IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; *et al.*,	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION
v.	)	
	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
	)	
Defendants.	)	

DIRECT TESTIMONY OF DANIEL GROSSMAN, M.D.

DANIEL GROSSMAN, M.D., under penalty of perjury, testifies as follows:

1. I am a board-certified obstetrician-gynecologist; an Assistant Clinical Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF); and a Fellow of the American College of Obstetricians and Gynecologists (ACOG), where I recently completed a term as Vice Chair of the Committee on Practice Bulletins for Gynecology. I am currently a member of the ACOG Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Medical Association (AMA) and the American Public Health Association (APHA).

2. I provide clinical services, including abortion care, as a consultant to Planned Parenthood Shasta Pacific, and I serve as a liaison member of the Planned Parenthood Federation of America National Medical Committee.

3. In addition, I serve as Vice President for Research at Ibis Reproductive Health, a nonprofit research organization. My research is supported by grants from federal agencies and private foundations. I have published over 85 articles in peer-reviewed journals, and I am a member of the Editorial Board of the journal *Contraception*.

4. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics, Gynecology, and Reproductive Sciences at UCSF.

5. My curriculum vitae, which sets forth my experience and credentials more fully, is annexed hereto as Exhibit P-002. It contains a complete list of the publications that I have authored or co-authored.

6. I am testifying as an expert in the fields of obstetrics and gynecology, abortion care, and public health. My opinions are based on my education, clinical training, sixteen years of experience as a practicing physician, attendance at professional conferences, my own medical research, and regular review of other medical research in my field.

7. I am familiar with the requirements of Texas House Bill No. 2 ("HB2"), including the "admitting privileges requirement," which mandates that all physicians who provide abortion services "have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced," and the "ASC requirement," which mandates that "the minimum standards for an abortion facility must be equivalent to the minimum standards . . . for ambulatory surgical centers" under Texas law.

Impact of Abortion Facility Closures on Texas Women's Access to Legal Abortion Services

8. I am a Co-Investigator of the Texas Policy and Evaluation Project, which is a research project undertaken jointly by the University of Texas at Austin, Ibis Reproductive Health and the University of Alabama at Birmingham. Since 2011, the Texas Policy Evaluation Project has been tracking the number of open facilities providing abortion care in the state by intermittently requesting information from the Texas Department of State Health Services (DSHS) on licensed abortion providers. Through interviews with clinic staff and review of

publicly available information, we identified clinics that ceased providing abortion services during the three time periods: (1) November 1, 2012 through April 30, 2013; (2) May 1, 2013 through October 31, 2013; and (3) November 1, 2013 through April 30, 2014. We did not include hospitals or physicians not licensed as an abortion facility in our analysis because they perform only a very small percentage of abortions in Texas. In 2012, this percentage was 0.3%. We also calculated changes in the distance that reproductive age women in Texas must travel to access a licensed Texas abortion provider, as well as changes in the abortion rate during this time frame.

9. Our findings were recently accepted for publication by the peer-reviewed journal, *Contraception*.

10. There were 41 facilities in Texas providing abortion care during November 1, 2012-April 30, 2013 (Period 1). Eight of these closed or stopped providing abortion services during the period from May 1, 2013-October 31, 2013 (Period 2), and a net of 11 facilities closed or stopped providing abortion services during the period from November 1, 2013-April 30, 2014 (Period 3). Thus, from May 1, 2013, through April 30, 2014, 19 of 41 facilities closed or stopped providing abortion care, including all of the facilities in the Northern Plains, the Lower Rio Grande Valley, and southeast Texas, and all but one facility in West Texas. That amounts to a 46% decline in the number of facilities providing abortion care (Table 1 and Figure 1).

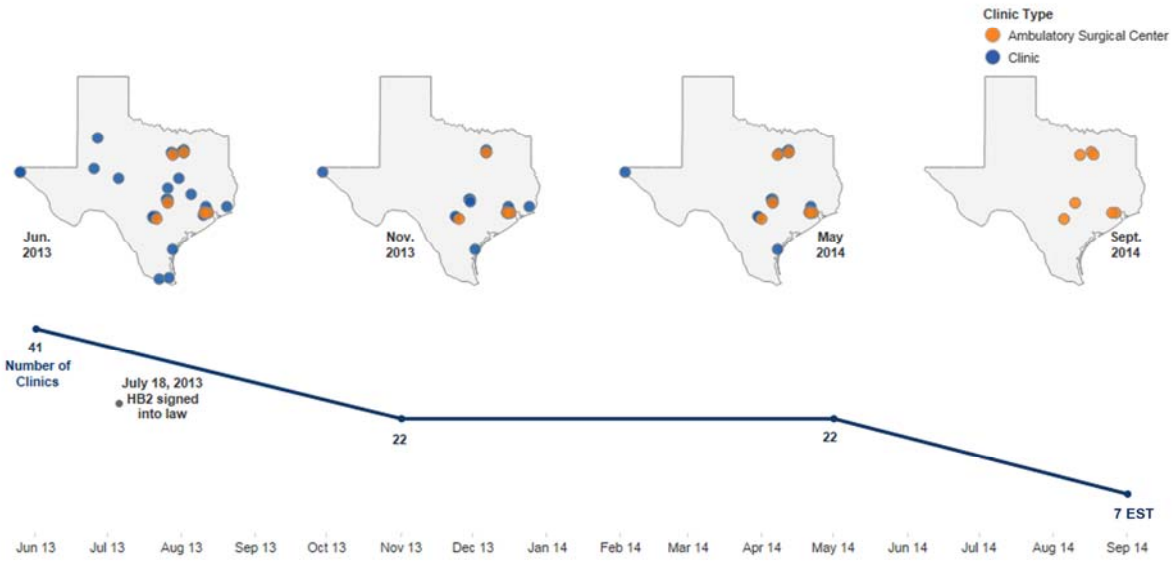
Table 1. Number of facilities providing abortion services on different dates by geographic region

Location	Number of open clinics					
	5/1/13	10/31/13	11/1/13	4/30/14	6/11/14	9/1/14*
West Texas and Northern Plains (Health Regions 1/9/10)						
El Paso	2	2	1	1	1	0
Lubbock	1	1	0	0	0	0
Midland	1	0	0	0	0	0
San Angelo	1	0	0	0	0	0
Regional subtotal	5	3	1	1	1	0
North Texas (Regions 2/3/4)						
Dallas	5	5	3	4	4	2^
Ft. Worth	3	3	0	1	1	1
Regional subtotal	8	8	3	5	5	3
Houston and East Texas (Regions 5/6)						
Beaumont	1	1	1	0	0	0
Houston	10	10	10	8	7	2
Stafford	1	0	0	0	0	0
Regional subtotal	12	11	11	8	7	2
Central Texas (Region 7)						
Austin	4	4	3	4	4	1
College Station	1	0	0	0	0	0
Killeen	1	1	0	0	0	0
Waco	1	0	0	0	0	0
Regional subtotal	7	5	3	4	4	1
San Antonio (Region 8)						
San Antonio	6	3	3	3	3	1
Regional subtotal	6	3	3	3	3	1
South Texas (Region 11)						
Corpus Christi	1	1	1	1	0	0
Harlingen	1	1	0	0	0	0
McAllen	1	1	0	0	0	0
Regional subtotal	3	3	1	1	0	0
Total	**41**	**33**	**22**	**22**	**20**	**7**

*Assumes that currently operating ASCs have physicians with admitting privileges at nearby hospitals.

^ Assumes that the new ASC announced by Planned Parenthood of Greater Texas will be operational by 9/1/14.

Figure 1. Decrease in Number of Licensed Facilities Providing Abortion Services from June 2013 to Sept. 2014



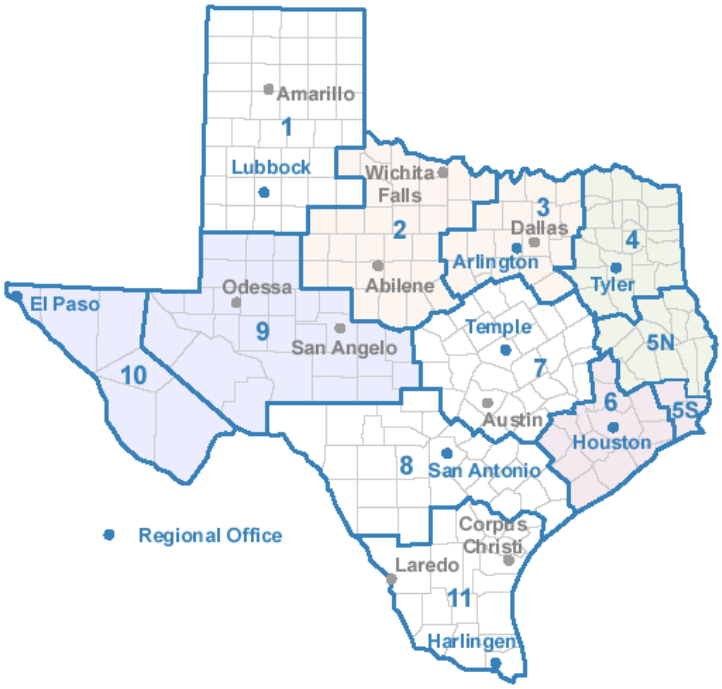
11. With respect to the Lower Rio Grande Valley, there had been two facilities providing abortion services there in November 2012—Reproductive Services of Harlingen and Whole Woman's Health in McAllen. My research determined that both of these facilities ceased providing abortion services during Period 3.

12. The decline in the number of facilities providing abortion services appears to be related to changes in State law—including the enactment of HB2, which imposes restrictions on the provision of abortion care, and a restructuring of the State's program for funding family planning services. But I am not here offering any opinion on the cause of the decline in the

number of abortion facilities from November 2012 to April 2014. Instead, my testimony focuses on the impact of that decline, particularly with respect to women's ability to obtain legal abortion services in Texas, and how it enables us to forecast the impact of the ASC requirement.

13. As shown in Figure 2, DSHS assigns each Texas county to a health service "region." The abortion facility closures[1] resulted in a significant decrease in the number of abortions performed in Texas between Periods 1 and 3 across Texas's health service regions and four largest metropolitan areas.

Figure 2. Texas Health Service Regions

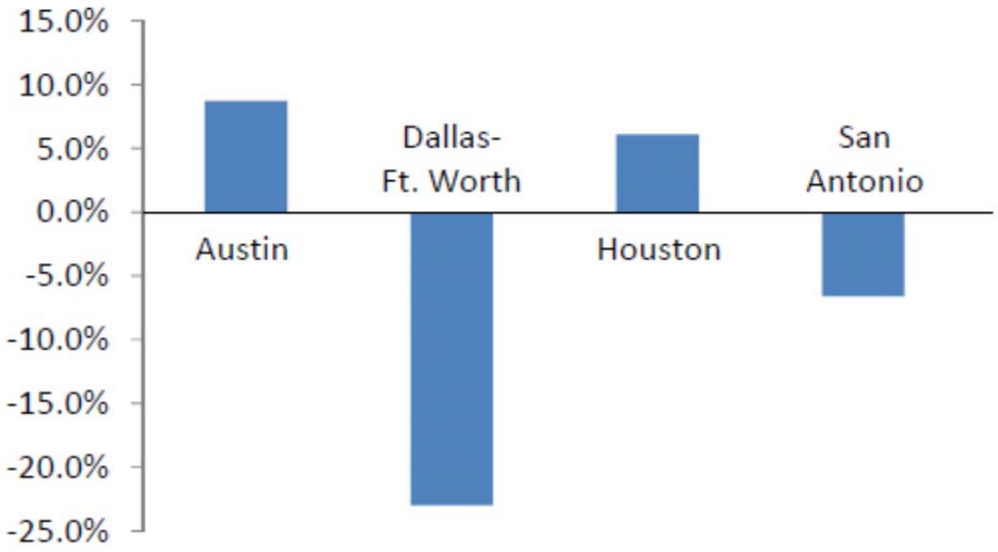


14. The Northern Plains and West Texas (regions 1/9/10) were hardest hit, with a 65% decline in the total number of abortions performed there. North Texas (regions 2/3/4) had a decline of 23%, which was also greater than the state average. Other regions had declines that

[1] From this point on, I will use the term "closure" to refer both to clinics that closed and clinics that remained open but ceased providing abortion services.

were less than the state average, and two regions had small increases. The number of abortions performed in Austin and Houston increased, while it decreased in Dallas-Fort Worth and San Antonio (see Figure 3).

Figure 3: Percent Change in total abortions performed in four metropolitan areas in Texas (Period 1 to Period 3)



15. Overall, the abortion rate in Texas declined 13% in Period 3 compared to Period 1 (the same 6-month period one year earlier), corresponding to about 9,200 fewer abortions each year (Table 2). This rate of decline is three times greater than the change in the national abortion rate, which declined by 13% over a three-year period between 2008 and 2011, or 4.3% per year.[2] For women living in the Lower Rio Grande Valley,[3] the number of abortions decreased by

[2] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

[3] The Lower Rio Grande Valley consists of the portion of region 11 comprised of Cameron, Hidalgo, Starr, and Willacy counties.

approximately 20% from Period 1 (1,349 abortions) to Period 3 (approximately 1,065 abortions), which appears to be a greater decline than for the state overall.

16. Abortions, like births, are known to have seasonal variation.[4] In Texas, more abortions are performed in months at the beginning of the year; the monthly number of abortions declines steadily until November and then increases in December. When comparing abortion rates in different years for a period of less than a full year, it is important to either compare data from the same months or otherwise control for seasonality.

[4] Weerasinghe DP, MacIntyre RC. Seasonality of births and abortions in New South Wales, Australia. Med Sci Monit. 2003 Dec;9(12):CR534-40: Parnell AM, Rodgers JL. Seasonality of induced abortion in North Carolina. J Biosoc Sci. 1998 Jul;30(3):321-32; Cesario SK. The "Christmas Effect" and other biometeorologic influences on childbearing and the health of women. J Obstet Gynecol Neonatal Nurs. 2002 Sep-Oct;31(5):526-35; Rojansky N, Brzezinski A, Schenker JG. Seasonality in human reproduction: an update. Hum Reprod. 1992 Jul;7(6):735-45.

Table 2. Abortions performed in Texas during three periods

	DSHS 2012 statewide statistics (12 months)	Period 1 (1 Nov 2012- – 30 Apr 2013)	Period 2 (1 May 2013 – 31 Oct 2013)	Period 3 (1 Nov 2013 – 30 Apr 2014)	% change from Period 1 to 3
Total number of abortions	68,298	35,415	32,611	30,800	-13.0%
Annualized abortion rate (per 1000 women age 15-44)	12.5	12.9	11.9	11.2	-13.0%
Number of early medical abortions	18,960 (27.8%)	9,948 (28.1%)	9,079 (27.8%)	2,991 (9.7%)[a]	-69.9%
Number of first-trimester surgical abortions (<12 weeks)	42,017 (61.5%)	20,698 (58.4%)	19,343 (59.3%)	23,531 (76.4%)	13.7%
Number of second-trimester surgical abortions (≥12 weeks)	7,321 (10.7%)	4,768 (13.5%)	4,190 (12.8%)	4,278 (13.9%)[b]	-10.3%
Number of women living in Lower Rio Grande Valley[c] obtaining abortion	N/A[d]	1,349	1,304	1,065	-21.1%
Total number of abortions performed at an ambulatory surgical center	14,361 (21.0%)	9,378 (26.4%)	8,867 (27.2%)	6,786 (22.0%)	

[a] X^2 p-value<0.001 for medical abortion compared to surgical abortion <12 weeks for both Period 1 vs. Period 3 and Period 2 vs. Period 3

[b] X^2 p-value<0.001 for surgical abortion ≥12 weeks compared to surgical abortion <12 weeks for both Period 1 vs. Period 3 and Period 2 vs. Period 3

[c] Women reporting a residence in Starr, Hidalgo, Willacy or Cameron County

[d] Data not available for 2012. In 2011, 2,634 women living in the Lower Rio Grande Valley obtained an abortion.

17. Of those women from the Lower Rio Grande Valley who did receive abortions in Period 3, about half obtained abortions in Corpus Christi, about one-quarter obtained them in Houston, and 15% obtained them in San Antonio. Of note, the clinic providing abortion care in Corpus Christi closed in June 2014, after the period of this analysis.

18. The number of medical abortions declined by 70% in Period 3 compared to Period 1; only 9.7% of abortions in Texas in Period 3 were medical abortions, much lower than in the state vital statistics for 2012 (when 28% of all Texas occurrence abortions were early medical abortions). In contrast to our findings in Texas, the national trend is toward an increase in the proportion of abortions that are medical abortion, from 17% in 2008 to 23% in 2011.[5]

19. Notably, there was a small but significant increase in the proportion of abortions performed in the second trimester in Period 3 compared to Periods 1 and 2.

20. The number and proportion of abortions performed in ASCs decreased during the study. In Period 1, 9,378 abortions (26% of all abortions) were performed in ASCs, while in Period 3, 6,786 abortions (22% of all abortions) were performed in ASCs. In 2012, 21% of all abortions were performed in ASCs.[6] Each of the ASCs except one in Houston (which reported no change in the number of abortions performed in Period 3) reported declines in the number of abortions performed in Period 3 that were greater than the state average, ranging from a 17% decrease to a 62% decrease. These decreases occurred despite increasing demand for abortion in the cities in which these ASCs were located, as indicated by the fact that some of the other clinics in those cities reported an increase in the number of abortions performed. The decrease at

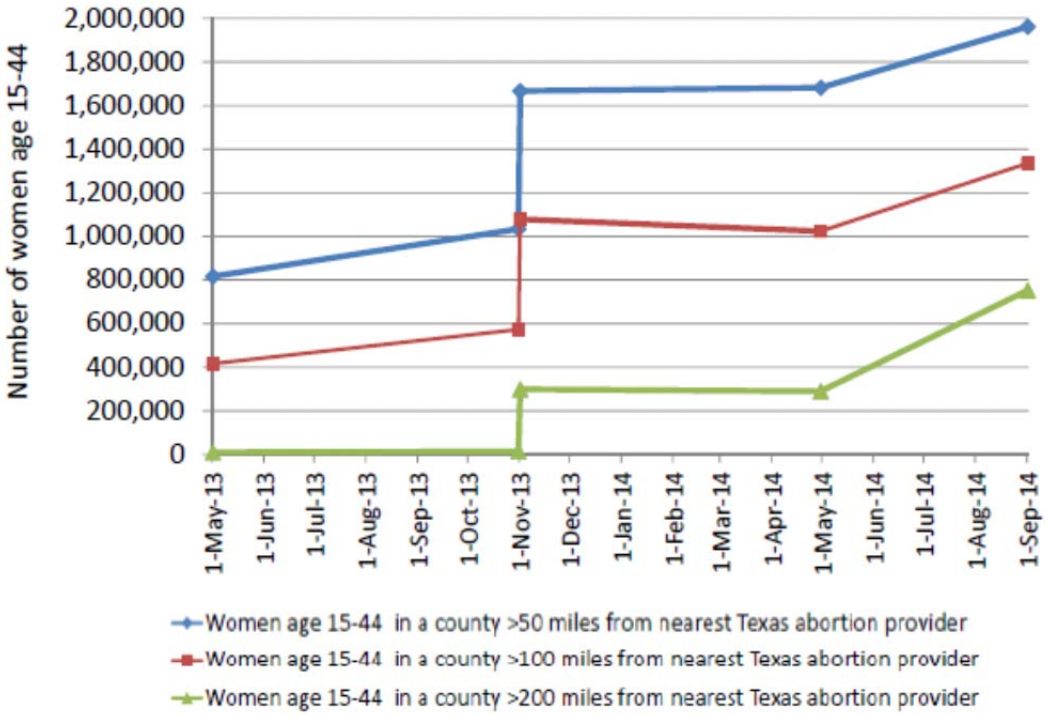
[5] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

[6] The data on 2012 Texas occurrence abortions were obtained from a request to the Texas Department of State Health Services.

the ASCs is likely indicative of their inability to increase capacity in the face of growing demand. This may be a result of the admitting privileges requirement, which limits physician staffing, or facility limitations. My opinion is that these existing ASCs as a group will not be able to go from providing approximately 14,000 abortions annually, as they currently are, to providing the 60,000 to 70,000 abortions that are done each year in Texas once all of the non-ASC clinics are forced to close.

21. Due to the facility closures, women now face longer travel distances to reach an abortion clinic. The number of women of reproductive age in Texas living in a county more than 50 miles from a clinic providing abortion in Texas increased from 816,000 in Period 1 to 1,680,000 at the end of Period 3 (Figure 4). The number of women of reproductive age in Texas living in a county more than 100 miles from a clinic providing abortion in Texas increased from 417,000 in Period 1 to 1,020,000 at the end of Period 3. The number of women of reproductive age in Texas living in a county more than 150 miles from a clinic providing abortion in Texas increased from 86,000 in Period 1 to 400,000 at the end of Period 3. The number of women of reproductive age in Texas living more than 200 miles from a clinic providing abortion in Texas increased from 10,000 in Period 1 to 290,000 at the end of Period 3.

Figure 4. Number of women age 15-44 living in a county at various distances from the nearest Texas abortion provider on various dates



22. The data described above provide strong evidence that the abortion facility closures have had a significant negative impact on women's ability to obtain abortion services in Texas. In my opinion, the best explanation for the decline in the Texas abortion rate and the decline of the abortion rate for women living in the Lower Rio Grande Valley—both of which are greater declines than the national average—is that some women who would have otherwise obtained abortion care were unable to negotiate the increased costs and travel distances that resulted from abortion facility closures.[7]

[7] An alternative hypothesis to explain the declining abortion rate is improved contraceptive use—especially use of long-acting reversible contraceptive (LARC) methods. This seems particularly unlikely in Texas given the severe reduction in public family planning funding that the Texas legislature imposed in 2011. Although the legislature restored most of the funding for family planning services in 2013, many organizations that served low-income women had not yet

23. The ASC requirement, which goes into effect on September 1, 2014, will increase the impact observed in this study substantially by resulting in a greater number of clinic closures. Based on the information that the Texas Policy Evaluation Project gathered from the Texas Department of State Health Services, interviews with abortion facility staff members, and reports in the press, it appears that the only remaining ASCs providing abortion care will be located in Texas's four largest metropolitan areas: Dallas-Fort Worth, Houston, San Antonio, and Austin. There will be no abortion facilities remaining south or west of San Antonio. This will significantly increase distances that women in South and West Texas must travel to obtain abortion services. The number of women of reproductive age in Texas living more than 50 miles from a clinic providing abortion in Texas will increase to 1,960,000, which is a 140% increase compared to May 2013. The number of women of reproductive age in Texas living more than 100 miles from a clinic providing abortion in Texas will increase to 1,335,000 when the ASC requirement goes into effect (a 220% increase compared to May 2013). The number of women of reproductive age in Texas living more than 150 miles from a clinic providing abortion in Texas will increase to 930,000 when the ASC requirement goes into effect (a 980% increase compared to May 2013). The number of women of reproductive age in Texas living more than 200 miles from a clinic providing abortion in Texas will increase to 752,000 when the ASC requirement goes into effect (a 7400% increase compared to May 2013). These distances are much greater than the national mean distance traveled to an abortion clinic, which was 30 miles

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received these funds by the end of 2013. In addition, data from the Centers for Disease Control and Prevention (CDC) indicate an increase in births to women in Texas between 2012 and 2013, although the data for the later year are not yet final. Martin JA, Hamilton BE, Osterman JK, et al. Births: Final data for 2012. National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013; Hamilton BE, Martin JA, Osterman MJK, Curtin SC. Births: Preliminary data for 2013. National vital statistics reports web release; vol 63 no 02. Hyattsville, MD: National Center for Health Statistics. 2014.

in 2008; only 6% of abortion patients traveled more than 100 miles.[8]

24. I understand that the Defendants' expert, Todd Giberson, estimates the number of Texas women of reproductive age women who will live more than 150 miles from a Texas abortion provider on September 1, 2014 to be 891,888. Even if we rely on his calculation, it would still be a very large number of Texas women who would have to travel over 150 miles to access legal abortion care. To put this number in context, consider that half of all states and the District of Columbia have a total population of reproductive age women that is less than 891,888 (Table 2).

[8] Jones RK, Jerman J. How far did US women travel for abortion services in 2008? J Women's Health (Larchmt). 2013 Aug;22(8):706-13.

Table 2. Number of Reproductive-Age Women (Age 15-44) in U.S. States and the District of Columbia

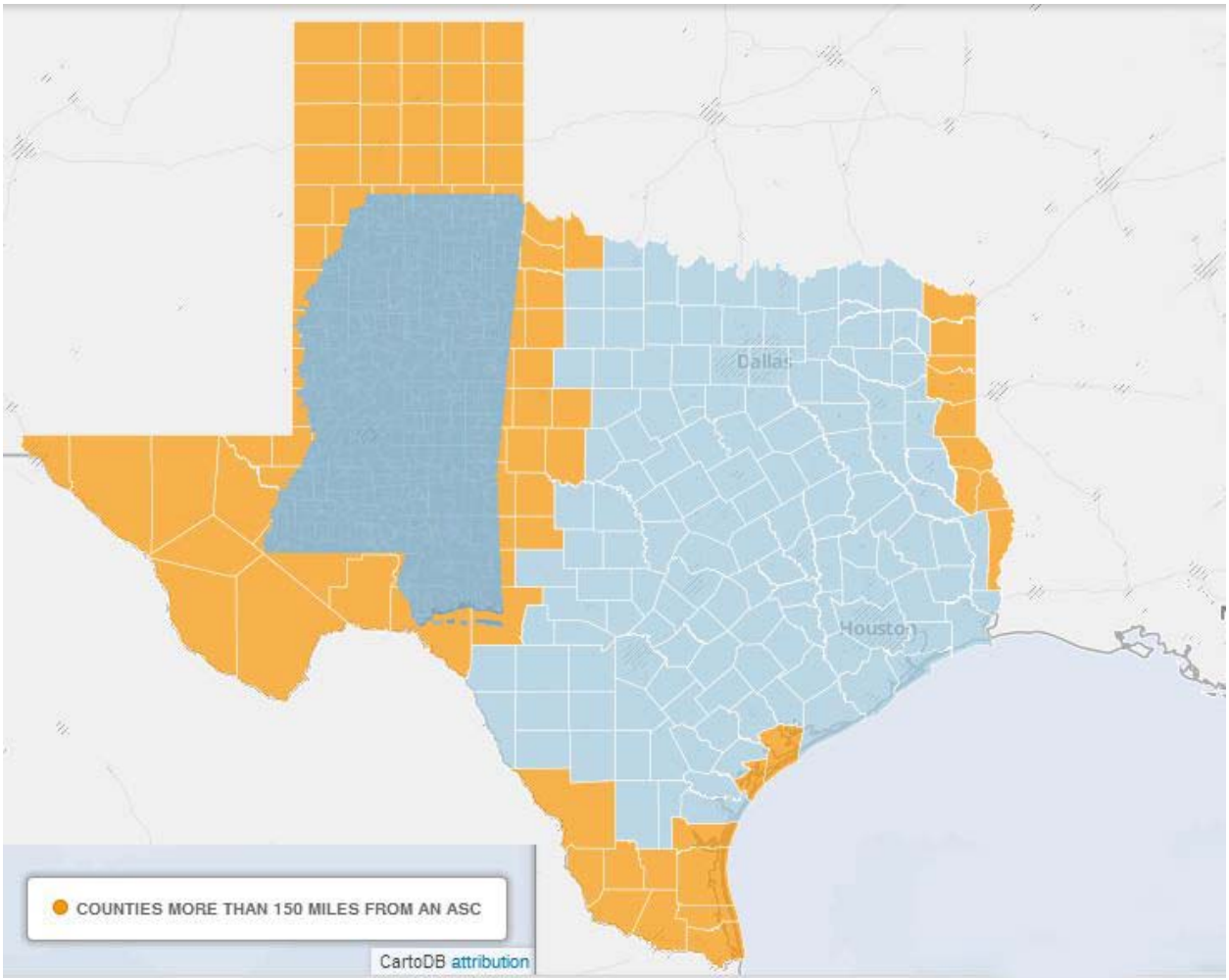
California	7,876,871
Texas	5,326,162
New York	4,047,947
Florida	3,560,982
Illinois	2,631,753
Pennsylvania	2,442,538
Ohio	2,235,171
Georgia	2,073,006
North Carolina	1,949,350
Michigan	1,918,594
New Jersey	1,738,419
Virginia	1,652,698
Washington	1,355,704
Massachusetts	1,350,576
Arizona	1,287,393
Tennessee	1,274,350
Indiana	1,262,557
Maryland	1,193,402
Missouri	1,176,684
Wisconsin	1,097,595
Minnesota	1,045,681
Colorado	1,025,085
Alabama	960,620
Louisiana	928,335
South Carolina	928,310
Texas Women More Than 150 Miles From Texas Abortion Provider Per State Defendants	**891,888**
Kentucky	854,846
Oregon	754,077
Oklahoma	736,629
Connecticut	691,265
Utah	604,036
Mississippi	602,120
Iowa	576,692
Arkansas	569,446
Nevada	554,584
Kansas	549,924
New Mexico	398,587
Nebraska	355,031
West Virginia	341,981
Idaho	306,303
Hawaii	262,107
New Hampshire	250,133
Maine	241,923
Rhode Island	214,647
Montana	179,670
Delaware	179,232
District of Columbia	162,314
South Dakota	152,353
Alaska	143,229
North Dakota	129,143
Vermont	118,297
Wyoming	106,612

Source: U.S. Census Bureau Summary File 1, Table P12

Amended Rebuttal Report of Todd Giberson, dated July 11, 2014

25. Further, the counties in Texas that are more than 150 miles from the nearest abortion provider will occupy an area that is substantially larger than the State of Mississippi (Figure 3).

Figure 3. Texas Counties More Than 150 Miles from a Texas Abortion Provider as of September 1, 2014



26. We did not collect data on the number of women traveling out of state for abortion services. It is unlikely that women in the Rio Grande Valley would have traveled out of state because doing so would have entailed even greater travel distances than traveling to San Antonio, Austin, or Houston. And abortion is legally restricted everywhere in Mexico except Mexico City, which is over 600 miles from the Rio Grande Valley. For women in many other parts of Texas, the availability of out-of-state abortion services is likely to decrease because

neighboring states Oklahoma and Louisiana have recently enacted admitting privileges requirements that are about to take effect.

27. Increased travel distances have been shown to cause some women to delay receiving abortion care or forego it altogether.[9] Our analysis found a relative increase in second-trimester abortion during the same time period as the clinic closures. Although this increase is small in magnitude, it nonetheless means that a larger proportion of women faced the higher risk of complications associated with later abortion, as well as its higher cost.[10] The findings from this study are consistent with the findings of earlier studies that increased travel distance causes a delay in receiving abortion care.[11]

28. They are also consistent with Texas' experience following the 2003 enactment of a law limiting the performance of abortions at 16 weeks or later to ASCs and hospitals. A detailed study by economists found that, when the law took effect, there was an immediate and dramatic reduction in both the number of licensed facilities in Texas able to provide abortion services at 16 weeks and later and in the number of abortions performed in Texas at those gestational ages.[12] Two years later, the abortion rate for those gestational ages remained 50% below what it was

[9] Colman S, Joyce T. Regulating Abortion: Impact on Patients and Providers in Texas. Journal of Policy Analysis and Management 2011;30:775-97 (P-152); Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. Denial of Abortion Because of Provider Gestational Age Limits in the United States. Am J Public Health 2013 (P-156).

[10] Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol. 2004 Apr;103(4):729-37 (P-098); Jones RK, Kooistra K. Abortion incidence and access to services in the United States, 2008. Perspect Sex Reprod Health. 2011 Mar;43(1):41-50.

[11] Dobie SA, Hart LG, Glusker A, Madigan D, Larson EH, Rosenblatt RA. Abortion services in rural Washington State, 1983-1984 to 1993-1994: availability and outcomes. Fam Plann Perspect. 1999 Sep-Oct;31(5):241-5.

[12] Colman S, Joyce T. Regulating Abortion: Impact on Patients and Providers in Texas. Journal of Policy Analysis and Management 2011;30:775-97 (P-152).

prior to the law's enactment.

Expected Rise in Attempted Self-Induction of Abortion

29. I have been the lead investigator on several recent studies concerning self-induction of abortion. The term "self-induction" generally refers to attempts by a woman to terminate her own pregnancy without seeking treatment from a licensed medical professional. My research and the research of others has found that a variety of methods are used to self-induce abortion in the United States. Invasive intravaginal techniques appear to be rare, but they are still used by some women.[13] More commonly drugs such as misoprostol, which is a prostaglandin analogue, vitamin C, aspirin, laxatives, or hormonal preparations are used, as are herbs, certain foods, alcohol or drugs.[14] Women have also reported intentionally falling down stairs or getting beaten in the abdomen to cause an abortion.[15] Other than misoprostol, most of these methods are generally not effective to induce an abortion.

30. Misoprostol is widely available in Mexico and other parts of Latin America. It is commonly trafficked across the Texas-Mexico border and sold on the black-market, including at Texas flea markets and over the internet.

31. In a nationally representative study of US abortion patients conducted in 2008-2009,

[13] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160); Saultes TA, Devita D, Heiner JD. The back alley revisited: sepsis after attempted self-induced abortion. West J Emerg Med. 2009 Nov;10(4):278-80.

[14] Jones RK. How commonly do US abortion patients report attempts to self-induce? Am J Obstet Gynecol 2011;204:23.e1-4; Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

[15] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

1.2% of participants reported having used misoprostol to try to induce an abortion, and 1.4% reported having ever used other methods to try to induce an abortion.[16] Only 0.8% reported taking misoprostol in the current pregnancy. In that study, foreign-born women were significantly more likely to report attempting abortion self-induction. In a non-representative study conducted in Boston, New York City, San Francisco, and McAllen, TX, 4.6% of ever-pregnant women surveyed in low-income clinics reported attempting self-induction at some point in the past.[17]

32. In October-December 2012, colleagues and I conducted a survey with 318 abortion patients at 8 clinics in 6 cities across Texas and included several questions about abortion self-induction.[18] Overall, 7% of women reported taking steps prior to coming to the clinic to try to end the pregnancy on their own. At clinics in McAllen and El Paso, about 12% reported attempting self-induction in the current pregnancy. These proportions are much higher than those reported in the only nationally representative study, suggesting that self-induction is more common in Texas, particularly in locations close to the Texas-Mexico border.

33. There are a variety of health risks associated with abortion self-induction. Traumatic methods using intravaginal or external manipulation can obviously be quite dangerous. Depending on the medication and dosage used, some medications may also be dangerous. Misoprostol in correct dosages is one of the safest methods that can be used to self-induce

[16] Jones RK. How commonly do US abortion patients report attempts to self-induce? Am J Obstet Gynecol 2011;204:23.e1-4.

[17] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

[18] Grossman D, White K, Hopkins K, Potter JE. The public health threat of anti-abortion legislation. Contraception 2014;89:73-4.

abortion. However, especially if it is used later in pregnancy, there is a higher risk of hemorrhage, and if high doses are used in women with a history of cesarean delivery, there is a risk of uterine rupture.[19]

34. Although women report a variety of reasons for attempting self-induction, one of the most common reasons is lack of local access to clinical abortion care.[20] In other words, often, when women attempt self-abortion, it is because they are unable to access care from licensed abortion providers—typically because of distance or legal restrictions such as gestational limits and parental consent laws. Another reason sometimes reported is lack of access to a women's preferred method of abortion (meaning that a woman would like to have a medical abortion but only surgical abortion is available).

35. As abortion access in Texas becomes more limited, I expect that self-induction will become more prevalent in the state, particularly in places like the Lower Rio Grande Valley, where all of the clinics providing abortion care closed, there is a significant population of immigrants from Latin America with knowledge of methods of self-induction, and there is relatively easy access to misoprostol across the border in Mexico.

Safety of Abortion and Complications at an ASC versus non-ASC clinic

36. Legal abortion is one of the safest medical procedures in the United States, and it is quite common. Approximately 3 in 10 women will obtain an abortion by the age of 45.[21]

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[19] Ashok PW, Templeton A, Wagaarachchi PT, Flett GM. Midtrimester medical termination of pregnancy: a review of 1002 consecutive cases. Contraception 2004;69(1):51-8.

[20] Grossman D, Holt K, Pena M, Lara D, Veatch M, Cordova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reproductive Health Matters 2010;18(36): 136-146 (P-160).

[21] Jones RK & Kavanaugh M. Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. Obstet & Gynecol. 2011;117:1358.

37. Over 90% of all abortions performed in the United States are performed in an outpatient setting.[22] Complications associated with abortion are not common, and almost all of the complications associated with abortion prior to 16 weeks of pregnancy post-fertilization, can be safely and appropriately managed in an outpatient, clinic setting.

38. In terms of risks, rate of complication, and duration of the procedure, surgical abortion is comparable to other procedures routinely performed in a physician's office, such as dilation and curettage (D&C) for gynecological diagnosis and/or treatment of miscarriage, diagnostic hysteroscopy (to visualize the inside of the uterus), endometrial biopsy (to take a small tissue sample from the uterine lining), or vasectomy. In fact, performing a surgical abortion by suction aspiration is basically the same procedure as performing a D&C for a patient with a miscarriage. By way of comparison, vasectomy is reported to have a prevalence of complications of 2% and a prevalence of major complications requiring hospitalization of 0.2% to 0.8%, depending on the surgeon's experience.[23]

39. A recent large study found that the prevalence of any complication of first-trimester surgical abortion performed by physicians in an outpatient setting was 0.89%, and the prevalence of major complications requiring treatment at a hospital was 0.05%.[24] Another recent study found that the risk of an adverse event associated with outpatient abortions performed up to 16 weeks post-fertilization was 0.3%, and the risk of an adverse event requiring hospitalization was

[22] Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspect Sex Reprod Health. 2014 Mar;46(1):3-14.

[23] Adams CE, Wald M. Risks and complications of vasectomy. Urol Clin North Am. 2009 Aug;36(3):331-6.

[24] Weitz TA, Taylor D, Desai S, et al. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health 2013;103:454-61.

0.07%.[25] In another retrospective cohort study, the prevalence of major immediate complications (defined as uterine perforation or hospital transfer) was 0.3% at 10-13 weeks post-fertilization and 0.7% at 14-16 weeks post-fertilization.[26]

40. Almost all of the complications associated with abortion before 16 weeks post-fertilization, can be appropriately and safely managed in the clinic setting. For example, most cases of hemorrhage are managed in the clinic setting with uterotonics, medications that increase the tone of uterine contractions and reduce bleeding. Likewise, most cases of cervical laceration are managed in the clinic setting with either cauterizing medications or by suturing the laceration. And cases of incomplete abortion are generally managed in the clinic through repeat aspiration and medications.

41. As noted above, major complications of abortion before 16 weeks performed in a clinic are rare. These rare complications include severe hemorrhage not responsive to medical management or re-evacuation of the uterus; uterine perforation; or severe complications related to anesthesia, such as a seizure or aspiration. Patients undergoing these complications must be transferred to a hospital for appropriate management, which might include blood transfusion, uterine artery embolization, or major abdominal surgery such as hysterectomy. This kind of treatment is not generally available at an ambulatory surgical center (ASC). Therefore, I would not expect that the overall risk of major complications requiring hospitalization would differ between abortions performed at a non-ASC clinic and abortions performed at an ASC for the same gestational age period.

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[25] Wilson LC, Chen BA, Creinin MD, Low-dose fentanyl and midazolam in outpatient surgical abortion up to 18 weeks of gestation. Contraception 2009;79(2): 122-28.

[26] Racek CM, Chen BA, Creinin MD, Complication rates and utility of intravenous access for surgical abortion procedures from 12 to 18 weeks of gestation. Contraception 2010;82: 286–290.

42. Nor do I expect that the heightened construction and staffing requirements for ASCs would lead to a reduction in major complications of abortion. The heightened construction requirements are largely aimed at maintaining a sterile operating environment. These requirements enhance the safety of surgeries that involve cutting into sterile body tissue by reducing the likelihood of infection. But surgical abortion is not performed in this manner. Rather, it entails insertion of instruments into the uterus through the vagina, which is naturally colonized by bacteria. Accordingly, precautions aimed at maintaining a sterile environment, beyond basic handwashing and use of sterile instruments, provide no health or safety benefit to abortion patients. Similarly, the heightened staffing requirements for ASCs are geared toward surgeries that are more complex that abortion. Many of the personnel typically needed for those types of surgeries, such as scrub nurses or technicians and circulating nurses, are not needed for abortion procedures.

43. In order to explore the prevalence of complications at ASCs compared to non-ASC clinics, I reviewed complications of abortions performed at less than 16 weeks actual gestation at the ASC in San Antonio currently operated by Whole Woman's Health and three non-ASC clinics currently operated by Whole Woman's Health.

44. The ASC opened in August 2010; therefore the period of this analysis was between August 2010 and April 2014. With assistance from a colleague at Ibis Reproductive Health, I reviewed clinic logs and worked with clinic staff to determine the total number of abortions before 16 weeks performed at each clinic during this period. These clinics also maintain complication logs where all hospital transfers are recorded, as well as any delayed complication that is reported by a patient at the time of a follow-up visit or telephone call. I reviewed these logs to identify major complications, defined as those that required hospitalization, abdominal

surgery (including laparoscopy), intravenous antibiotics or blood transfusion. Death is also considered a major complication, but there were no abortion-related deaths during this period in Texas. In the case of a hospital transfer for bleeding, if no details of the treatment were available, I assumed it was a major complication.

45. During this period, a total of 2,980 abortions before 16 weeks were performed at the ASC, while 17,628 abortions were performed at the three non-ASC clinics. There were five major complications at the non-ASC clinics. During this same period there were five major complications at the ASC. The proportion of abortions before 16 weeks with a major complication at the non-ASC clinics was 0.028% (95% confidence interval 0.004% – 0.053%), while this proportion was 0.17% (95% confidence interval 0.021% – 0.315%) for the ASC. The difference between the proportion of abortions with a major complication is statistically significantly different, with the non-ASC clinics having a significantly lower proportion of major complications (p=0.008, Fisher's exact test).

46. Of note, six of the ten major complications occurred in 2011. Between January 1, 2012, and April 30, 2014, we identified only one major complication at the ASC (among 1,938 abortions before 16 weeks, or 0.05%) and three major complications at the non-ASC clinics (among 11,616 abortions before 16 weeks, or 0.03%).

47. These proportions are low for both the non-ASC clinics and the ASC, and they are consistent with the literature. The slightly higher major complication proportion for the ASC facility may be because higher risk patients (such as obese women or those with a prior cesarean delivery) are more likely to have their procedure done at an ASC. Women may also be more likely to have deeper sedation at an ASC, and deep sedation confers more risk than moderate or less sedation, which may be used at a non-ASC clinic. Unfortunately, we were not able to

control for these factors in the analysis. But the findings show that, under real-world conditions, as abortion is currently performed in Texas, major complications are not less prevalent in ASCs than in non-ASCs.

48. Overall, these findings reflect the safety of abortion performed in non-ASC clinics. There is no indication from this analysis that the risk of major complications is reduced when abortion is performed in an ASC or that patients who would otherwise choose to have an abortion in a clinic would derive any health benefit from having the procedure in an ASC instead.

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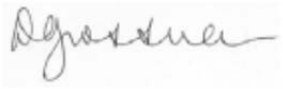
Austin, Texas



By:_____
Daniel Grossman, M.D.