D&E Abortion

Thank you for giving me this brief time to discuss the question at hand, ie., the prohibition of an abortion by the D&E (Dilation and Evacuation) method, generally used for abortions done at about 13-22 weeks. For clarification, surgical first trimester abortions are done by D&C (dilation and curettage). Surgical abortions beyond a D&E, up to the legal limit of 24 weeks, have been done by a procedure called D&X , in which the cervix is dilated, the fetus is partially delivered in a breech presentation, then the fetal skull is collapsed so that the delivery can be completed.

I've tried to be open to arguments on both sides of the issue by discussing this issue with several obstetrician/gynecologist friends who are "pro-choice," and who have done D&E abortions. I've also brought to you today a letter which attempts to strongly support the value and safety of legal abortions. It is authored by 100 professors of obstetrics, published in the American Journal of Obstetrics and Gynecology in Sept. 2013. I've also brought a response to that letter, authored by myself and many "pro-life" obstetricians, published in Issues in Law and Medicine, Vol 29, No 1, Spring 2014. I will leave copies of both so that you can read and judge for yourself which arguments are better documented by the published literature, and will send further copies if requested.

I hope we can all agree on a few things:

1. Abortion is one of the most, if not the most, divisive issues in our nation – more important and emotionally charged to many citizens than a flat tax, immigration reform, gun control, etc.

2. No one on either side of the debate is smarter or better than those on the other side. We're all trying to do what we believe is best in a difficult situation.

3. Pregnancy involves two patients. William's textbook Obstetrics, long the leading textbook in our field, has clearly stated years ago:

> "Obstetrics is an unusual specialty of medicine. Practitioners of this art and science must be concerned simultaneously with the lives and well-being of two persons; indeed the lives of the two who are interwoven."

4. Abortion kills the fetus, which is even admitted by Planned Parenthood, the largest abortion provider in the country. In one of their earlier pamphlets, before they became involved in the abortion industry, their pamphlet clearly stated, when discussing birth control:

> "Is it an abortion?"
>
> "Definitely not. An abortion kills the life of a baby after it has begun. It is dangerous to your life and health. It may make you sterile so that when you want a child you cannot have it. Birth control merely postpones the beginning of life."

Though the current issue is a bill prohibiting D&E abortions, to discuss a particular type or timing of an abortion, without considering the question of abortion as a whole, is similar to discussing whether to allow child abuse of a five year old, as opposed to a 2 year old, or what methods of child abuse might be acceptable or unacceptable. If something is wrong, it's wrong no matter how or when it's done.

Those of us on the "pro-life" side of the debate believe abortion is the unnecessary killing of an unborn child, 'unnecessary' meaning for any reason other than truly to save the life of the mother, which is exceedingly rare. I've been a physician for 41 years, finished my residency in Obstetrics in 1987, and my fellowship in Maternal-Fetal Medicine (high risk pregnancy care) in 1989, and have been board certified in both since 1991. In all those years, I have seen only 6 such cases, and have not hesitated recommending that the pregnancy be ended, even though the fetus was too early to survive. In those situations, the primary intent was not to kill the child, but to save the mother and the only way to do that was to empty the uterus quickly. Unfortunately the child's life is ended in the process, but the aim is to treat the mother's medical problem, not to harm the child. In almost every abortion, the aim is to kill the child, since the vast majority of abortions are not done on patients who are in imminent danger of death – we all know that.

Now to the point of today's discussion, ie., is a D&E abortion really necessary? There are articles which claim that it's safer than induction if done by someone skilled at the procedure, but others disagree, particularly with the agents we now have for induction, such as Cytotec (Misoprostol, a prostaglandin which stimulates the uterus to contract). My argument is not with the actual D&E procedure. Similar to such things as fire or sex or exceeding the speed limit – it can be good or bad, depending on the situation. I have no problem with a D&E if it's to empty a uterus when the child is deceased, or in the rare situation when a problem needs to be resolved more quickly than induction, eg., if a patient is bleeding heavily, or if she has severe preeclampsia with severe liver and neurologic manifestations, and the time needed for an induction would truly put her at risk of losing her life. I have called on one my friends to do a D&E for a severely preeclamptic patient at 18 weeks gestation, with a BP of 240/120, neurologic symptoms, and severe liver inflammation – all due to what is known as a partial (incomplete) molar pregnancy in which both a fetus and an abnormal placenta are present. The fetus commonly has a lethal genetic problem involving 69 chromosomes, but the fetal abnormality wasn't the issue, but rather it was the abnormal placenta causing the mother's critical condition, so the placenta needed to be removed quickly. Unfortunately the fetus is lost at the same time. The D&E was done under general anesthesia so as to avoid fetal pain.

A D&E is not totally benign for the mother, however, and surgical abortions in general have been found by several authors to increase the risk for preterm births in future pregnancies by about 30%., an odds ratio of approximately 1.3:1. With two abortions, the odds ratio increases to 1.9:1, almost doubling the risk for a preterm birth in the future, and since preterm birth is the leading cause of infant morbidity and mortality, it's not only this current fetus who is destroyed, but the mother's future children are also put at risk.

The three "pro-choice" friends I discussed this with (including my partner of 26 years) all agree that there is a degree cervical trauma from rapid dilation of the cervix (with Hagar dilators) up to close to 2 cm., and that this does predispose to future cervical insufficiency. For this reason,

they will use laminaria inserted into the cervix the day prior to the procedure to soften and partially dilate the cervix before the D&E, hopefully lessening the cervical trauma. However, if the situation is not urgent, and there's enough time to place laminaria and wait until the next day, then is there really a reason to do the D&E at all in most cases? They agree that it's better to use the time for an induction, though even abortion by induction is also not risk free for the mother, since there is sometimes bleeding or retained tissue which requires a curettage, but at least the cervix is not being forced open. These "pro-choice" friends hope that the option for the D&E procedure is not taken away because there are rare situations, as described above, where it is the best option for the mother., and they would prefer to have the option still available for patients who simply choose this option – it's one of the points on which we disagree.

Point of disagreement:
1. Legal abortion is claimed to be safer than illegal, but "safer" does not mean "safe," and there are still significant risks to the mother's physical and mental health, and the health of her future children. The following statements are clearly documented in "A second Opinion: Response to 100 Professors (2014), which was written in response to "A statement on abortion by 100 professors of obstetrics: 40 years later."(2013)

a) Even in the first trimester, complications involve hemorrhage (2-15%), incomplete abortion (1.6% to 6.7%); need for surgical reevacuation (1.8-5.95%), and these complications increase dramatically as gestational age increases. According to the CDC, the maternal mortality rate from legal abortion after 22 weeks exceed the risk of death from live birth.

b) Psychological problems are documented in a 2011 comprehensive meta-analysis published by Coleman PK, in the British Journal of Psychiatry, which noted an overall 81% increased risk for mental health problems, including depression, anxiety, alcohol abuse, and suicide behaviors associated with abortion.

c) Increased pre-menopausal breast cancer risk has been documented in studies from around the world, as noted by Angela Lanfranchi, FACS, in 2014, "Breast Cancer and Induced Abortion". The pathophysiology of this connection is explained in her article in the same Spring 2014 issue of Issues in Law and Medicine presented here today for your reading.

d) A significant increase risk of prematurity in future pregnancies has been documented in numerous publications, as noted above and referenced (Iams, 2010 AJOG; Hardy, 2013 J Obstet Gynaecol Can; Shaw, BJOG 2009, etc) in our "Response to 100 professors."

These complications of legal abortions are, not surprisingly, denied by many advocates of induced abortion. The "pro-choice" obstetrician friends I've mentioned are kind, intelligent human beings who care greatly for their patients, but once someone has crossed that line, ie., once someone has done an abortion, or encouraged someone else to abort, or voted for legislation legalizing abortion, or supported "pro-choice" candidates, it must be very difficult to admit that you've been part of something which destroys a life. We all come to this debate with

our own background and ethical positions, so we may not be totally objective in our evaluation of the literature. The bottom line remains that an abortion kills an innocent, defenseless, member of the human family, and should never be done unless the mother's life is truly going to be lost if the pregnancy continues. All other reasons given are false, and hopefully someday this great country will cherish all of its members, born and unborn. It's not only the mothers and the unborn children who suffer from abortion – we all do. Mother Theresa once said:

"Any country that accepts abortion is the poorest of the poor."

My suggestion is that a D&E is a surgical procedure that is occasionally necessary for a deceased fetus, but as a method of abortion, ie., to kill a living child by tearing that child to pieces, it should be illegal, except in the rare situation mentioned above, when a mother is critically ill and there's no time for a Cytotec induction, and in those cases it should be done only after a consultation (at least by phone) has been obtained from a "pro-life" obstetrician, and the D&E should be done under general anesthesia, with time allowed for fetal anesthesia.

While some authors argue that a D&E is safer than induction, the experienced "pro-choice" obstetricians I've spoken with do not agree, and some countries with liberal abortion laws do not use this technique.

My background, if anyone is interested: After medical school, I worked in a large Cincinnati hospital for two years, rotating in obstetrics, pediatrics, internal medicine, and ~~pediatrics~~ orthopedics, in preparation for working as a general practitioner in the Appalachian area of Kentucky. I delivered babies, set broken bones, treated heart attacks, meningitis, etc., for eight years, living in a log cabin, on call 24/7. I eventually decided that the area where I could do the most good was in obstetric care, and I wanted the surgical skills to be able to do some mission work. I did a residency in Ob/Gyn, then a MFM fellowship, and have now been practicing in high risk pregnancy care since 1989. I continue to be available 24/7 to any physician or patient. My pager number is 989-2226594 (put in your # after prompt) if you know anyone who is in need of help.

We present some more positive solutions to abortion in the appendix to our response. My wife and I are married 43 years, have 12 children including 2 adopted through special needs programs. We've had 3 young pregnant women live with us until 6-8 weeks after delivery, when they felt able to be on their own. We've had over 25 foster children and have started 529 college funds for all except the few who were only with us for a couple weeks or less. We've had over 20 foreign exchange students from other countries. We've had families from Africa live with us when they needed medical care here in the US, and we've had a family from New Orleans after Katrina. I've served temporarily in an American Indian hospital, in Africa, South America, Haiti, and a small island in the Caribbean. We don't feel we're doing anything special, just trying to fill the needs we see, trying to be "pro-life" in ways other than just saying no to abortion requests.

GENERAL GYNECOLOGY

A statement on abortion by 100 professors of obstetrics: 40 years later

One Hundred Professors of Obstetrics and Gynecology

In this Journal in 1972, 100 leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade. They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility. They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists. Forty years later, 100 professors examine the statement of their predecessors in light of medical advances and legal changes and suggest a further course of action for obstetrician gynecologists.

Key words: abortion, law, teaching hospital

Forty years ago, leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade (Supplementary Data available at www.AJOG.org).[1] They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility.[1] They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists.

Since then, we have advanced the fields of reproduction and family planning. Thanks to these developments, women can now prevent pregnancy with safer and more effective forms of contraception (most recently long-acting reversible methods), with simple and sensitive hormonal and sonographic methods to determine pregnancy status and duration, and with new methods of infertility treatment and prenatal testing that rely on the option of terminating intended pregnancies that are diagnosed as abnormal. To terminate pregnancies, clinicians now use misoprostol and mifepristone for "medical abortion" (which in 2009 accounted for 16.5% of terminations in the United States and can be office-based) and use sonographic guidance of intrauterine procedures along with new methods for inducing cervical dilation and uterine contraction; patients benefit from innovations in counseling and new approaches to pain control.[2-6] Studies of abortion practice and outcomes are also much more sophisticated than they were 40 years ago.[7,8]

We have had 40 years of medical progress but have witnessed political regression that the 100 professors did not anticipate. In 2011 alone, 24 states passed 92 legislative restrictions on abortion.[9] Waiting periods after consent are now law in 26 states. Alabama, Arizona, Florida, Kansas, Louisiana, North Carolina, Oklahoma, and Texas require patients to view ultrasound images and, in Arizona, Louisiana, Mississippi, and Texas, to listen to fetal heart beats.[10] Laws in 27 states force physicians to provide deceptive counseling including false statements about risks of breast cancer, infertility, and mental health. They include laws to limit second-trimester abortion under the guise of protecting the fetus from pain (Alabama, Idaho, Indiana, Kansas, Louisiana, Nebraska, and Oklahoma).[11] Laws directed specifically at medical education in Arizona, Kansas, and Texas prohibit abortion training in public institutions and another 7 states ban abortion in public hospitals, precluding training in them.[12]

What vision of the future of legalized abortion did the 100 professors have? How accurately did they estimate the need for safe, legal abortion and anticipate their colleagues' willingness and commitment to meeting it? They wrote, "In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we believe it helpful to [respond] to this increasingly liberal course of events…by contributing to the solution of an imminent problem."[1] Forty years later, the change is not liberal. Its effects will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices. We review our predecessors' 1972 statement and judge how it comports with what actually occurred and with legislation that has been adopted over the 40 years since their writing and the passage of Roe v Wade.

The 100 professors were remarkably prescient in anticipating the need for 1 million legal abortions and today's abortion rate of 1 in 4 pregnancies.[13,14] They predicted that teaching hospitals with specialized outpatient facilities could meet the demand and believed that abortions were the responsibility of hospitals. But today, 90% of abortions, which include the 10% that are in the second trimester, are done away from hospitals.[15] Many hospitals enforce fetal and maternal health restrictions that

From the 100 Professors (Appendix).

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are not based in the law but are contrived and enforced by the same kind of "ethics committees" that were common before the professors' 1972 statement.[1] Some institutions offer terminations only to save a woman's life; others will perform the procedure under no circumstances at all. At the same time, many states have passed legislation to shut down the freestanding clinics that are now responsible for most abortions by enacting cumbersome and expensive building regulations that are disguised as patient safety requirements.[16] There are now 25 states that, under the guise of patient safety, restrict abortions to hospitals that have their own restrictions or to specialized facilities.

In our view, hospitals have disregarded the responsibility that our academic predecessors expected them to assume. Although most first-trimester and many second-trimester abortions can be done safely and efficiently in a clinic setting, some second-trimester abortions, particularly those that are complicated by medical conditions, should be done in a hospital with rapid access to the operating room, interventional radiology, blood bank, and other emergency interventions.[17] Hospitals and expert clinicians are essential for the education of students and training residents who care for complicated cases and for treating complications.

The 100 professors went on to say that physicians should learn uterine aspiration, which is an outpatient procedure that today accounts for 82.3% of abortions, and local anesthesia and analgesia, which includes conscious sedation, so that complications and expense of general anesthesia would be reduced.[6] Today, some hospitals confine pregnancy termination, even routine first and uncomplicated second-trimester spontaneous and induced abortions, to operating rooms and have credentialing rules that prohibit the use of conscious sedation for these patients.[18] Ignoring the 100 professors' counsel not only dramatically increases patients' recovery time and expense, but also adds significant and unnecessary staffing and clinical costs that discourage hospitals from providing abortions at all.

Regarding hospital policies and the role of "abortion committees," the 100 professors wrote "therapeutic abortion boards will have no place...in states with laws which stipulate that abortion decisions are to be made by the physician and his [her] patient."[1] The 100 professors commented on the physician's duty to counsel regarding abortion: "There are patients...who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies." At that time, the professors would have been thinking of rubella and did not know that advances in prenatal diagnosis would give obstetricians the opportunity and responsibility to make their patients aware of a wide range of genetic anomalies and to offer abortion if requested. The 100 professors certainly would not have envisioned the legislation recently proposed in Oklahoma to entitle physicians to withhold information in cases of known fetal deformity because a knowledgeable patient might choose termination.

Writing about doctors with conscientious objections, the 100 professors said that these physicians must be excused from performing abortion but must refer patients to colleagues who can care for them. Recent "conscience clause" legislation does not require referral for abortion, and some states (Colorado, Ohio, Wisconsin, Michigan, and Texas) specifically prohibit referral for abortion by physicians who work in institutions that receive state funding for women's health services.[19] The American College of Obstetricians and Gynecologists, which discussed the limits of objection, recommends that "Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled."[20] Despite this guidance, many physicians are now prohibited by law from referring patients to vital services. In Texas, for example, referral for abortion can result in denial of contraceptive funding.

The 100 professors predicted that space and resources for hospitals to provide abortion would result from "...the lessened number of septic abortions."[1] The Centers for Disease Control and Prevention and others subsequently documented a steep decline in hospital admissions and morbidity and mortality rates from illegal abortion promptly after Roe v Wade made abortion legal in all the states.[21]

The savings in lives and money from legalization were soon forgotten, and many hospitals now claim they cannot afford to provide abortions even if they wanted to because, among other arguments, reimbursement rates are too low (but abortion is certainly not the only service in this category), free-standing clinics provide faster and cheaper services with which hospitals cannot hope to compete (but some hospitals are able to provide cost-effective abortions), and hospital employees, notably nurses, refuse to provide abortion care (unlikely true of all or most nurses).

Some hospitals with abortion services still face legislative challenges. Even though many residency programs have integrated abortion training successfully, individual states and, recently the US Congress, have legislated restrictions on abortion training in disregard of Accreditation Council on Graduate Medical Education training mandates.[22,23] These restrictions ultimately threaten women's health by denying residents training in uterine evacuation, which further reduces access to safe abortion.

The 100 professors considered the consent process for abortion, stating that "...it has been ruled by [some] courts that an adult woman is free to make this decision by herself."[1] However, several state legislatures have interfered in the consent process by requiring that irrelevant, even untrue, information be given by the physician (eg, abortion causes breast cancer and fetal pain) and enacting burdensome waiting periods that increase risks and costs.[9,11] They further predicted "that the courts will someday decide that "any girl who is physically mature enough to conceive should, ipso facto, be granted the freedom to determine the fate of her pregnancies." Yet politicians in 37 states have restricted freedom of access of minors to abortion by implementing parental consent or notification laws,

often with clumsy, prolonged "judicial bypass" requirements that lead to dangerous delays.[24]

The professors addressed the need for postabortion contraception to decrease the need for abortion, endorsing it as "an integral part of any abortion program,"[1] but today the most effective contraceptives are still not easily accessible immediately after abortion when women most want them. Although the American College of Obstetricians and Gynecologists, Planned Parenthood, and other organizations promote postabortion use of long-acting reversible contraception, the family planning funding regulations of many states do not pay for immediate postabortion methods, and several states (eg, Indiana and Texas) and the US House of Representatives have attempted to eliminate family planning from their budgets entirely.[19]

Finally, the 100 professors recommended that "abortion should be made equally available to the rich and the poor."[1] Ironically, shortly after the 1973 Roe v Wade decision that our predecessors anticipated, the Hyde Amendment prohibited the use of federal dollars for abortion so that women in the military or who have received Medicaid have had severely limited access to abortion for nearly 40 years, unless they can pay themselves or happen to live in one of the 13 states that use their own funds for abortion.[25] Richer women, on the other hand, usually have private health insurance for abortions but there, too, the US Congress threatens women's health by insisting that the Affordable Care Act restrict even private payers from directly including abortion.

In consideration of current legislative threats to the autonomy of our patient relationships, to evidence-based medical practice, to the training of our students and residents, and ultimately to the health of our patients, we 100, including 2 of the original signers, join the 100 of 1972 in affirming our academic responsibilities to (1) teach future practitioners about all methods of contraception and about uterine evacuation throughout pregnancy, which ranges from miscarriage management to emergent evacuations and the treatment of complications in accordance with our professional mandate from Accreditation Council for Graduate Medical Education; (2) provide evidence-based information to all patients who seek family planning or pregnancy termination; (3) provide evidenced-based information to legislators who propose laws requiring inaccurate information or unindicated procedures for women seeking to terminate a pregnancy; (4) insist that the hospitals where we care for women and teach students and residents admit patients who require hospital-based pregnancy terminations, and (5) ensure the availability of all methods of contraception, particularly long-acting reversible contraception methods, to reduce the need for abortion. ■

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Appendix

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