Statement for the Record

Of

The American College of Obstetricians and Gynecologists

Before the

Subcommittee on Health

In the

House Committee on Energy and Commerce

Regarding the Hearing

Protecting Women's Access to Reproductive Health Care

February 12, 2020

Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Subcommittee on Health in the House Committee on Energy and Commerce, thank you for the opportunity to submit this statement for the Committee's record of its hearing entitled "Protecting Women's Access to Reproductive Health Care".

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. With more than 60,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care.

ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care for all women. Policy related to reproductive health care must be based on medical science and facts**.** The government can serve a valuable role in making health policy when its purpose is to improve patient health and advance medical and scientific progress.[1]

ACOG thanks the Committee for its consideration of H.R. 2956, the Women's Health Protection Act of 2019, which would create federal protections against state restrictions that fail to protect women's health and intrude upon personal decision-making. This bill promotes and protects a woman's individual constitutional rights by ensuring that abortion providers have the ability to provide abortion services free from any limitations or requirements imposed for the sole purpose of impeding access to abortion services or singling out the provision of abortion services, health care providers who provide abortion services, or facilities in which abortion services are provided.[2] Passage of H.R. 2956 is a critical first step in protecting women and their physicians from unwarranted intrusions into the practice of medicine and the patient-physician relationship and we urge its swift passage.

Abortion is an essential component of women's health care.[3] Like all medical matters, decisions regarding reproductive health care, including abortion care, should be made by patients in consultation with their health care providers and without undue interference by outside parties.[4] Like all patients, women seeking abortion are entitled to privacy, dignity, respect, and support.[5]

The Committee's hearing today could not come at a more pivotal time. Abortion, although still legal, is increasingly out of reach because of mounting government-imposed restrictions

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[1] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference (reaffirmed July 2016)
[2] Women's Health Protection Act of 2019, H.R. 2975, 116th Cong. (2019)
[3] *Abortion Policy Statement*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Abortion-Policy (Nov. 2014)
[4] *Id.*
[5] *Id.*

targeting women, physicians, and other clinicians who provide care to women.[6] This mosaic of state laws and regulations has escalated access disparities and threatens to criminalize or otherwise penalize physicians and other clinicians for providing care consistent with their medical judgment, standards of care, and their patients' needs. It is a crisis for both women and their physicians that warrants urgent scrutiny and swift action by Congress.

When considering testimony today, ACOG urges the Committee to rely on this statement to generate a dialogue informed by science and medical facts. This statement reviews the clinical facts regarding the provision of abortion and gives voice to the physicians—ACOG's members—who every day face the real-world implications of ill-advised political intrusions in patient care.

Clinical Guidance and Medical Research Regarding Reproductive Health Care

Politics should never outweigh scientific evidence, override standards of medical care, or drive policy that puts a person's health and life at risk.[7] Reproductive health care is essential to the health of women throughout the country.

ACOG issues evidence-based clinical practice guidelines and has developed evidence-based statements of policy on reproductive health care, through a thorough, deliberative, collaborative process among leading experts in the field of women's health. Pertinent today for the Committee's consideration is our robust body of clinical guidance that spans information regarding the medical management of first trimester abortion that can be accomplished through medication[8], abortion training and education[9], abortion access[10], and clinical management of second trimester abortion procedures.[11]

Abortion is extremely safe. It has complication rates that are lower than other routine medical procedures and its complication rates are substantially lower than childbirth.[12] In the United States, 90% of abortions occur within the first trimester, when abortion is safest. Serious

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[6] *Increasing access to abortion. Committee Opinion No. 613*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060—5.
[7] *Abortion Can Be Medically Necessary.* Statement of the American College of Obstetricians and Gynecologists (Sept. 2019), *at* https://www.acog.org/About-ACOG/News-Room/Statements/2019/Abortion-Can-Be-Medically-Necessary
[8] *Medical management of first-trimester abortion*. Practice Bulletin No. 143. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:676—92.
[9] *Abortion training and education*. Committee Opinion No. 612. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1055–9.
[10] *Increasing access to abortion*. Committee Opinion No. 613. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060—5.
[11] *Second-trimester abortion*. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394—1406.
[12] National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018) ("Safety and Quality of Abortion Care"); *see also* Raymond & Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 Obstetrics & Gynecology 215, 216 (2012).

complications from abortions at all gestational ages are rare. Advances in medical science have expanded safe options for pregnancy termination. For example, medical abortion, which involves the use of medications rather than a procedure to induce an abortion, is a safe, effective option for women who seek termination of a first-trimester pregnancy.[13]

Notwithstanding the safety of abortion, the provision of abortion is highly regulated in many states. Particularly relevant to the hearing topics today is ACOG's Committee Opinion 613, Increasing Access to Abortion, which examines the impact that restrictions on abortion access have on women's health.[14] The Opinion highlights certain factors that may influence or necessitate a woman's decision to have an abortion. These factors include but are not limited to contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, illness during pregnancy, and exposure to teratogenic medications. Pregnancy complications, including placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and cardiac or renal conditions, may be so severe that abortion is the only measure to preserve a woman's health or save her life.

ACOG's Committee Opinion 613 further considers the substantial damage abortion restrictions may impose on women's health care, stating that legislative restrictions fundamentally interfere with the patient-provider relationship and decrease access to abortion for all women, particularly for low-income women and those living long distances from health care providers.[15] The Committee Opinion calls for advocacy to oppose and overturn restrictions, improve access, and mainstream abortion as an integral component of women's health care. Obstacles such as government restrictions, result in the "marginalization of abortion services from routine clinical care," the Committee Opinion concludes, and "are harmful to women's health." This conclusion is consistent with a recent study published by the National Academies of Medicine, Engineering, and Science that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations on abortion.[16] In its assessment, the report cited that these threats impact all six attributes of health care quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[17]

Moreover, ACOG, along with representatives from the National Partnership for Women & Families, American College of Physicians, American Academy of Family Physicians, American College of Nurse Midwives, Nurse Practitioners in Women's Health, and the Society of Family Planning recently led a rigorous review of the available evidence and guidelines that inform safe

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[13] *Medical management of first-trimester abortion*. Practice Bulletin No. 143. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:676—92.
[14] *Increasing access to abortion*. Committee Opinion No. 613. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060—5.
[15] *Id.*
[16] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine. (March 2018). *At* https://www.nap.edu/read/24950/chapter/1
[17] *Id*.

delivery of outpatient care.[18] The objective of this study was to inform policy regarding the provision of procedures in primary care, including in the field of obstetrics and gynecology, in order to further health care quality, safety, affordability, and patient experience without imposing unjustified burdens on patients' access to care or on clinicians' ability to provide care within their scope of practice. In the published findings, the authors note that in policy and law, regulation of abortion is frequently treated differently from other health services.[19] They affirm that the safety of abortion is similar to that of other types of office- and clinic-based procedures, and any facility requirements should be based on assuring high quality, safe performance of all such procedures, but conclude that false concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion.

As you consider today's testimony, we urge your discourse and questioning to be informed by this evidence-based research and guidance.

The Importance of Using Medically Accurate Terminology and Information

Public and political discourse regarding abortion is all too often inaccurate and not based on medical science. As the leading association of physicians who are dedicated to the health care of women, it is important for ACOG to ensure that the Committee has information regarding false claims that undermine the public's trust in ob-gyns and stigmatize necessary health care for women. We urge members of the Committee today to be aware that medically inaccurate and inflammatory language can contribute to or encourage hostility or violence toward doctors, other medical professionals, or individuals seeking or receiving basic health care services.

ACOG also seeks to correct false claims that have been made in the public discourse that abortion is never medically necessary. This is a dangerous narrative, which ACOG appreciates the opportunity to clarify for the Committee. Pregnancy imposes significant physiological changes on a woman's body. These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death. Our members are focused on protecting the health and lives of their patients, and determining the appropriate medical intervention based on a patient's specific condition, without unjustified government mandates, is critical to their ability to provide quality care. This includes situations where abortion is the only medical intervention that can preserve a patient's health or save their life.[20]

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[18] *Report from the project on facility guidelines for the safe performance of primary care and gynecology procedures in offices and clinics*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:255–60.

[19] *Id*.

[20] *Abortion Can Be Medically Necessary.* Statement of the American College of Obstetricians and Gynecologists (Sept. 2019), *at* https://www.acog.org/About-ACOG/News-Room/Statements/2019/Abortion-Can-Be-Medically-Necessary

When discussing policy related to health care, terminology is critically important. Patient care should never be legislated on false or inaccurate premises. One example found in many policy contexts is the deployment of the term "heartbeat" to impose arbitrary abortion bans that are not reflective of clinical fact. While contemporary ultrasound can detect an electrically induced flickering of a portion of the fetal tissue at about six weeks gestation, structurally and in function, a fetus' heart develops over the entire course of pregnancy and does not complete development or function fully until after delivery.[21]

State Restrictions on Reproductive Health Care

Today, this Committee will shine a light on the escalating attacks on reproductive health care across the country, as it considers a legislative remedy. ACOG strongly supports H.R. 2956 as a necessary step to counter state efforts that force physicians to practice outside the bounds of evidence-based medicine and create unnecessary obstacles for women trying to access constitutionally protected, medically appropriate care.

In many states our members are forced to navigate unfounded laws and restrictions intended to eliminate access to abortion by regulating health care facilities out of existence or making it unsustainable to keep their doors open. ACOG has long opposed unnecessary, unjustified government restrictions on abortion, and works to prevent political interference into medical decision making that is inappropriate, ill-advised, and dangerous.[22] While ACOG recognizes and respects that individuals, including obstetricians and gynecologists, may be personally opposed to abortion, neither politicians nor health care providers should seek to impose their personal beliefs upon patients or allow personal beliefs to compromise patient health, access to and quality of care, or informed consent.[23]

In the past decade alone, states have enacted hundreds of statutes and pursued regulations that undermine evidence-based practice, impose barriers to care for women, and threaten the patient-provider relationship. Clinicians across the country are being faced with an absurd paradox: providing appropriate, evidence-based care to a patient is tied to penalties that in some cases include jail time. HR 2956 would protect our members and their patients from such untenable situations by precluding unjustified restrictions on abortion services, including, but not limited to:

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[21] *Doctor's Organization: Fetal Heartbeat Bills Language Is Misleading*, The Guardian, June 7, 2019, https://www.theguardian.com/world/2019/jun/05/abortion-doctors-fetal-heartbeat-bills-language-misleading

[22] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference (reaffirmed July 2016)

[23] *Abortion Policy Statement*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Abortion-Policy (Nov. 2014)

- **Requirements that clinicians perform specific tests or medical procedures that are not clinically indicated** or generally required for the provision of medically comparable procedures.[24,25]
- **Forcing clinicians to offer or provide patients medically inaccurate information prior to or during abortion services.** Laws that compel physicians to provide or steer patients toward medically-inaccurate scripted information are in direct violation of a physician's oath to care. They infringe on patient counseling and manipulate informed consent, an ethical doctrine that is rooted in the concept of self-determination and the fundamental understanding that patients have the right to make their own decisions regarding their own health.[26]
- **Banning abortion at arbitrary gestational ages with no medical justification**, treating physicians like criminals for offering compassionate and evidence-based care.[27]
- **Banning abortion based on a woman's reason or perceived reason for seeking care,** threatening honest, open conversations between patients and their health care providers.[28]
- **Mandating medically specific procedures or diagnostic protocols clinicians must follow.** Decisions about a patient's medical care and management are always best made between the patient and the expert in medical care. Government mandates such as an ultrasound or pelvic exam before an abortion force clinicians to practice medicine without regard for clinical best practices.[29]
- **Banning medically indicated procedures, such as dilation and evacuation (D&E)**. The proliferation of bans across the country on the safest and medically preferred abortion procedure in the second trimester tie the hands of physicians. D&E is an evidence-based procedure, and in some cases it is necessary to preserve a woman's health or her future fertility.[30]
- **Holding abortion facilities and providers to exhaustive regulatory standards without justification,** including that facilities meet unnecessary structural requirements, and that

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[24] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference (reaffirmed July 2016)

[25] *Legislative interference with the patient-physician relationship.* Weinberger SE, Lawrence HC 3rd, Henley DE, Alden ER, Hoyt DB.. N Engl J Med 2012;367:1557-9.

[26] *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials.* Richardson, C.T., & Nash, E.. Guttmacher Policy Review 2006; 9 (4), 6-11. At https://www.guttmacher.org/sites/default/files/article_files/gpr090406.pdf

[27] *ACOG Statement on Abortion Bans*, The American College of Obstetricians and Gynecologists, https://www.acog.org/About-ACOG/News-Room/Statements/2019/ACOG-Statement-on-Abortion-Bans?IsMobileSet=false

[28] *Abortion Can Be Medically Necessary.* Statement of the American College of Obstetricians and Gynecologists (Sept. 2019), *at* https://www.acog.org/About-ACOG/News-Room/Statements/2019/Abortion-Can-Be-Medically-Necessary

[29] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference (reaffirmed July 2016)

[30] *Second-trimester abortion*. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394—1406.

physicians obtain admitting privileges and transfer agreements at local hospitals. As mentioned before, ACOG, along with colleague organizations across the women's health and primary care fields, led a rigorous review of the available evidence and guidelines that inform safe delivery of outpatient care. In the published findings, the authors note that in policy and law, regulation of abortion is frequently treated differently from other health services and that false concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion.[31]

- **Requiring facility inspections and reporting requirements that do not improve safety, jeopardize patient privacy, and intimidate physicians, patients, and clinic staff.**[32]
- **Requiring a patient to make multiple in-person trips prior to an abortion irrespective of any medical justification**. Requiring a woman to make multiple unnecessary trips when seeking abortion care imposes prohibitive geographic and financial barriers on women, and disproportionately negatively impacts low-income women, women living in rural areas, and women in states with a paucity of abortion clinics.[33]
- **Bans on telemedicine abortion as an option for patients.** ACOG practice guidelines endorse the telemedicine model for medication abortion delivery. Telemedicine is a tool that promises to improve access to many health services in our country, yet states, while innovating telemedicine delivery in many areas of health care, have singled out, rather than included, abortion care in these efforts. Peer-reviewed studies have confirmed the safety and effectiveness of medication abortion using telemedicine, including one study that concluded little differentiation in outcomes in a data set of nearly 20,000 patients, and another that evaluated data from across the country and found no difference in safe outcomes by region as well as high rates of patient satisfaction with their experience.[34,35]
- **Restrictions on the use of medication abortion**, further exacerbated by outdated FDA requirements of mifepristone, one of the medications used in a medical abortion, which substantially limit access to this safe, effective method.[36]

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[31] *Increasing access to abortion. Committee Opinion No. 613*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060—5.
[32] *Increasing access to abortion. Committee Opinion No. 613*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060—5.
[33] *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from States.* Jerman,J., Frohwirth, L. Kavanaugh, ML. & Blades, N. Perspect Sex Reprod Health. 2017 Jun; 49(2):95-102.
[34] *The TelAbortion project: Delivering the Abortion Pill to your Doorstep by Telemedicine and Mail.* Chong, E., Ryamond, W., Kaneshiro, B., Baldwin, M. Prigue, E., Winikoff, B. Obstetrics & Gynecology: May 2018 - Volume 131 - Issue - p 53S
[35] *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person.* Grossman, D & Gindlay, K. Obstet Gynecol. 2017 Oct;130(4):778-782.
[36] *Improving Access to Mifepristone for Reproductive Health Indications*, The American College of Obstetricians and Gynecologists (June 2018). *At* https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Improving-Access-to-Mifepristone

- **Limiting the pool of appropriately trained and credentialed providers from whom women can access care by banning qualified advanced practice clinicians from providing abortion care and restricting clinical training.** Advanced practice clinicians (APCs) possess the clinical and counseling skills necessary to provide first-trimester abortion safely, and there is no medical rationale or benefit to restricting early abortion care to physicians. A substantial body of evidence demonstrates that advanced practice clinicians can safely and effectively provide early abortion care.[37,38] These studies conclude that complications are rare and no more common for APCs than for physicians.[39] In addition to equivalent efficacy and safety of abortion provision by physicians and APCs, studies also show that patient experience and satisfaction is not statistically different than when the services are provided by physicians.
- **Impeding abortion services even when it is in a health care provider's medical judgement that delay would pose a risk to the patient's health.[40]** Pregnancy imposes significant physiological changes on a person's body. These changes can exacerbate underlying or preexisting conditions and can severely compromise health. Doctors should never be put in the position of having to wait for a medical condition to worsen or become life-threatening before being able to provide evidence-based, compassionate care to their patients, including abortion.

States have imposed a panoply of other barriers to care on the patients our members care for. They include requiring forced waiting periods prior to the provision of abortion care which can, in practice, amount to delays of weeks; insurance coverage bans, both federally and at the state level, that make abortion care cost-prohibitive; and parental involvement requirements that routinely deny young women access to confidential care.

None of these restrictions are medically justified and they sometimes create insurmountable barriers for women across the United States. It cannot be overstated that the patients disproportionately harmed are women of color, women who must travel long distances to receive care such as those living in rural or other underserved areas, and low-income women. We commend the Chairwoman for inviting witnesses to participate in the hearing who can shed light on the lived experiences of these women and the role that state restrictions have in indefensibly limiting their access to care.

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[37] *Abortion Training and Education*. *Committee Opinion No. 612.* American College of Obstetricians and Gynecologists (Reaffirmed 2019). *At* https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education

[38] *The Safety and Quality of Abortion Care in the United States*. National Academies of Sciences, Engineering, and Medicine. (March 2018). *At* https://www.nap.edu/read/24950/chapter/1

[39] *Id.*

[40] *Increasing access to abortion.* Committee Opinion No. 613. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1060–5.

What Abortion Restrictions Mean for Physicians and Other Clinicians

Representing more than 60,000 physicians and other providers of women's health care, ACOG takes this opportunity to also highlight for the Committee the lived experiences of our members, and to share what restrictions have meant in real terms for their practices and their patients.

In the face of abortion bans sweeping the country, ACOG has received reports of concern and accounts from our ob-gyn members. They have described patients for whom long distances to travel, multiple trips to a clinic, and forced waiting periods delayed care beyond their states' arbitrary gestational age limit. ACOG's physicians have also shared accounts of parental-consent mandates forcing young women from abusive and neglectful homes to face additional obstacles in already fraught situations.

ACOG members from many states have expressed how restrictions and, in some cases, the threat of criminal penalties impede their ability to provide evidence-based medical care.

For example, we heard from one ACOG Fellow in Wisconsin who described how restrictions with limited exceptions and vague legal language have created an environment of confusion as to when providing lifesaving care would result in criminal penalties for physicians. Another ACOG Fellow recounted how restrictive policies with limited exceptions force physicians to wait until a patient's health has so deteriorated the she would die without such care. An ACOG Fellow practicing in Pennsylvania noted how the combined restrictions of the Hyde Amendment and state insurance prohibitions have limited or delayed access to lifesaving abortion care. These stories teach us that as with so many one-size-fits-all government mandates, proffered "exceptions" are often unworkable in practice.

Even in states where litigation has halted state restrictions from going into effect, their damage is profound. One ACOG Fellow living in Ohio who is a specialist in high-risk obstetrics recounted that even though some of the most extreme abortion restrictions in his state are currently blocked by the courts, their mere existence undermines patient care, with clinicians never knowing when the legal environment could change and turn them into criminals.

ACOG physicians have also recounted the ways in which their patients accessed abortion care to save their lives, protect their health, attain their educational goals, and to take care of their children. Again and again, our physicians' experiences demonstrate that every patient's circumstance is unique, and why one-size-fits-all mandates, combined with medically inaccurate rhetoric and stigma, impose significant harmful barriers to women's access to care.

Conclusion

ACOG urges Congress to protect women and their physicians from unwarranted intrusions into the practice of medicine and the patient-physician relationship. Critical first steps include

passage of H.R. 2956, as well as the H.R. 1692, the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act to ensure that all women, regardless of economic status and geographic location, have access to abortion by repealing the Hyde Amendment. Additionally, we respectfully urge Congress to call on the Food and Drug Administration to remove unnecessary requirements from mifepristone to increase access to this safe medication for all women.

Thank you for the opportunity to highlight our clinical guidance regarding reproductive health care, the importance of evidence-based research, our members' experiences, and the experiences of the patients for whom they care. ACOG looks forward to continue working with the Committee to protect women's access to comprehensive reproductive health care.