NJTODAY.NET
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News Record | Patriot | The Atom Tabloid
CMD media
online 24/7 since 2002
ISSN 2328-6113 (print)
ISSN 2328-6121 (online)

TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price

njtoday.net/2013/09/06/trap-laws-gain-political-traction/

Staff Report

September 6, 2013

CMD media NJTODAY.NET Online Business Directory

By Rachel Benson Gold and Elizabeth Nash

Waiting periods. Inaccurate counseling scripts. State-mandated ultrasounds. Over the years, these have been among the many favored obstacles antiabortion activists have thrown in the path of women seeking to terminate their pregnancies—all under the guise of protecting women's health. Hundreds of these requirements are now law across the country at the state level. And at this point, having mostly exhausted legal means of discouraging women from choosing abortion, opponents recently have stepped up their efforts to block clinics from providing them. More than half the states now have laws instituting onerous and irrelevant licensing requirements, known as Targeted Regulation of Abortion Provider (TRAP) laws, which have nothing to do with protecting women and everything to do with shutting down clinics.

Not surprisingly, abortion foes are exploiting the case of Kermit Gosnell—a Philadelphia physician who was convicted in May of numerous crimes, including three counts of murder—as proof positive that regulation of abortion clinics is inadequate and restrictions on abortion are insufficient. Ironically, Gosnell was able to prey on low-income women seeking abortions not because of inadequate regulation, but because of the negligence of Pennsylvania authorities, who failed to enforce the regulations already on the books. The horrors of the Gosnell case are not in dispute. Using that case to justify regulating abortion clinics out of existence is a cynical ploy, however, that is yet another obvious step in the march toward making safe abortion care even less accessible, if not illegal.

Abortion Is Safe

The rationale behind the campaign to single out abortion clinics for special treatment is that abortion is inherently dangerous; however, the facts say otherwise. Abortion is an extremely safe medical procedure. Less than 0.3% of abortion patients in the United States experience a complication that requires hospitalization.1 The risk of dying from a legal abortion in the first trimester—when almost nine in 10 abortions in the United States are performed—is

no more than four in a million.2 In fact, the risk of death from childbirth is about 14 times higher than that from abortion.3

Nearly all U.S. abortions take place in nonhospital settings,4 and data going back decades confirm the safety of these procedures. In fact, in 1983, the Supreme Court held in *Akron v. Akron Center for Reproductive Health* that requirements that abortions be performed in hospitals during the second trimester of pregnancy could not be justified on the basis of protecting the woman's health and safety. Research from the Centers for Disease Control and Prevention on abortions performed between 1974 and 1977 found no difference in the risk of death between procedures performed in a hospital and those performed in a clinic or a physician's office.5 More recent studies have also found low complication rates for abortions performed in outpatient settings.6,7

According to the American College of Obstetricians and Gynecologists (ACOG), providing abortions in the context of private practice is entirely appropriate, as long as physicians who do so in their offices are equipped to handle any emergencies that arise.8 In 2008, 18,000 abortions were provided in physicians' offices in the United States.4 And beyond the United States, this question has arisen as well, leading the World Health Organization (WHO) to make clear that abortions can safely be performed not only in outpatient clinics, but also in physicians' offices.9WHO guidelines state that regulation of abortion providers and settings "should be based on evidence of best practices and be aimed at ensuring safety, good quality and accessibility."

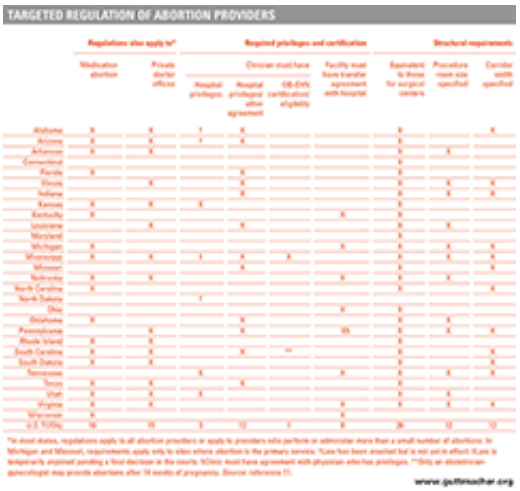
One reason that the procedure is so safe in the United States is that providers have rigorously developed evidence-based standards to follow. The National Abortion Federation (NAF) first published its *Clinical Policy Guidelines* in 1996, which are updated annually using a process developed by a scientific advisor affiliated with the federal Agency for Healthcare Research and Quality.10 The NAF standards are intended to provide a basis for ongoing quality assurance and include standards on a wide range of topics, such as infection prevention; use of antibiotics, analgesia and sedation; and treatment of complications. Adherence to the guidelines is a condition of membership; all members of the organization are assessed when they apply to join the organization and on a regular basis thereafter. Noting that "optimal management of abortion emergencies reduces morbidity," the NAF standards have detailed provisions relating to emergency care when needed. For example, they require that functioning equipment and medication be available on-site to handle emergencies. The guidelines also require protocols for the management of medical emergencies and emergency transport, and written and readily available directions for contacting external emergency assistance. Planned Parenthood Federation of America maintains similarly detailed requirements for affiliates offering abortion services.

States Rush In

States have broad authority to regulate abortion providers as they regulate other health care providers to ensure safe and sanitary care. Using this authority, many states have long required that facilities where abortions are performed be licensed and undergo regular inspections to ensure that they are sanitary and safe and that they are prepared to handle any emergency that should arise. For example, to be licensed, abortion providers in Maryland, according to state regulations, must have policies for such matters as preoperative testing and examinations, surgical procedures, postanesthesia care, discharge planning and emergency services.

In the years immediately following the Supreme Court decision in *Roe v. Wade*, several states moved to impose strict regulations on abortion clinics beyond those necessary to ensure patients' safety. Many such requirements were struck down by lower federal courts, so starting in the early 1980s, states moved on to other ways to restrict access to abortion, such as limiting public funding for abortions or requiring state-prescribed counseling and waiting periods. The focus on the clinics, as opposed to the abortion patients themselves, resurfaced in the 1990s and has gained steam in the past few years.

TRAP requirements are now in place in 27 states, where fully 60% of women of reproductive age live (see table).11 Nearly all of these states apply the requirements to abortion clinics, although the definition of clinic varies from state to state. In 15 states, the requirements also apply to private physicians who perform abortions in their private practices. And in the most extreme application, 18 states impose the rules on facilities in which medication abortions are performed, even if surgical procedures are not offered on-site (see "Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion," Winter 2013).



Twenty-one states require abortion facilities or their clinicians to have unnecessary and burdensome connections to a local hospital. Most of these states require clinicians at abortion facilities to have admitting privileges or some type of alternative arrangement—depending on the state, either an arrangement with a physician who has privileges or an agreement with a local hospital, under which the provider may transfer patients in need of treatment. Several states require the abortion facility itself to have such an alternative arrangement in place. Three states take the extreme step of requiring physicians to have admitting privileges, providing them with no other options. In addition, Mississippi is the only state, so far, to require that physicians performing abortions either be a board-certified obstetrician-gynecologist or eligible for certification, and a legal challenge to that requirement is pending. That standard is clearly unnecessary, because abortion can safely be performed by a range of providers. Notably, the American Academy of Family Physicians includes first-trimester abortion training in its Curriculum Guidelines for Family Medicine Residents.12

Nearly all state TRAP laws and regulations require abortion facilities to meet standards crafted for ambulatory surgical centers, even though these centers provide more invasive and risky procedures than abortion and use higher levels of sedation than commonly provided in abortion clinics. Virginia goes even further and requires clinics to meet standards based on those applied to hospitals. Several of these laws have extremely detailed requirements. For example, 12 states specify the size of procedure rooms and the same number specify hallway widths, often giving a minimum width well in excess of what is actually needed to accommodate a gurney to transport a patient in case of an emergency.

Mandating Links to Hospitals

Requiring links to hospitals does little to add to long-standing patient safeguards, but it can amount to granting hospitals effective veto power over whether an abortion provider can exist. The federal Emergency Medical Treatment and Labor Act of 1986 (EMTALA), for example, already entitles individuals seeking care at nearly all hospitals to an appropriate examination and to either stabilizing treatment or a medically appropriate transfer, if an emergency need is identified. Because EMTALA already assures patients emergency care in the unlikely event of a serious complication following an abortion, the Virginia section of ACOG considers requiring specific agreements with individual hospitals "onerous and unnecessary."13

More specifically, supporters often assert that these requirements would allow abortion providers to provide ongoing care to patients in the case of a complication. But the realities of abortion provision belie that contention. In 2008, 10 states had five or fewer abortion providers.4 Moreover, similar to many other specialized medical services in the United States ranging from heart transplant centers to cancer treatment specialists, abortion services are concentrated in population centers; 97% of all nonmetropolitan counties have no abortion services whatsoever. An agreement secured by an abortion provider would likely be with a hospital close to where the provider is located. But a woman would likely be at home, potentially at a great distance from the abortion clinic, should a complication

develop in the days following an abortion, so she would be likely to seek care from a hospital nearby, rather than from the facility with which the clinic has an agreement. This is especially true in a large, rural state such as Arizona, where abortion providers are available only in a handful of urban areas. According to Patricia Gross of Planned Parenthood Arizona, the distances mean that requiring a hospital agreement "serves no useful purpose."14

In addition, supporters of requiring admitting privileges assert that the requirement gives abortion providers some connection to the local area and, by extension, their patients—a type of connection that an out-of-state physician cannot easily establish. According to Barbara Whitehead, president of Mississippi Right to Life, "The purpose is to make certain that people don't just fly in once a week and perform abortions…and then fly out, leaving young women to their own devices."15 But states already have adequate controls to protect patients served by physicians from out-of-state. According to the Health Law Section of the American Bar Association, all states require that a physician who provides medical care to a patient be licensed to practice medicine in that state.16 Physician licensing is how states routinely ensure that patients receive care from qualified providers. To be licensed, physicians generally have to graduate from an accredited medical school, have passed a licensing exam and have some level of post–medical school training, generally in an accredited residency program.

Requiring admitting privileges does little, if anything, to add to these existing patient protections. But it does establish a requirement that is very difficult, and in some cases impossible, for providers to meet. Often, hospitals condition privileges on physicians admitting a certain number of patients per year. For example, Detroit Medical Center requires 10 admissions a year and Stanford Hospital requires three.17,18 Physicians practicing in abortion clinics may well be unable to meet these quotas, because they rarely need to admit patients.

In practice, requiring admitting privileges effectively gives hospitals a veto power over abortion providers, and proponents of these kinds of restrictions know it and count on it. As Lester "Bubba" Carpenter—a member of the Mississippi House of Representatives—said, "Anybody here in the medical field knows how hard it is to get admitting privileges to a hospital."19Moreover, at the time he signed Mississippi's TRAP bill into law in 2012, Gov. Phil Bryant (R) declared "Today you see the first step in a movement to do what we campaigned on.…to try to end abortion in Mississippi."15 The state's lieutenant governor, Tate Reeves, echoed that sentiment, declaring that the bill "should effectively close the only abortion clinic in Mississippi. This is a strong bill that will effectively end abortion in Mississippi."20

The lawmakers' predictions panned out, leaving the state's lone remaining abortion clinic to fight for its survival in the courts. According to Michelle Movahed of the Center for Reproductive Rights, one of the clinic's attorneys, all seven local hospitals refused to grant privileges to the clinic's physicians:

One hospital said it was a closed medical staff, so you could not apply for privileges unless you were already on the faculty. Another hospital said you could get an application only if…you got a letter from another doctor already on the medical staff of the hospital…and none of the doctors would provide that letter. The other five hospitals allowed the doctors to apply. But apparently, in the denial letters, they said they stopped reviewing the applications. They didn't even consider the merits, because of hospital policies concerning abortion and because of their concern about the effect on relationships in the community of granting privileges to the doctors.15

As a result, the clinic missed the January deadline to comply with the law. However, on April 16, a judge blocked enforcement of the law while he considers the merits of the clinic's case, and a hearing on the case is scheduled for August.

Setting Superfluous Facility Requirements

Nearly all TRAP laws dictate that abortions need to be performed at sites that are the functional equivalent of

ambulatory surgical centers, or even, in a few cases, hospitals. Proponents' claims notwithstanding, these laws cannot be justified as protecting patients' health and safety; however, similar to the mandatory hospital linkages, they do set standards that are extremely difficult for providers to meet.

Because of new requirements in Pennsylvania that became effective in 2012, for example, Planned Parenthood Southeastern Pennsylvania needed to comply with pediatric care requirements, even though these situations are unlikely to arise in an abortion setting, according to CEO Dayle Steinberg.21 The agency also needed to undertake myriad physical plan upgrades, including installing hands-free sinks, replacing flooring and upgrading the HVAC system at its two abortion sites—all at a cost of over $400,000.

Planned Parenthood of Western Pennsylvania faced similar issues related to sinks, ceilings, flooring and ductwork, according to CEO Kimberlee Evert.22 Evert estimates the total cost of compliance to the agency was about $350,000.

Evert also noted that some of the rules apply not just to the medical facilities in a building, but to the building as a whole. As a result, all of the building's tenants must, for example, inspect fire extinguishers monthly (rather than annually, as previously required) and replace light fixtures that use dimmer switches (which are banned under the rules). These requirements put abortion providers in an untenable position of needing to secure compliance by all the tenants in a building, without having any leverage to be able to do so. This leaves other tenants needing to incur remodeling expenses even though, according to Evert, "they may not have the capacity or feel it's their responsibility." As Evert put it, "unless you own the building and you are the only tenant in it, you could easily get blocked. It gives the other tenants in a building veto power."

The situation is similar in Virginia, which, in 2012, implemented rules requiring abortion providers to meet standards based on those for hospitals, even though the state's ACOG chapter called them unnecessary to protect patient safety.13 The new rules mandate dimensions for procedure rooms and corridors, specify requirements for the ventilation system and place requirements outside the facility itself, including specifications for the parking lot and covered entrances. Already one of the state's abortion clinics has been forced to close as a result, and the state department of health estimates that the total cost of compliance statewide will approach $15 million—likely, an average cost of $700,000–969,000 per site.23

Abortion Is the Real Target

Promoting health and safety—including in clinic settings and practices—is a fundamental rationale for states having a role in licensing any health care facility. For example, regulations in South Carolina say that "health licensing has the ultimate goal of ensuring that individuals…are provided appropriate care and services in a manner and, in an environment that promotes their health, safety, and well-being." In Pennsylvania, the state's regulations set standards that are intended to "promote the health, safety and adequate care of the patients."

In the case of TRAP laws, however, Mississippi's governor was just more candid than most abortion opponents when he made it clear that the goal is entirely different. *The Washington Post*characterized Virginia's law, for example, as an "ideological crusade masquerading as concern for public health."24 Indeed, if these increasingly burdensome TRAP laws are allowed to stand, they may prove remarkably successful in accomplishing what decades of restrictions, protests and even outright violence failed to do. Clinics have already closed in Pennsylvania, Virginia and Tennessee. And the last clinic in the entire state of Mississippi is perilously close to being shuttered.

Whether other advocates of TRAP laws are honest enough to admit their true purpose, as lawmakers in Mississippi have, these laws must be seen for what they truly are. Mallory Quigley, spokeswoman for the antiabortion Susan B.

Anthony List, described Virginia's approach as "common sense regulations."25 They do seem to be increasingly common, but they only make sense if the goal is to make abortion less accessible.

This article was made possible by a grant from the Lisa & Douglas Goldman Fund. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute. *Rachel Benson Gold is the director of policy analysis at the Guttmacher Institute and Elizabeth Nash is the state issues manager in the Guttmacher Institute's Washington DC office.*

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