



AAPLOG

COMMITTEE OPINION

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State Restrictions on Abortion: Evidence-Based Guidance for Policymakers

The Supreme Court decision on Dobbs v. Jackson returns abortion regulation to each state, similar to the way the practice of medicine is regulated at the state level. State policymakers must be aware of the most up-to-date evidence on abortion and the effects of abortion restrictions in order to implement what is best for their constituents. There is no scientific evidence that restricting elective abortions leads to increasing maternal mortality; in fact, several good-quality studies show a decrease in maternal mortality after abortion restrictions have been implemented. State restrictions which enforce standard medical care, such as making a diagnosis before implementing an intervention, requiring full informed consent with appropriate waiting periods between decision and intervention, and requiring screening for contraindications, including mental health risk factors, are common-sense interventions. Restrictions on elective abortions—those procedures done with the primary intent to produce dead offspring—will have no effect on medically-indicated separation procedures necessary to save the life of a woman.

Background

The court that wrote *Roe v. Wade* into jurisprudence recognized that governments have legitimate interests in protecting a fetus, such as the interest in population and economic growth. However, the *Roe* court did not delineate what this fetal interest is or how it is to be applied. The Court only commented that state interests increase with gestational age, and they created a

“trimester” system (then unknown in obstetrics) to crudely delineate when the states were allowed to pass any regulations on abortion.¹

For the past 50 years, *Roe* largely quashed difference of interpretation of that interest — all states were functionally required to relinquish any interest in protecting fetuses until the third trimester, when they could theoretically restrict abortion, protecting

fetal life. As the limits of fetal viability were extended into the second trimester by survivals of fetuses born at 24 weeks, a second Supreme Court decision, *Casey*, eliminated the *Roe* trimester limitations, instead substituting a viability standard that allowed states to restrict abortion on the basis of fetal interests after viability.² Since then, states have passed laws displaying varying interpretations of the state's interest in protecting fetal life and some judges have treated some fetuses as juridical persons.³

Roe's court acknowledged that there is difference in opinion about when human life begins, but did not engage with any evidence for these opinions or allow any opinion other than its own. The *Dobbs* court has appropriately reestablished the legal exercise of states to determine how to protect their compelling and legitimate interests in fetal life, in accord with the values held by the people.

Additionally, there are a variety of perspectives on how to define women's health and how this intersects with the interest in protecting the fetus. Although abortion advocates often discuss the harms to women due to abortion restrictions, there are very few comparisons of abortion policy in the United States given the forced uniformity of *Roe*. However, available data from natural experiments worldwide suggest that abortion restrictions are not automatically associated with undesired or adverse outcomes.

Clinical Questions and Answers

Q Do abortion restrictions prevent physicians from ending pregnancy for the sake of saving maternal lives?

Appropriate abortion restrictions do not prohibit physicians from ending pregnancy in the case that the life of the mother is threatened. A recent survey of obstetricians in private practice indicates that only 7% perform abortions, suggesting that abortion is not essential to women's health if over 90% of women's health physicians do not offer it.⁴ If a life-threatening maternal medical condition requires separation from the fetus, delivery can be initiated without the primary intent to cause a fetus to die. Preterm and even previable delivery of an intact (and usually living) infant to save the life of the mother is fundamentally different from intentionally ending the life of the fetal human being prior to delivery, often by means of dismemberment.⁵

Q Do abortion restrictions actually decrease abortion rates?

Abortion restrictions can decrease abortion rates, but statistics are often used to misrepresent this effect. One example of this statistical misrepresentation is found in the assessment of the Mexico City Policy, later known as the Protecting Life in Global Health Assistance Policy (PLGHA). PLGHA is a policy through which the United States restricts USAID funding to organizations that promote abortion in the

developing world, while still permitting maternal care. PLGHA has been instated and revoked several times with the changing United States political landscape.

Authors associated with the Guttmacher Institute have asserted that countries impacted by this policy saw an *increase* in abortions while the policy was implemented.⁶ This is alarming for PLGHA supporters, who aim to promote authentic maternal healthcare and decrease the rate of abortion. However, this conclusion emerges from a misuse of a statistical model called the difference-in-differences assessment, which obscures the impact of policies on abortion rates.

The difference-in-differences model is an econometric model designed to assess the impact of an intervention over time using a comparison group in which the intervention was not implemented.⁷ The method compares the difference between the intervention and comparison groups before the intervention is implemented, to the difference between them afterwards. The impact of the intervention is judged by how much the difference between the two groups changes, not on the actual change within the intervention group, which accounts for background trends due to other causes. With this model, investigators compared relative changes in abortion rates, not actual numbers.⁶ The authors compared abortion rates in countries most reliant on USAID funding to those less reliant on USAID funding. Their data are presented so that it appears there was a paradoxical increase in abortions with the PLGHA in the countries reliant on USAID

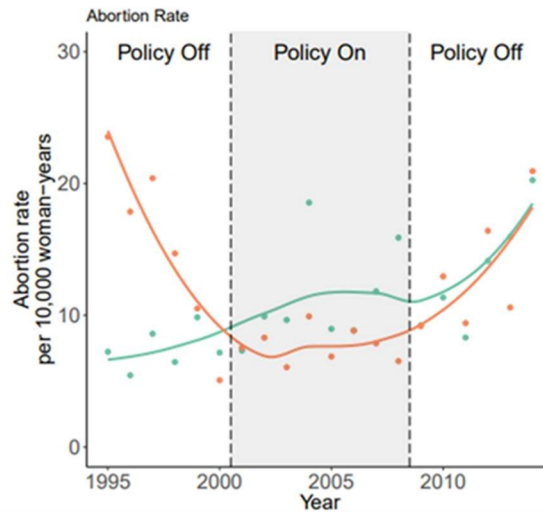


Figure 1. Rates of abortion in countries receiving significant (green) vs less (orange) USAID. Reproduced from The Lancet, Brooks et al., with permission.

funding, when in fact those countries' rates stopped rising and began to fall while the policy was in place.

A closer examination of the data demonstrates this (Figure 1). The abortion rates between countries with the most influence from USAID funding (green) and the least influence from USAID funding (orange) did not move in parallel prior to the PLGHA. Without PLGHA, abortion rates were rising in the countries receiving more USAID funding, but were falling in countries receiving less. This violates the "equal trends" assumption of the difference-in-differences model and therefore makes it an inappropriate analysis of the impact of PLGHA. With the implementation of PLGHA, countries reliant on USAID funding eventually saw a decline in abortion rates before the policy was revoked, when abortion rates increased sharply again. This picture is against a somewhat confusing background of countries less dependent on USAID funding, which saw increases and

decreases in abortion rates less connected with PLGHA.

Overall, there is not a universal answer available as to whether abortion restrictions uniformly decrease abortion rates; many variables are at play, such as socioeconomic and cultural factors, as well as access to maternal and child healthcare. Further study would be necessary to respond to the answer in each case with straightforward data.

Q Does expanding abortion access increase abortion rates?

A common assertion is that legalizing abortion keeps the number of abortions stable while decreasing the proportion of unsafe abortions, but this contradicts U.S. estimates between 1972 and 1973. In 1972, NARAL estimated there were 200,000 illegal abortions,⁸ and census data documents approximately 64,176,000 females aged 15 to 44,⁹ for a total rate of 3.1 abortions per 1000 women. The Guttmacher Institute, which provides statistics on abortion rates from 1973, reports an abortion rate of 16.3/1000 in 1973, more than five times the pre-*Roe* rate.¹⁰

Q Do abortion restrictions result in higher maternal mortality rates?

Abortion advocates often assert that maternal mortality rates inevitably increase when women cannot readily access abortion, but very poor data exist to support

this claim.¹¹ In fact, some data suggest that *abortion* is associated with higher mortality rates, and restrictions may result in improved maternal outcomes.

In Finland, where health data is centralized and progressive policies are in place, abortion is associated with 49.5 maternal deaths per 100,000 women; in comparison, all external causes of death after delivery only represented 8.1/100,000. For all pregnancy outcomes in all age groups under 40, mortality rates were highest after termination of pregnancy.¹² This may relate to several things, including that patients seeking abortion may have a higher baseline risk of maternal mortality. Even if this statistic is very biased, it shows that abortion is unable to resolve any underlying mortality risk.

It is noteworthy, too, that abortion is associated with high risk of maternal death even though Finland only permits abortions before 12 weeks, the least dangerous time of abortion. In contrast, most U.S. states permit abortion through the second trimester, even though the risk of death due to induced abortion increases by 38% for every week after eight weeks gestation.¹³ Maternal health outcomes in Finland are superior to U.S. outcomes, and statistics such as these support restriction of abortion to improve rates of maternal mortality.

Mexican states with more restrictive abortion laws had lower overall maternal mortality ratios (38.3 vs 49.6; $p < 0.001$) compared to Mexican states with more permissive abortion laws. Moreover, abortion

itself may also be safer in states with more restrictive laws, given that these states have lower maternal mortality ratios after induced abortion (0.9 vs 1.7; $p < 0.001$).¹⁴

In Chile, an enormous drop in the rate of maternal mortality over a fifty-year period was largely related to health and safety infrastructure. During this period, Chile made abortion illegal, but continued to see the same improvement in maternal mortality rates—making abortion illegal neither improved nor perturbed the improvement in maternal mortality.¹⁵

South Africa, a counter-example, has seen maternal mortality rates *improve* with legalization of abortion after a longstanding prohibition.¹⁶ As in Chile, abortion restrictions are one variable in a network of contributors to maternal mortality, but they do not automatically increase the rate of maternal deaths.

Q Do abortion restrictions result in substandard care for women?

Women seeking abortions deserve the same level of healthcare as any other woman. In many cases, abortion restrictions improve the level of care for women by making abortion more like other interactions between physicians and their patients. Restrictions such as ultrasound requirements, hospital privileges, and waiting periods can protect women who deserve care like patients in other areas of surgical and pregnancy care.

Ultrasound requirements require abortion providers to verify gestational age and pregnancy location. Put simply, these restrictions ensure that providers make an accurate diagnosis before beginning an intervention. The risks of abortion increase significantly the further along in pregnancy a woman is, so accurate assessment of her gestational age is crucial to providing her a correct sense of the risks she accepts by consenting to abortion.¹³ The American College of Obstetricians and Gynecologists (ACOG) describe that only half of women accurately recall their last menstrual period, the simplest way to date pregnancy. For this large proportion of women, dating should be based on ultrasound estimates and women without an ultrasound to confirm or revise their due date before 22 weeks are suboptimally dated.¹⁷

According to this guidance, women who do not receive an ultrasound prior to abortion are suboptimally dated, which diminishes the accuracy of providers' counseling about procedure risks. However, in the case of abortion, ACOG claims that ultrasounds are "medically unnecessary" prior to abortions.¹⁸ ACOG does not comment on how informed consent could be adversely impacted or even impossible without accurate knowledge of intrauterine location and gestational age. In contrast, AAPLOG recommends ultrasounds as medically appropriate.¹⁹

Hospital privilege requirements help abortion providers accurately assess complications and outcomes of their procedures and prevent women from being medically abandoned after their procedure.

Currently, the ramifications of abortions are not usually felt by the abortion providers or clinics, but by urgent care facilities, emergency departments, and other women's health providers who provide treatment for abortion complications.²⁰ These providers typically do not have contact with the abortion providers or access to patients' history, which represents a significant gap in communication about care.

ACOG acknowledges that "accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety" and that "[o]ne of the leading causes of medical errors is a breakdown in communication."²¹ In fact, ACOG describes a "handoff" as "the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another."²¹ ACOG does not encourage any form of handoff between abortion providers and emergency personnel and no standards for such handoff exist. One alternative to handoffs would be to have abortion providers on call for surgical complications, like many surgical providers in the American healthcare system, but ACOG guidelines do not support this practice.

In summary, ACOG's general communication standards are excellent for women's health, but need to be consistently applied to providers who perform abortion. In the absence of this practice, states may have a vested interest in regulating patient handoffs or admitting privileges to avoid medical error, patient abandonment, or

inaccurate perception of complications among those performing abortions.

Q Do abortion restrictions result in coercion of women?

Just as some restrictions aid diagnosis by confirming intrauterine pregnancy and gestational age, others can aid informed consent. Data suggest that many women are either unsure of their decision to pursue abortion or feel pressured into it.²² A 2004 study that surveyed women who had undergone abortions in the U.S. showed the importance of waiting periods, increased counseling and in-person visits in order to screen for coercion and ensure informed consent.²³ Selected findings include:

- 67% of women stated they received no counseling prior to their abortion.
- Only 11% of women felt that the counseling they received prior to their abortion was adequate.
- Only 17% of women were counseled on alternatives.
- 64% of women responded that they felt pressured to have the abortion.
- 54% of women were unsure about their abortion decision at the time of their abortion.
- 30% of women who responded had health complications after their abortions.

- 36% of women had suicidal ideations after their abortions and 54% felt bad about their decision.
- 60% of women stated that they felt "part of me died."
- Only 4% of women claimed to feel more in control of their life after their abortion.

This cohort of patients' experiences is vulnerable to recall bias and selection bias, but it nevertheless provides evidence that some women remember their abortion as an experience of uncertainty, incomplete counseling, and regret. This suggests a particular type of restriction, such as waiting periods or specific requirements for informed consent, may improve consent and sureness about decision-making.

Another advantage of waiting periods is the ability to provide standard medical care, such as Rho(D) immunoglobulin administration when indicated, which decreases the rate of alloimmunization in future pregnancies.²⁴

Q Could abortion restrictions decrease preterm birth rates?

This question has never been directly studied. However, the Institute of Medicine lists surgical abortion as an immutable risk factor for preterm birth (PTB),²⁵ as over 165 studies converge on increased risk and dose effect from multiple abortions.²⁶ Preterm birth adds \$26.2 billion to U.S. healthcare expenditures yearly²⁷ and has

unmeasured long-lasting costs related to the higher rates of cardiovascular disease and stroke among mothers who deliver preterm infants.²⁸ This increased risk of preterm birth is especially impactful in Black women, who already have a three-to-four-fold higher abortion rate and double the preterm birth rate compared to non-Black patients.^{29,30} As a result, states may see a compelling and legitimate interest in reducing preterm birth by restricting surgical abortions.

Q Could abortion restrictions decrease the burden of mental illness?

In addition to the physical ramifications of abortion, there is also a relationship between abortions and mental health complications. America is battling its largest mental health epidemic to date, and many women seeking abortion possess one or more of the 14 risk factors for adverse mental health outcomes determined by the American Psychological Association.³¹ From 1993 to 2018 there were 75 studies examining the relationship between abortion and mental illness, of which two-thirds showed an increased risk of mental health complications after abortion.³²

Abortion advocates usually focus on multiple studies that emerge from a single cohort of women (the Turnaway cohort), but these studies all carry biases that stem from the way the data was collected. The cohort had a response rate of 37%, low for

a highly-cited study with multiple secondary analyses.³² After recruitment, 44% of women dropped out leaving a cohort of only 17% of eligible participants. This small slice of the population is vulnerable to selection bias since women more wounded by abortions may be less likely to participate. The original Turnaway study did not collect variables known to increase the risk of adverse mental health outcomes such as gestational age. Given these weaknesses it is unwise to rely only on Turnaway data; instead, an honest assessment of the effects of abortion should use the entirety of the scientific literature on this topic.

The most comprehensive review of available literature done in the United States showed that 49 of 75 (65%) studies showed a positive correlation between abortion and adverse mental health outcomes.³² Here, abortion significantly increased the risk for depression, anxiety, substance abuse, suicidal ideation, and suicidal behavior, even when compared to women with unintended pregnancies who carried to term.

Outside of the U.S., the most complete data set on this topic is the previously-cited Finnish study on maternal mortality, which showed a seven-fold higher suicide rate after abortion when compared to giving birth. The mortality rate for suicides was 3.3/100,000 in ongoing pregnancies, 21.8/100,000 after termination of pregnancy, and 10.2/100,000 among non-

pregnant women.¹² Certainly there are many factors that differ between the group of women seeking abortions, the group of women who continue towards delivery, and women who are not pregnant. At the very least, these data suggest that abortion cannot nullify the effects of these differences—it is not a cure for any pre-existing determinants or conditions, nor is it a reliable preventative measure.

In summary, a minimum of 20-30% of women suffer from serious, prolonged negative psychological consequences after an abortion, which amounts to 260,000 new cases of mental health problems in the U.S. each year.³² Given the current mental health crisis in the U.S., lawmakers may seek abortion restrictions to alleviate this burden on Americans.

Q Do state-level abortion bans contradict “reproductive justice?”

According to certain definitions of a “just society,” claims have been made that abortion restrictions violate “the human right [to] maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”³³

This framework focuses on the real burdens of pregnancy and childbirth, which are indeed separate from the subsequent burdens of parenting and are not relieved by surrendering or adopting a newborn.³⁴

However, this framework fails to take into account the fetal patient, which is also being cared for by prenatal care providers. Abortion is not a decision to “not have children,” it is actively ending the life of a pre-born child.

State legislators need not endorse abortion as the only or best means of avoiding the legitimate burdens of pregnancy and childbirth. There are other options. Policy-makers on both sides should strongly consider funding initiatives that alleviate poverty, aid families in need, improve prenatal care services, and prevent unplanned pregnancies.

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. The large majority of OB/GYNs do not perform abortions, suggesting it is not essential to women’s healthcare.
2. Abortion restrictions do not prohibit physicians from separating mother and fetus through induction of labor or cesarean section in the case of life-threatening maternal conditions. Delivery can be initiated without the primary intent of causing the fetus to die.
3. Preterm or previable delivery of an intact (usually living) fetus due to a life-threatening maternal condition is

fundamentally different from intentionally ending the life of the fetal human being prior to delivery. The risk of death from induced abortion increases by 38% for every week after eight weeks gestation.

4. Surgical abortion is associated with increased rates of preterm birth; more abortions lead to higher increases in preterm birth rates.
5. There is an association between abortion and mental health problems, especially with certain underlying risk factors.
6. Abortion is associated with increased suicide rates in a Finnish sample.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

1. About 20-30% of women who undergo an abortion will subsequently suffer from serious, prolonged negative psychological consequences, which amounts to 260,000 new cases of mental health problems in the U.S. each year.
2. Some abortion restrictions reduce the rate of abortions, although many variables affect these situations.
3. Some women remember their abortion as an experience of uncertainty, incomplete counseling, and regret.

The following recommendations are based primarily on consensus and expert opinion (Level C):

1. Regulating handoff of post-abortion patients or requiring admitting privileges may support patient care by avoiding medical error, preventing patient abandonment, and improving measurement of abortion complications.
2. Waiting periods may improve consent and sureness about decision-making.

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