate diagnosis with respect to gestational age.

(b) Except in a medical emergency as specifically defined in Subsection 4(c) of this Act, no physician or person shall knowingly perform, induce, or attempt to perform an abortion upon a pregnant woman when the probable gestational age of her unborn child has been determined to be at least twenty (20) weeks.

(c) ***Medical Emergency Exception***: For the purposes of this Act, "**medical emergency**" means a condition in which an abortion is necessary to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function (as specifically defined in Section 3(e) of this Act) of the pregnant woman.



**Section 5. Reporting.**

(a) Any physician who performs an abortion pursuant to Section 4(c) of this Act shall report, in writing, to the medical facility in which the abortion is performed the reason(s) for the determination that a medical emergency existed. The physician's written report shall be included in a written report from the medical facility to the [*Insert appropriate State department, department head, or regulatory body*]. If the abortion is not performed in a medical facility, the physician shall report, in writing, the reason(s) for the determination that a medical emergency existed to the [*Insert appropriate State department, department head, or regulatory body*] as part of the written report made by the physician to the [*Insert appropriate State department, department head, or regulatory body*]. The physician and the medical facility shall retain a copy of the written reports required under this Section for not less than five (5) years.

(b) Failure to report under this Section does not subject the physician to criminal or civil penalties under Sections 6 and 7 of this Act.

(c) Subsection 4(b) does not preclude sanctions, disciplinary action, or any other appropriate action by the [*Insert appropriate citation or reference to State Medical Board or other appropriate agency*].

**Section 6. Criminal Penalties.**

(a) Any person who intentionally or knowingly violates this Act is guilty of a [*Insert appropriate penalty/offense classification*].

(b) Any physician who intentionally or knowingly performs or induces an abortion in violation of this Act and thereby kills an unborn child shall be fined not less than ten thousand (10,000) nor more than one-hundred thousand (100,000) dollars under this Act, or be imprisoned [*at hard labor*] not less than one (1) year nor more than ten (10) years, or both.

**Section 7. Civil Penalties.**

(a) The woman, the father of the unborn child, if married to the mother at the time she receives an abortion in violation of this Act, and/or, if the mother has not attained the age of eighteen (18) years at the time of the abortion, the maternal grandparents of the unborn child, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or, if brought by the maternal grandparents, the maternal grandparents consented to the abortion.

(b) Such relief shall include

(1) Money damages for all injuries, psychological and physical, occasioned by the violation of this Act; and

(2) Statutory damages equal to [*Insert number*] times the cost of the abortion performed in violation of this Act.

**Section 8. Review by State Medical Board [*of Medical Licensure and Supervision*].**

(a) A physician-defendant accused of an offense under this Act may seek a hearing before the State Medical Board [*or other appropriate State agency*] as to whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; and/or as to whether the continuation of the pregnancy would have created a serious risk of substantial and irreversible impairment of a major bodily function (as specifically defined in Section 3(e) of this Act) of the pregnant woman.

(b) The findings on this issue are admissible at the civil and criminal trials of the physician-defendant. Upon a motion of the physician-defendant, the court shall delay the beginning of the trial(s) for not more than thirty (30) days to permit such a hearing to take place.

**Section 9. Penalties for Medical Facilities.**

(a) A medical facility licensed pursuant to [*Insert reference(s) to appropriate statute(s) or regulation(s)*] in which an abortion is performed or induced in violation of this Act shall be subject to immediate revocation of its license by the [*Insert name of appropriate department or agency*].

(b) A medical facility licensed pursuant to [*Insert references to appropriate statute(s) or regulation(s)*] in which an abortion is performed or induced in violation of this Act shall lose all state funding for [*Insert number*] years and will be required to reimburse the State for funds from the calendar [*fiscal*] year in which the abortion in violation of this Act was performed.

**Section 10. Prosecutorial Exclusion.**

A woman upon whom an abortion in violation of this Act is performed or induced may not be prosecuted under this Act for a conspiracy to violate Section 4 of this Act.

**Section 11. Construction.**

(a) Nothing in this Act shall be construed as creating or recognizing a right to abortion.

(b) It is not the intention of this Act to make lawful an abortion that is currently unlawful.

**Section 12. Severability.**

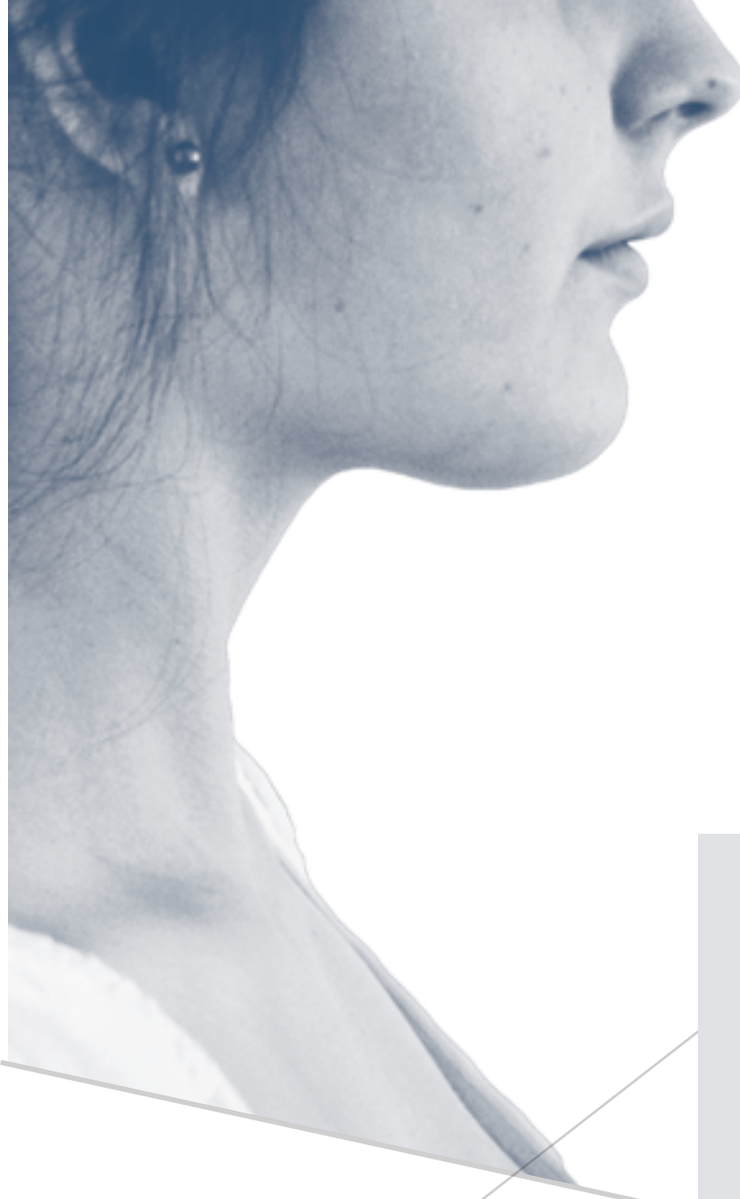
Any provision of this Act held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to give it the maximum effect permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event such provision shall be deemed severable herefrom and shall not affect the remainder hereof or the application of such provision to other persons not similarly situated or to other, dissimilar circumstances.

**Section 13. Right of Intervention.**

The [*Legislature*], by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this Act in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

**Section 14. Effective Date.**

This Act shall take effect on [*Insert date*].



# *Enforcement Options for State Abortion Laws*

# Enforcement Options for State Abortion Laws

In *Planned Parenthood v. Casey*, the U.S. Supreme Court validated abortion regulations that advanced a state's "legitimate interest" in maternal health.[1] Such maternal health laws can take a variety of forms and include mandating that abortion clinics meet medically appropriate standards for patient care, requiring the informed consent and parental involvement, demanding that abortion clinic personnel report suspected child sexual abuse, ensuring that abortion-inducing drugs are administered safely, and prohibiting dangerous late-term abortions.

These and other abortion-related requirements vary widely from state to state, and the enforcement and potential penalties for violations of these laws also differ. Some states have no statutory penalties for violation of maternal health laws, some have penalties but no reliable methods of enforcement, and others have statutory or administrative penalties but decline to consistently or adequately enforce them.

How each state protects women from the negative impact of abortion and simultaneously ensures that abortion-related laws are properly enforced remains an important issue for state officials and the public. This collection of model statutory provisions provides a variety options to create or enhance enforcement and penalty options for violations of state abortion-related laws. These provisions may be enacted in whole, in part, or in combination and may be introduced as an amendment to existing abortion-related laws or as a component of any new related legislation.

Sample complaint forms are also provided for suspected professional, facility, or administrative violations of state abortion-related laws.

## General Criminal Liability

(a) A [*person*] who intentionally, knowingly, or recklessly violates any provision of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*] is guilty of a [*Insert appropriate penalty/offense classification*]. In this Section, "**intentionally**" is defined by Section [*Insert section number*] of the [*Penal Code*].

(b) No criminal penalty may be assessed against the pregnant woman for a violation of any provision of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*].

## General Civil Liability

**Option 1: Civil Penalties Administered by State Authorities.**

(a) Any violation of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*] may be subject to a civil penalty or fine up to [*Insert appropriate amount*] imposed by [*Insert name of appropriate state official(s), department(s), and/or agencies*].

1 *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992).



(b) No civil penalty may be assessed against the pregnant woman upon whom the abortion is performed.

(c) Each day of violation constitutes a separate violation for purposes of assessing civil penalties or fines.

(d) In deciding whether and to what extent to impose fines, by [*Insert name of appropriate state official(s), department(s),or agencies*] shall consider the following factors:

(1) Gravity of the violation including the probability that death or serious physical harm to a patient or individual will result or has resulted;

(2) Size of the population at risk as a consequence of the violation;

(3) Severity and scope of the actual or potential harm;

(4) Extent to which the provisions of the applicable statutes or regulations were violated;

(5) Any indications of good faith exercised by [*abortion facility, physician, licensee, and/or other appropriate term*];

(6) The duration, frequency, and relevance of any previous violations committed by the [*abortion facility, physician, licensee, and/or other appropriate term*]; and

(7) Financial benefit to the [*abortion facility, physician, licensee, and or other appropriate term*] of committing or continuing the violation(s).

(e) Both the Office of the Attorney General and the Office of the District Attorney [*or other appropriate term*] for the county in which the violation(s) occurred may institute a legal action to enforce collection of civil penalties or fines.

**Option 2: Statutory Cause of Action for Harmed Party.**

Any [*person*] who violates [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]*] shall be civilly liable to the person or persons adversely affected by the violation(s). A court may award damages to the person or persons adversely affected by any violation(s) of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]*] including compensation for emotional, physical, and psychological harm; attorneys' fees, litigation costs, and punitive damages.

**Option 3: Third-Party's Ability to Initiate Civil [or Administrative] Enforcement Actions.**[2]

(a) Except as provided in subsection (b) of this [*Section*], any person [*or class of persons*] with [*direct*] knowledge of the relevant facts may commence a civil [*or administrative*] action on his or her [*or their*] own behalf

2 Adapted from 42 U.S.C. § 7604 (2013).

(1) Against any physician who is alleged to have violated or to be in violation of [*any provision of* [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*];

(2) Against [*staff member, employee, or volunteer*] at an [*abortion facility*] who is alleged to have violated or to be in violation of [*any provision of* [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*];

(3) Against any [*abortion facility*], including specifically its [*owner(s) and director(s)*], that is alleged to have violated or to be in violation of [*any provision of* [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statutes*]; or

(4) Against any [*official , department, agency, or agent*] of the State of [*Insert name of State*], in his, her, or its official capacity, who is alleged to have violated or to be in violation of [*any provision of* [*this Act [or Section] or any rules and regulations adopted under this Act [or Section];OR insert specific reference(s) to state abortion-related statutes*] or who is alleged to have improperly failed to enforce [*any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statutes*] as required by [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to enforcement provisions of state abortion-related statutes*].

(b) No civil action may be commenced under subsection (a) prior to thirty (30) days after the plaintiff(s) has given notice of the violation(s) to the [*official, department, agency, or agent*] of the State of [*Insert name of State*] charged with enforcing [*any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statutes*].

(c) Nothing in this [*Act [or Section]*] shall restrict any right which any person [*or class of persons*] may have under any statute or at common law to seek enforcement of [*any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statutes*] or to seek any other legal or equitable relief.

(d) Nothing in this [*Act [or Section]*] or in any other law of the State of [*Insert name of State*] shall be construed to prohibit, exclude, or restrict any person [*or class of persons*] from

(1) Bringing any enforcement action or obtaining any judicial remedy or sanction in any state or local court; or

(2) Bringing any administrative enforcement action or obtaining any administrative remedy or sanction in any state or local administrative agency, department or instrumentality; any department, agency, or instrumentality thereof; or any officer, agent, or employee thereof under state or local law respecting [*any provision of this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statutes*].



## Administrative Action Against Facility License

The [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*] may deny, suspend, revoke, or refuse to renew [*a license*] in any case in which it finds that there has been a substantial failure of the any [*person, physician, licensee, applicant, abortion facility, and/or other appropriate term*] to comply with the requirements of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*]. In such case, the [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*] shall furnish the [*person, physician, licensee, applicant, abortion facility, and/or other appropriate term*] thirty (30) days notice specifying reasons for the action.

Any [*person, physician, licensee, applicant, abortion facility, and/or other appropriate term*] who feels aggrieved by the action of the [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*] in [*denying, suspending, revoking, or refusing to renew a license*] may appeal the action in accordance with the [*delay, notice, and other*] procedures established [*Insert reference(s) to applicable agency or administrative appeal procedure(s)*].

## Injunctive Remedy

In addition to any other penalty provided by law, whenever in the judgment of the [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*], any [*person, physician, licensee, abortion facility, and/or other appropriate term*] has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*], the [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*] shall make application to any court of competent jurisdiction for an order enjoining such acts and practices, and upon a showing by the [*Insert reference(s) to appropriate state official(s), department(s), and/or agencies*] that such [*person, physician, licensee, abortion clinic, and/or other appropriate term*] has engaged, or is about to engage, in any such acts or practices, an injunction, restraining order, or such other order as may be appropriate shall be granted by such court without bond.

## Professional And Disciplinary Remedies

In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of [*this Act [or Section] or any rules and regulations adopted under this Act [or Section]; OR insert specific reference(s) to state abortion-related statute(s)*] shall:

(a) Provide a basis for a civil malpractice action for actual and punitive damages.

(b) Provide a basis for a professional disciplinary action under [*state Medical Malpractice Act or other appropriate statutory and/or administrative authority*].

## Appendix A: Professional Complaint Form

[**Drafter's Note**: Many state medical boards and other professional licensing bodies have complaint forms that can be submitted online directly through the agency website. This form can be adapted for online submission or used as a downloadable mail-in form.]

**Sample Professional Complaint Form**[3]

***This form is to be used by anyone alleging a violation of [Insert reference(s) to appropriate statutory or regulatory provision(s)]. Please provide as much specific detail as possible, including full names of the clinic staff and/or other parties involved, date(s) of the incident(s), the type of violation(s), and whether or not the incident was reported to clinic staff or another agency.***

***Please fill out this form completely and return to [Insert name and address of state medical board or other professional licensing board].***

| PERSONAL INFORMATION (OPTIONAL) | | |
|---|---|---|
| Name: (Last) | (First) | (M.I.) |
| Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |
| Email Address: | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| Name: | | |
| Practice Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |
| License Number: | | |

| ALLEGED VIOLATION(S) | |
|---|---|
| Date of Incident(s): | Person(s) involved: |

Nature of Incident:
(check all that apply)

- ❑ Quality of care
- ❑ Misdiagnosis of condition
- ❑ Patient abandonment/neglect
- ❑ Failure to release patient records
- ❑ Impairment/incompetence
- ❑ Sexual contact with patient
- ❑ Substance abuse
- ❑ Unlicensed provider or aiding/abetting unlicensed practice
- ❑ Misfilled prescription
- ❑ Insurance fraud
- ❑ Other

Description of Incident:

[3] Sample form is modeled after from Florida Health Care Facility Complaint Form, *available at* http://apps.ahca.myflorida.com/hcfc/ (last visited Sept. 11, 2013); Arizona Election Grievance Complaint Form, *available at* http://www.azsos.gov/election/grievance/Grievance_Form.pdf (last visited Sept. 11, 2013); Oregon Medical Board Complaint Form, *available at* http://www.oregon.gov/omb/pdfforms/complaintform.pdf (last visited Sept. 11, 2013); and Florida Healthcare Practitioner Complaint Form, *available at* http://doh.state.fl.us/mqa/enforcement/frm_general-medUCF.pdf (last visited Sept. 11, 2013).

## Appendix B: Abortion Facility Complaint Form

[**Drafter's Note**: Many state agencies maintain complaint forms that can be submitted online directly through the agency website. This form can be adapted for online submission or used as a downloadable mail-in form.]

**Sample Abortion Facility Complaint Form**[3]

***This form is to be used by anyone alleging a violation of [Insert reference(s) to appropriate state statutory or regulatory provision(s)]. Please provide as much specific detail as possible, including full names of the clinic staff and/or other parties involved, date(s) of the incident(s),the type of violation(s), and whether or not the incident was reported to clinic staff or another agency.***

***Please fill out this form completely and return to [Insert name and address of appropriate state department or agency].***

| PERSONAL INFORMATION (OPTIONAL) | | |
|---|---|---|
| Name: (Last) | (First) | (M.I.) |
| Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |
| Email Address: | | |

| FACILITY INFORMATION | | |
|---|---|---|
| Name: | | |
| Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |

| ALLEGED VIOLATION(S) | |
|---|---|
| Date of Incident(s): | Person(s) involved: |

| Describe incident here: |
|---|
| |

[3] Sample form is modeled after Florida Health Care Facility Complaint Form, *available at* http://apps.ahca.myflorida.com/hcfc/ (last visited Sept. 11, 2013); and Arizona Election Grievance Complaint Form, *available at* http://www.azsos.gov/election/grievance/Grievance_Form.pdf (last visited Sept. 11, 2013).

## Appendix C: Administrative Enforcement Complaint Form

[**Drafter's Note**: Many state agencies maintain complaint forms that can be submitted online directly through the agency website. This form can be adapted for online submission or used as a downloadable mail-in form and for a variety of administrative violations.]

**Sample Administrative Enforcement Complaint Form**[3]

***This form is to be used by anyone alleging a violation of [Insert reference(s) to appropriate state statutory or regulatory provision(s)]. Please provide as much specific detail as possible, including full names of the clinic staff and/or other parties involved, date(s) of the incident(s), the type of violation(s), and whether or not the incident was reported to clinic staff or another agency.***

***Please fill out this form completely and return to [Insert name and address of appropriate state department or agency].***

| PERSONAL INFORMATION (OPTIONAL) | | |
|---|---|---|
| Name: (Last) | (First) | (M.I.) |
| Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |
| Email Address: | | |

| FACILITY INFORMATION | | |
|---|---|---|
| Name: | | |
| Address: (No. and Street) | City: | |
| State: | Zip: | Telephone: |

| ALLEGED VIOLATION(S) | |
|---|---|
| Date of Incident(s): | Person(s) involved: |

| Describe incident here: |
|---|
| |

[3] Sample form is modeled after Florida Health Care Facility Complaint Form, *available at* http://apps.ahca.myflorida.com/hcfc/ (last visited Sept. 11, 2013); Arizona Election Grievance Complaint Form, *available at* http://www.azsos.gov/election/grievance/Grievance_Form.pdf (last visited Sept. 11, 2013); and New York Public Integrity Unit Complaint Form, *available at* http://www.ag.ny.gov/sites/default/files/pdfs/complaints/piu001_complaint_form.pdf (last visited Sept. 11, 2013).

# Endnotes

## Significant Potential for Harm: Growing Medical Evidence of Abortion's Negative Impact on Women

By Dr. Byron C. Calhoun, M.D.[1] and Mailee R. Smith, J.D., Staff Counsel, Americans United for Life

[1] Dr. Byron C. Calhoun, MD, FACOG, FACS, MBA, serves as Professor and Vice-Chair in the Department of Obstetrics and Gynecology at the West Virginia University-Charleston and is involved in resident and medical student education. Dr. Calhoun continues to actively practice maternal-fetal medicine, perform diagnostic obstetrical ultrasound, and participate in prenatal diagnosis counseling. Dr. Calhoun has authored over 70 peer review articles in the obstetric and gynecologic literature, presented over 100 scientific papers, participated in over 40 research projects, and has published numerous articles on medical and ethical aspects of obstetrics and gynecology.

[2] *McCorvey v. Hill*, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring).

[3] For more on the legal and medical landscape in 1973, *see* C.D. Forsythe, Abuse of Discretion: The Inside Story of the Supreme Court's Creation of the Right to Abortion (forthcoming 2013).

[4] J.M. Thorp et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, Obstet. & Gynecol. Survey 58(1):67, 68 (2003).

[5] *See*, *e.g.*, Planned Parenthood, *In-Clinic Abortion Procedures* (2012), *available at* www.plannedparenthood.org/health-topics/abortion/abortion-procedures-4359.htm (last visited Dec. 15, 2011).

[6] *See* J.M. Thorp, *Public Health Impact of Legal Termination of Pregnancy in the U.S.: 40 Years Later*, Scientifica (forthcoming 2013). Uterine perforation or puncture, which can result in excessive blood loss, occurs in 10 to 15 out of every 1000 procedures. When the perforation goes undiagnosed, it can have severe consequences.

[7] Guttmacher Institute, *Abortion in the United States: Quick Stats* (2012), *available at* www.guttmacher.com/media/presskits/abortion-US/statsandfacts.html (last visited Aug. 29, 2012).

[8] J.M. Thorp, *supra* (citing L. Rahangdale, *Infectious complications of pregnancy termination*, Clin. Obstet. Gynecol. 52(2):198-204 (June 2009)).

[9] *See*, *e.g.*, N.M. Niinimaki et al., *Immediate Complications after Medical compared with Surgical Termination of Pregnancy*, Obstet. Gynecol. 114:795 (Oct. 2009); J.T. Jenson et al., *Outcomes of Suction Curettage and Mifepristone Abortion in the United States: A Prospective Comparison Study*, Contraception 59:153-59 (1999).

[10] *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).

[11] *See*, *e.g.*, R.T. Burkman et al., *supra*; 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).

[12] Mifeprex Final Printed Labeling (FPL), *available at* www.accessdata.fda.gov/drugsatfda_docs/label/2005/020687s013lbl.pdf (last visited Aug. 29, 2012).

[13] *Id*.

[14] Planned Parenthood, *The Abortion Pill (Medication Abortion)* (2012), *available at* www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.asp (last visited Sept. 5, 2012).

[15] *See* Mifeprex FPL, *supra*.

[16] Food and Drug Administration, *Mifepristone U.S. Postmarketing Adverse Events Summary Through 04/30/2011*, (July 19, 2011), *available at* www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf (last visited Aug. 29, 2012).

[17] *Id*.

[18] J.M. Thorp et al., *supra,* at 75.

[19] W.M. Callaghan, *The Contribution of Preterm Birth to Infant Mortality Rates in the U.S.*, Pediatrics 118(4):1566 (Oct. 2006); B. Rooney & B.C. Calhoun, *Induced Abortion and Risk of Later Premature Births*, J. Am. Physicians & Surgeons 8(2):46, 46-47 (2003).

[20] 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).

[21] *Id*.

[22] P. Shah et al., *Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis*, B.J.O.G. 116(11):1425 (2009).

[23] R.H. van Oppenraaij et al., *Predicting adverse obstetric outcome after early pregnancy events and complications: a review*, Human Reprod. Update Advance Access 1:1 (Mar. 7, 2009).

[24] *Id*. Various researchers define "very pre-term" or "very premature" at different weeks. The gestational week considered in each study is included in the text above.

[25] H.M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis*, J. Reprod. Med. 54:95 (2009).

[26] R. Klemetti et al., *Birth outcomes after induced abortion: A nationwide register-based study of first births in Finland*, Human Reprod. (Aug. 29, 2012).

[27] J.M. Thorp et al., *supra*, at 75.

[28] B. Rooney & B.C. Calhoun, *supra*, at 46-47.

[29] R.E. Behrman, Preterm Birth: Causes, Consequences, and Prevention 519 (2006).

[30] B. Luke, Every Pregnant Woman's Guide to Preventing Premature Birth 32 (1995).

[31] *Id*.

[32] J.M. Thorp, *supra*.

[33] J.M. Thorp et al., *supra*, at 75.

[34] *Id*.

[35] *See* C.D. Forsythe, *supra*.

[36] J.M. Thorp et al., *supra*, at 70-71.

[37] National Cancer Institute, *Breast Cancer*, *available at* www.cancer.gov/cancertopics/types/breast (last visited Aug. 29, 2012).

[38] *Id*.

[39] J. Lecarpentier et al., *Variation in breast cancer risk associated with factors related to pregnancies according to truncating mutation location, in the French National BRCA1 and BRCA2 mutations carrier cohort (GENEPSO)*, Breast Cancer Research 14:R99 (2012).

[40] American Association of Pro-Life Obstetricians and Gynecologists, *Induced Abortion and Subsequent Breast Cancer Risk: An Overview* (2008), *available at* www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-breast-cancer/induced-abortion-and-subsequent-breast-cancer-risk-an-overview/ (last visited Sept. 5, 2012).

[41] Scientists define an "early first full-term pregnancy" as one that takes place before the age of 24. Coalition on Abortion/Breast Cancer: *The ABC Link: Two Ways that Abortion Raises Breast Cancer Risk* (2007), *available at* www.abortionbreastcancer.com/The_Link.htm (last visited Sept. 5, 2012).

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[43] *Id*. at 229.

[44] *Id*. at 229-30.

[45] *Id*.

[46] C. Kahlenborn, M.D., Breast Cancer: Its Link to Abortion and the Birth Control Pill 1-2 (2000).

[47] A. Lanfranchi, *supra*, at 231.

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[49] *Id*. at 232.

[50] C. Kahlenborn, *supra*, at 2.

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[53] J.R. Daling, *supra*, at 1584-92. Daling specifically controlled for "recall bias"—the allegation that a woman with breast cancer is more likely to report a prior abortion than a healthy woman who has had a prior abortion—and found that it did not impact her results. *Id*.

[54] While this small group of 12 is "statistically insignificant" from a research standpoint, it is certainly a significant finding for a 17-year-old contemplating abortion.

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[67] V.M. Rue et al., *Induced abortion and traumatic stress: A preliminary comparison of American and Russian women*, Med. Sci. Monitor 10:SR5 (2004).

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## Exposing the Pervasiveness of "Back Alley" Abortions

By Denise M. Burke, J.D. Vice President of Legal Affairs, Americans United forLife

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[78] *Id*.

[79] *Id*.

[80] *Id*.; *see also,* Enforcement Action, Revised Proposed Agreed Order, Texas Commission on Environmental Quality, Docket N. 2011-0955-MSW-E; Enforcement Case No. 41833, dated Sept. 2, 2011; Enforcement Action, Revised Proposed Agreed Order, Texas Commission on Environmental Quality, Docket N. 2011-0955-MSW-E; Enforcement Case No. 41836, dated Sept. 2, 2011; and "14 Texas abortion clinics cited for health violations: only one fined," *available at* www.lifesitenews.com/news/14-texas-abortion-clinics-cited-for-health-violations-only-one-fined/ (last visited May 21, 2013).

[81] *See e.g.,* "Houston doctor accused of illegal abortions," *available at* www.chron.com/news/houston-texas/houston/article/Houston-doctor-accused-of-illegal-abortions-4519565.php (last visited May 20, 2013); "Tenth Texas Abortion Practitioner Under State Investigation," *available at* www.lifenews.com/2011/08/24/tenth-texas-abortion-practitioner-under-state-investigation/ (last visited May 22, 2013).

[82] *See e.g.,* "Tenth Texas Abortion Practitioner Under State Investigation," *available at* www.lifenews.com/2011/08/24/tenth-texas-abortion-practitioner-under-state-investigation/ (last visited May 22, 2013).

[83] *Id.*

[84] *Id.*

[85] *Id.*

[86] *Id.*

[87] *Id.*

[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *See e.g.,* "Teen sought abortion, so why is Utah doc charged with murder?" *available at* www.sltrib.com/sltrib/news/53333105-78/riley-maryland-utah-abortion.html.csp?page=3%20(last%20visited%20Mar.%2029,%202012) (last visited May 22, 2013).
[92] *See e.g.,* "Anti-abortion group releases Va. clinic inspection records," *available at* www.wafb.com/story/13880557/new-allegations-about-baton-rouge-abortion-clinic (last visited May 22, 2013).
[93] *See e.g.,* Statement of Deficiencies and Plan of Correction, Planned Parenthood of Southeastern Virginia, dated May 1, 2012, *available at* www.sba-list.org/sites/default/files/content/shared/planned_parenthood_of_se_va.pdf (last visited May 22, 2013).
[94] *See e.g.,* Statement of Deficiencies and Plan of Correction, Roanoke Medical Center for Women, dated Dec. 19, 2012, *available at* www.sba-list.org/sites/default/files/content/shared/roanoke_medical_center_for_women_-_1st_revisit_report_12-19-2012.pdf (last visited May 22, 2013).
[95] *See e.g.,* "WV abortionist forced, botched abortion," *available at* www.adfmedia.org/News/PRDetail/8246 (lasted visited June 10, 2013).
[96] *See e.g.,* "WV abortionist forced, botched abortion," *available at* www.adfmedia.org/News/PRDetail/8246 (lasted visited June 10, 2013).
[97] For model legislation regulating abortion clinics, *see* AUL's "Abortion Patients' Enhanced Safety Act" and the "Women's Health Defense Act," Defending Life 2013, *supra*.


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