Risks of Second and Third Trimester Abortion – The Case for State Oversight to Preserve Women's Health and Lives

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Overview of the problem:

Conventional wisdom suggests that abortions are safe and there is little need for procedure-specific regulations to ensure public health and safety. This is based on widely cited publications such as the National Academies Report entitled "The Safety and Quality of Abortion Care in the United States".[1] The problem with these assessments is that they don't differentiate risks based on gestational age or procedure type.

Assessments of abortion safety also suffer from a lack of reliable statistics since the US doesn't have a national health registry to accurately correlate pregnancy outcomes with maternal morbidity or maternal deaths. Submission of abortion data to the CDC is voluntary and, consequently, incomplete. To identify abortion related deaths, the CDC relies on the Pregnancy Mortality Surveillance System (PMSS), which is based on death records, media reports, and case reports from public health departments and state maternal mortality review committees. This has been shown to underestimate abortion-related mortality when compared to countries such as Finland with robust national health registries.[2] In contrast to the US, Finland has universal health coverage and can identify abortion related deaths through a comprehensive health registry that allows linkage between pregnancy, abortion, and death. If Finland relied on death records alone, which is the primary source in the US, 73% of maternal deaths from abortion would be missed.

First-trimester abortions are done almost exclusively using drugs or aspiration techniques. They represent approximately 90% of abortions in Colorado based on the latest CDPHE data from 2023. Second-trimester abortions are primarily performed using Dilation and Extraction (D&E), which poses a substantially increased risk.

Since serious complications are uncommon in first-trimester abortions, a global quantification of abortion risk will systematically understate the risk posed by second and third-trimester abortions. The mortality from an abortion performed at 21 weeks or more is 77 times higher than the mortality from an abortion at 8 weeks or less, based on data from 1988-1997.[3] According to the CDC, for each additional week of gestation beyond 8 weeks, the risk of dying from abortion increases by 38%.[3] The latest CDC abortion mortality research encompassed data from 1998-2010 and confirmed the earlier findings and emphasized that gestational age was the best predictor of mortality.[4] Reviews of abortion safety commonly miss this vital fact.

The risk from abortion increases exponentially by gestational age, not just for mortality but also for morbidity. Minor and major complications of D&E second-trimester abortions are increased for each additional week of gestation.[5] For example, each one-week increase in gestation has been associated with a 7.1% increase in mean estimated blood loss.[6] This is relevant since hemorrhage is the most common cause of death in the second trimester.[3]

To put this in perspective, abortion advocates often compare the risk of abortion to other common medical procedures to make the case that abortions are safe. But they routinely compare global mortality rates rather than gestational-specific rates.

For abortions performed between 16 and 20 weeks, the mortality rate is 3.4 deaths/100000 abortions, but the rate increases to 8.9/100000 at 21 weeks or greater. [3] The risk of dying during natural childbirth is less than the risk for these late abortions.[3-4] Another pertinent comparison is the risk relative to ambulatory surgical centers. The mortality rate at ambulatory surgery centers certified by AAAASF is 2/100000 based on a study from the US.[8] A survey of accredited Canadian ambulatory surgical centers indicates an even lower rate of 1/100000.[9]

This suggests that late abortions are 4-8 times more deadly than ambulatory surgeries. Ambulatory surgical centers are licensed, regulated, and inspected in Colorado, but second and third-trimester abortion clinics are not.

Facilities that perform colonoscopies are not regulated, but they pose 1/3 the risk of 21-week abortions.[1] Plastic Surgery poses only 8-19% of the risk of late abortion and is typically performed in regulated facilities.[1] Adult tonsillectomies pose 32-70% the risk of late abortion and are performed in either a hospital or ambulatory surgical center.[1]

The other common problem with publications exploring the risk of abortion is that they often rely on large medical claim databases, which systematically underestimate the number of patients who have had an induced abortion and inadequately quantify complications for those who did.[9] Even with the methodological limitations of these studies, the risks of second-trimester abortions are markedly higher than the risks of first-trimester abortions.[10]

Second and third trimester abortion practice represents an opportunity ripe for quality improvement programs to minimize the known morbidity and mortality associated with these high-risk procedures.

Specific Risks of Second and Third Trimester Abortions:

There were 1220 second-trimester abortions and 137 third-trimester abortions reported to the CDPHE in 2023. This represented 8.3% and 0.9% of all abortions in Colorado. Abortions performed after the lower limit of fetal viability numbered 468, which represents 3.2% of all abortions.

While prospective double-blind placebo-controlled trials are considered the gold standard in establishing objective assessments of clinical risk, they aren't feasible for abortion since it would be unethical to submit women seeking abortion to different clinical procedural arms. Consequently, to understand the specific procedure and gestational age-specific risks of late abortion, the best evidence is obtained from large retrospective case series from abortion centers across the US.

The largest series of second-trimester D&E abortion complications was reported from the University of California, San Francisco, which is recognized as the premier center for abortion research in the country.[11] They demonstrated a 9.8% risk of any complication, including cervical laceration, *hemorrhage*, uterine atony, *anesthesia complications*, *uterine perforation*, disseminated intravascular coagulation, and retained products of conception in over 4500 D&E procedures. There was a 1.7% incidence of serious, life-threatening complications, including those requiring hospitalization, transfusion, or further surgical intervention.

Second-trimester surgical abortion was associated with a 37% risk of greater than 500 ml hemorrhage and 8% risk of greater than 1000 ml in lower volume abortion centers in South Carolina.[12] (For reference, a whole unit of blood is 450 ml). Blood transfusion was administered to 3.73% of patients.

A study from our own University of Colorado demonstrated a 5.6% risk of cervical injury and a 4.2% risk of hemorrhage of greater than 500 ml in women undergoing suction D&C and D&E abortion in the second trimester.[13] There was a 2% risk of hospitalization.

Pregnancies sometimes involve complex comorbidities in the women or placental abnormalities with the fetus. This can further raise the risk from induced abortion, which may not be recognized in unregulated clinic settings.

In a large high-volume referral abortion clinic in New York, 14.2% of patients undergoing D&E abortion from 15 to 24 weeks gestation had placenta previa (PP) by ultrasound.[14] Second trimester surgical abortion was associated with a 1.3% risk of major hemorrhage requiring transfusion in those without PP, but in 3.4% of those with PP. Hemorrhage greater than 500 ml was observed in 4.2% of normal patients but 12.6% of women with PP. This would be hard to manage in an unregulated, lower-volume second or third-trimester abortion clinic in Colorado.

Medical abortion into the second trimester is also legal in Colorado, although this represents an off-label use. They may be performed in unregulated abortion clinics, although prudent clinicians would choose a hospital setting. They pose additional risks to the women undergoing this procedure.

Second-trimester medical abortions are associated with a 33% risk of any complication and a 6% rate of a serious complication based on a study from Northwestern and Rush Universities in Chicago. [15] There is a 16% risk of hemorrhage and a 2.2% risk of hemorrhage requiring transfusion. There is a 0.5% risk for ICU admission, 12% risk for retained placenta requiring surgery, and a 12% risk of infection requiring antibiotics. If there is a history of one or more prior C-sections, these risks are substantially increased – 56% risk of any complication and 19% risk of a serious complication.

A second study from Rush University suggested that second-trimester medical abortion was associated with a 1% risk of major hemorrhage requiring transfusion, 13% risk of hemorrhage greater than 500 ml, 17% risk of suspected infection requiring antibiotics, 6% risk of retained placenta, and overall complication rate of 17%.[16]

Another second trimester medical abortion study performed at Thomas Jefferson University Hospital in Philadelphia demonstrated a 1.6% incidence of severe hemorrhage requiring transfusion, 14% had retained tissue requiring D&C, and 9.5% chorioamnionitis requiring antibiotics.[17]

A small outlier study from the Medical College of Wisconsin showed no statistically different rate of complications from D&E compared to medical induction abortions in the second- trimester.[18] The complication rate ranged from 1.3 to 7% and included hemorrhage, retained tissue requiring manual or D&C removal.

There is little data on the risk of third-trimester abortions since they are rare outside a handful of states that permit them, including Colorado.

Third trimester abortions (like many later second trimester abortions) involve the injection of a feticide which carries its own independent risk for adverse events.[19]Because third trimester abortions in Colorado incorporate surgical instruments as well as drugs to extract the fetus, it can be anticipated that there is substantial risk to the woman – akin to instrument augmented deliveries.[20]

Reducing Reproductive Age Women's Morbidity and Mortality is a Priority in Colorado

Maternal mortality, which includes abortion-associated and abortion-related mortality, is a scourge in our nation and in the state of Colorado. Maternal mortality includes death from any cause within one year of pregnancy. The pregnancy can end by live birth, miscarriage, stillbirth, or abortion. Pregnancy-related deaths are a subset of pregnancy-associated deaths and are due directly to a complication of pregnancy/abortion or a chain of events initiated by pregnancy/abortion. These could include suicide and overdose, or the aggravation of an unrelated condition exacerbated by the physiological effects of pregnancy or abortion. As in the rest of the United States, maternal mortality in Colorado disproportionately impacts people of color, individuals living in poverty, those with less than a high school education, those over the age of 40 and those living in "frontier" areas.[21]

Maternal mortality is the "tip of the iceberg" since maternal morbidity is a much larger problem.[22] For every woman that dies as a result of her pregnancy, it is estimated that 20 or 30 more will experience significant life-long complications.[22]

The Colorado Maternal Mortality Prevention Program (MMPP) aptly states that "every person has the right to a safe and healthy pregnancy". Unsafe second and third-trimester abortion clinics are a direct challenge to this basic right.

The Colorado Maternal Mortality Review Committee (MMRC) reported 174 pregnancy-associated deaths and 80 pregnancy-related deaths between 2016 and 2020.[21] These numbers include abortion associated and abortion-related deaths.

There has been significant progress made in delivery-related mortality, which is an important component of pregnancy-related mortality. There has been a uniform decrease in delivery-related mortality across all racial and ethnic groups, age groups, and modes of delivery between 2008 and 2021.[22] This has been attributed to national and state strategies focused on improving maternal quality of care using evidence-based bundles during delivery-related hospitalizations.

There has not been a similar national or state strategy to institute evidence-based bundles for second and third-trimester abortion clinics. While some conscientious facilities may institute these best practices on their own, this represents an opportunity for the legislature to have a significant role in reducing maternal morbidity and mortality by instituting a licensing, regulatory, and an inspection regimen under the auspices of CDPHE for these clinics.

The MMRC has recommended that "health care facilities should implement evidence-based safety bundles".[21] They add "there should be a specific focus on implementing bundles that address supporting patients with substance abuse disorders and mental health challenges." A second recommendation is that "all health care providers should use evidence-based screening tools (e.g., PHQ-9, EPDS, C-SSRS) for mental health, substance use, suicidality, intimate partner violence, and social determinants of health including social support, housing, and barriers to care."

These recommendations from the MMRC are particularly pertinent to abortion care since women who seek abortions have significantly more mental health disorders compared to women who seek childbirth.[23] One high quality registry study suggested that women seeking an abortion were 4 times more likely to have a mental health disorder than women before a normal delivery.[24] They are much more likely to suffer from an anxiety disorder, mood disorder, substance use disorder, and suicidal ideation. Furthermore, abortion is twice as likely to trigger a substance use disorder as compared to childbirth.[23]

Colorado has the second-highest percentage (19.4%) of pregnancy-associated deaths from suicide in the country.[25] Significantly, 19.4% of Colorado's pregnancy-associated deaths are from drug overdose, and 10% from homicide. Besides standardizing the approach to anticipated complications of second and third trimester abortions (such as hemorrhage, infection, and anesthesia complications), there is a huge opportunity for abortion clinics to improve outcomes if they employ proper screening techniques and have access to a multidisciplinary team that addresses mental health, substance use disorders and domestic violence.

What requirements should the state emphasize when exercising oversight of second and third-trimester abortion clinics?

Since hemorrhage is the most urgent and life-threatening complication of a second-trimester abortion, the state CDPHE should develop regulations and an inspection schedule that ensures abortion patients have access to care that minimizes the risk of hemorrhage and affords prompt treatment options. Studies suggest that actual blood loss is twice as high as estimated blood loss, and therefore hemorrhage can quickly result in a critically ill woman or exacerbate any antecedent medical conditions.[26-27] A clinic should also be adept at administering anesthesia, including conscious sedation, and responding to anesthetic complications. They should have protocols in place to address infectious complications, even if these patients are more likely to present to an emergency department or urgent care center. Finally, they should employ screening tools for domestic violence, substance abuse, and mental health disorders.

Each clinic should ascertain whether the patient has a prior uterine scar, the gestational age of the fetus, the quality of cervical preparation, body mass index, procedural experience, fetal demise, and what kind of anesthesia is appropriate.[27] These all can impact the magnitude of hemorrhage following a D&E. They should have access and protocols for use of methylergonovine, misoprostol, oxytocin, vasopressin, tranexamic acid, and other novel agents to prevent or mitigate hemorrhage. Protocols to transfer patients in need of tertiary treatments such as uterine artery embolization, laparoscopy, laparotomy, or hysterectomy should be developed.

Second and Third trimester abortion facilities should be required to conduct a quality review of all cases of severe maternal morbidity and mortality. The American Association of OB/GYNs (ACOG) recommends that clinicians "characterize the events, diagnoses, and outcomes involved; and to determine if an identified morbidity is judged to have been potentially avoidable and, thus, present opportunities for system change and improved future performance."[28]

Is a clinic regulation law simply a solution in search of a problem?

The abortion industry will argue that abortion is safe and that if there is a significant problem, it would already be obvious, despite the enumeration of the risks outlined above.

The reality is that because of the stigma from abortion, patients are unlikely to seek redress for significant complications. They may indicate (or be told to say) that they are having a miscarriage rather than an induced abortion when presenting to an emergency department with complications. And we know that even health departments and prestigious medical centers, will turn a blind eye to abortion complications in service to what they perceive as the greater good – unfettered access to abortion.

To understand the magnitude of the problem, recognizing and reporting egregious public health and safety practices at abortion facilities, you simply have to peruse the details from the Grand Jury Report on Kermit Gosnell – the abortion provider currently serving time in prison for murder following decades of deplorable abortion practices.[29] The Pennsylvania Department of Public Health and Safety deliberately chose not to enforce law that would afford patients at abortion clinics the safeguards and assurances of quality care as patients of other medical providers. The Grand Jury stated that "the medical practice by which he carried out this business was a filthy fraud in which he overdosed his patients with dangerous drugs, spread venereal disease among them with infected instruments, perforated their wombs and bowels – and, on at least two occasions, caused their deaths." "Over the years, many people came to know that something was going on here. But no one put a stop to it.". Even the world-class Hospital of the University of Pennsylvania and the Presbyterian Hospital turned a blind eye to women who presented with life-threatening complications from Gosnell's clinic.

Gosnell is not an isolated rogue actor, since there are dozens of examples of gross medical negligence at abortion clinics from New Jersey to Florida, and from Pennsylvania to Indiana/Michigan, and California. If robust Department of Public Health and Environment licensing, regulation, and inspections were in place, none of these regrettable tragedies would have happened.

Here in Colorado, Mediatrackers first drew attention to the lack of regulation at abortion clinics in Colorado in 2013.[30] This was prompted by a malpractice lawsuit against Planned Parenthood of the Rocky Mountains that alleged malpractice and health standard violations. They found that Planned Parenthood abortion clinics were not held to the same standards as other facilities, which are regulated by CDPHE. Planned Parenthood's only state oversight consists of the licensure of

physicians, nurses, and pharmacists who must maintain the requirements of the Colorado State Board of Health, the Board of Nursing, and the Board of Pharmacy. They also operate within the constraints of OSHA (Occupational Safety and Health Administration) and CLIA (Clinical Laboratory Improvement Amendments). *There is no state licensing, regulatory, or inspection requirements for public health and safety at abortion facilities in Colorado, despite receiving millions of dollars of direct aid from the state.*

Another underappreciated factor is the fact that 29% of the abortions reported to CDPHE in 2023 were performed on out-of-state residents. Colorado is obligated to ensure quality care for these women so they don't suffer severe complications after they return home. This could delay appropriate care, worsen the severity of the complication, and have implications for their long-term health. Out-of-state women probably assume that the State of Colorado has their back with appropriate, evidence-based licensing, regulation, and inspections.

Finally, the truth is that there is a global shortage of abortion providers, and few OB/GYNs wish to include abortion in their practices.[31] There is a negative public perception of abortion providers, even if the public broadly supports abortion rights. According to a recent survey conducted by KFF after the Dobbs decision, only 7% of OB/GYNs offer telehealth abortions, 14% in-person drug-induced abortions, 13% aspiration abortions, and 12% D&E abortions [32]

Dr. Warren Hern, the prominent second and third post-viability abortionist who until recently practiced (at age 86) at the Boulder Abortion Clinic, acknowledges the problem of maintaining and recruiting quality abortion providers in his recent book *Abortion in the Age of Unreason*.[33] He lamented that there were two kinds of abortion providers. There are those motivated by "altruistic" concerns to help women and sacrifice much to deliver that care in a hostile environment. The second kind of abortion provider is the "commercial" provider who "cuts corners on patient care" and is the "choice of many abortion providers".

Even Planned Parenthood, which has 11 clinics in Colorado, isn't immune from allegations of putting the abortion "mission" above the health and safety of women.[34] The exposé reported that "Planned Parenthood has enjoyed a fund-raising boom …but little of it goes to the state affiliates to provide health care at clinics. Instead, under the national bylaws, the majority of the money is spent on the legal and political fight to maintain abortion rights." They went on to observe that

"employees at various affiliates said it was common to run out of over-the-counter pain medication and I.V. flushes. Salaries are so low that it is not unusual for staff members to qualify for Medicaid and federal food assistance." As a result of staff turnover, they say that "they did not receive adequate training for patient intake, blood draws, and other tasks." "Dozens of current and former employees also said that their complaints were met with reminders that they were in a "mission moment," meaning a time of crisis for reproductive rights so urgent that it overshadowed their concerns." In this kind of environment would-be whistleblowers remain silent. Women's health and safety is a secondary consideration because as one employee observed, "we're afraid of damaging the mission".

Given the risks, there is a compelling argument to be made why the state must act now to ensure the health and safety of women pursuing second and third-trimester abortions in Colorado. Not only is there a large risk to women who undergo late abortion in the best of circumstances, but Colorado's proabortion environment sets the stage for poorly qualified bad actors to come to the state to pursue remuneration for abortion services without regard for the women they may injure or even kill through their negligence.

Conclusion:

Amendment 79 enshrined access to abortion at any time for any reason in the state constitution. Colorado voters could not imagine at the time that they might be casting a vote to undermine the health and safety of women.

Second-trimester D&E abortions have a 10% complication rate and at least a 1.5% risk of severe, life-threatening complications such as severe hemorrhage and uterine perforation. At lower volume centers or using different techniques, or with underlying comorbidities and/or placental abnormalities, the complication rate can be as high as 56%. Hemorrhage is the greatest short-term risk and can be rapid and massive. Second and third trimester abortion clinics should be adequately prepared to minimize the risk of hemorrhage and mitigate the severity once established. They should be required to maintain a robust quality/peer review process. There is also an important role for screening tools given the high incidence of mental health and substance abuse disorders in abortion patients.

It is past time for Colorado to place second and third-trimester abortion clinics under the licensing, regulating, and inspection authority of CDPHE. CDPHE already has jurisdiction over other medical facilities with markedly less risk for significant morbidity and mortality.

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