Utah Abortion Status

A Primer for Clinicians

May 2024

Ogden Medical Society

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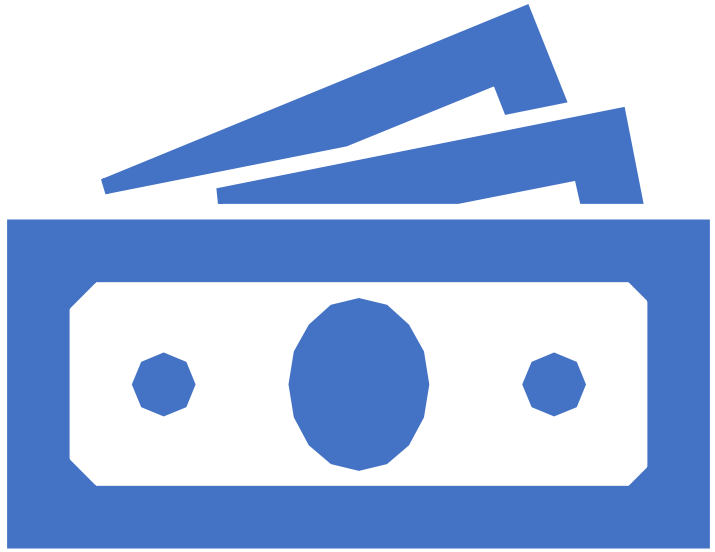
Format

- Introduction and background
- Legislative history and current landscape
  - Contraception
  - Abortion
- Prevention of unwanted/unplanned pregnancy
- Resources

Disclosures



- Cara Heuser has no financial disclosures
- Alexandra Eller has no financial disclosures
- We are here today to speak on behalf of ourselves, not Intermountain Health

Introduction and Background

Perspectives

“The exercise of conscience in health care is generally considered synonymous with refusal to participate in contested medical services, especially abortion. The depiction neglects the fact that the provision of abortion care is also conscience-based.”

-Lisa Harris, MD PhD

Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking.

- Atul Gawande, MD

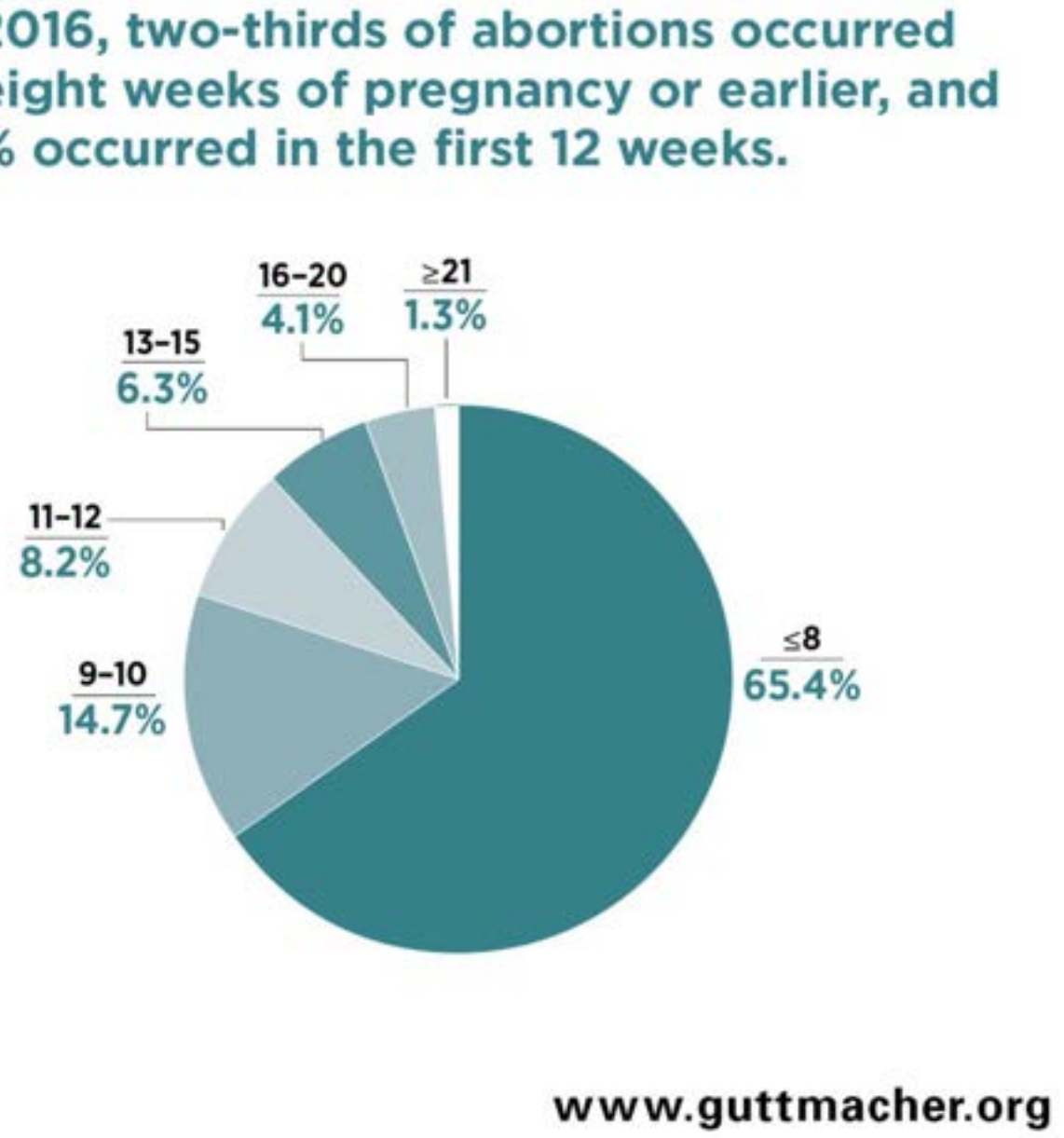
Session Norms

- This can be a difficult topic
- Differing beliefs, shared values
- Everyone is starting from a different place
- Medical providers, especially OBGYN providers, have a unique perspective
- We are not lawyers, this is not legal advice

Abortion in the US

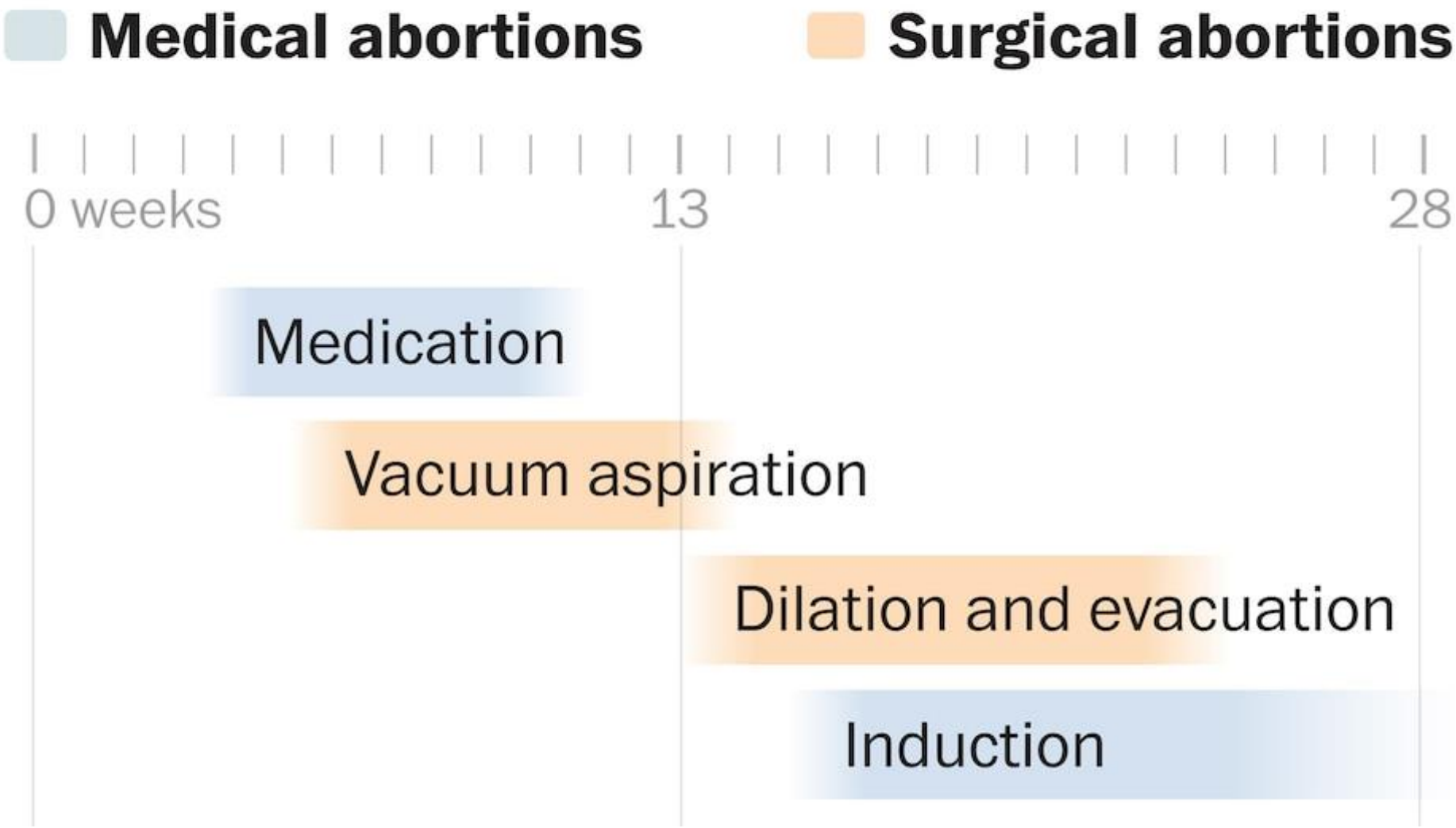
- 2015-2019 46% of all pregnancies in the US are unintended
  - Of those, 34% ended in abortion
- Poverty related health disparities impact unintended pregnancy and abortion rates
- In 2017 18% of all pregnancies ended in abortion
  - 1 in 20 women will have an abortion by age 20
  - 1 in 5 by age 30
  - 1 in 4 by age 45
- 59% of women having an abortion already have children

When do patients have abortions?

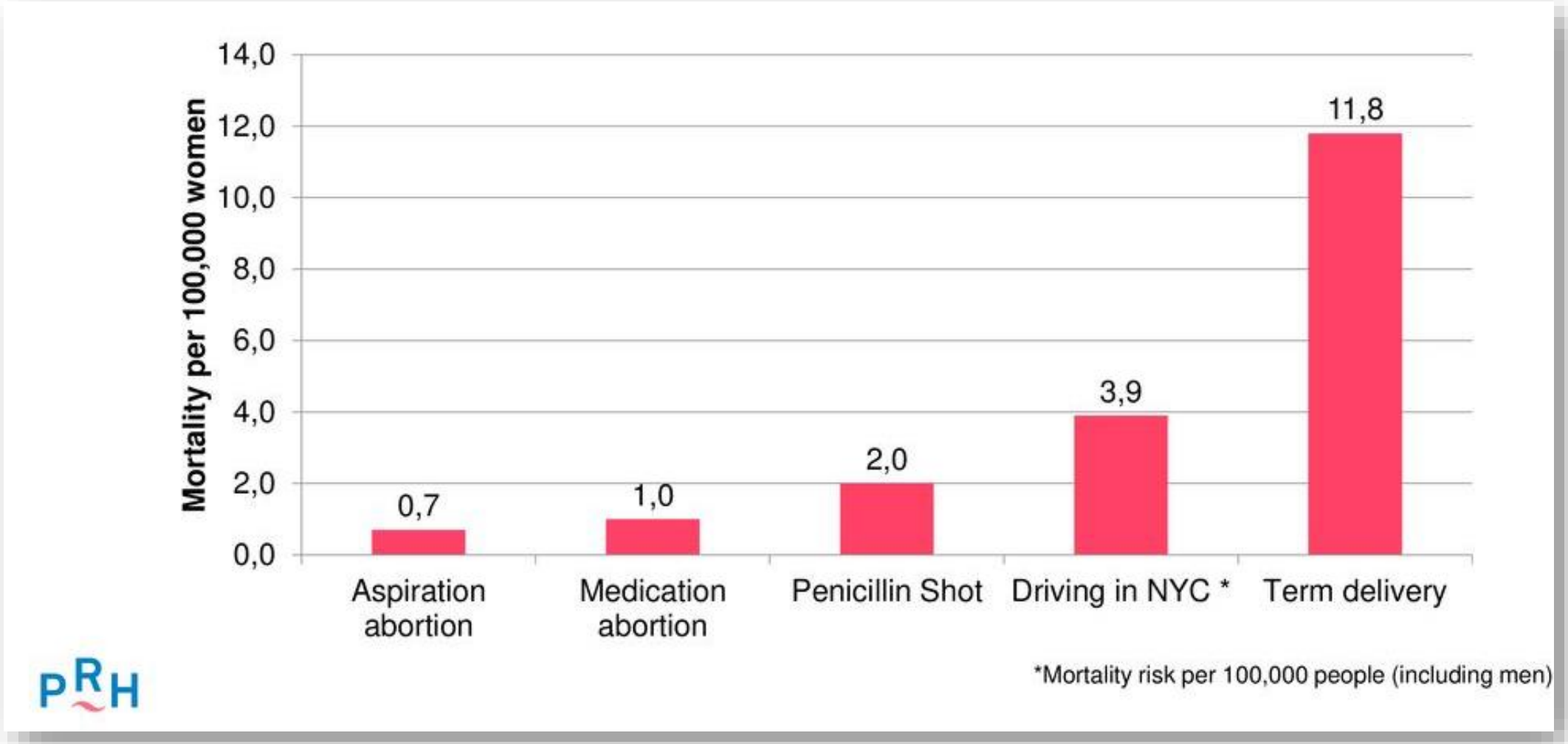


https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

Abortion Methods by Gestational Age

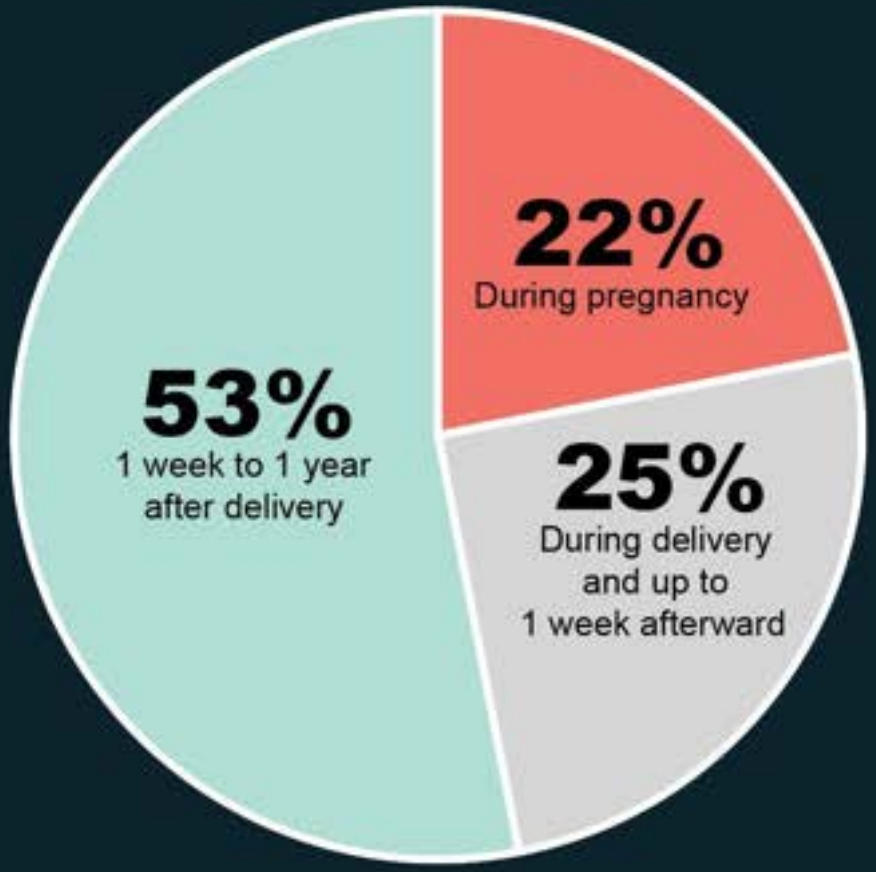


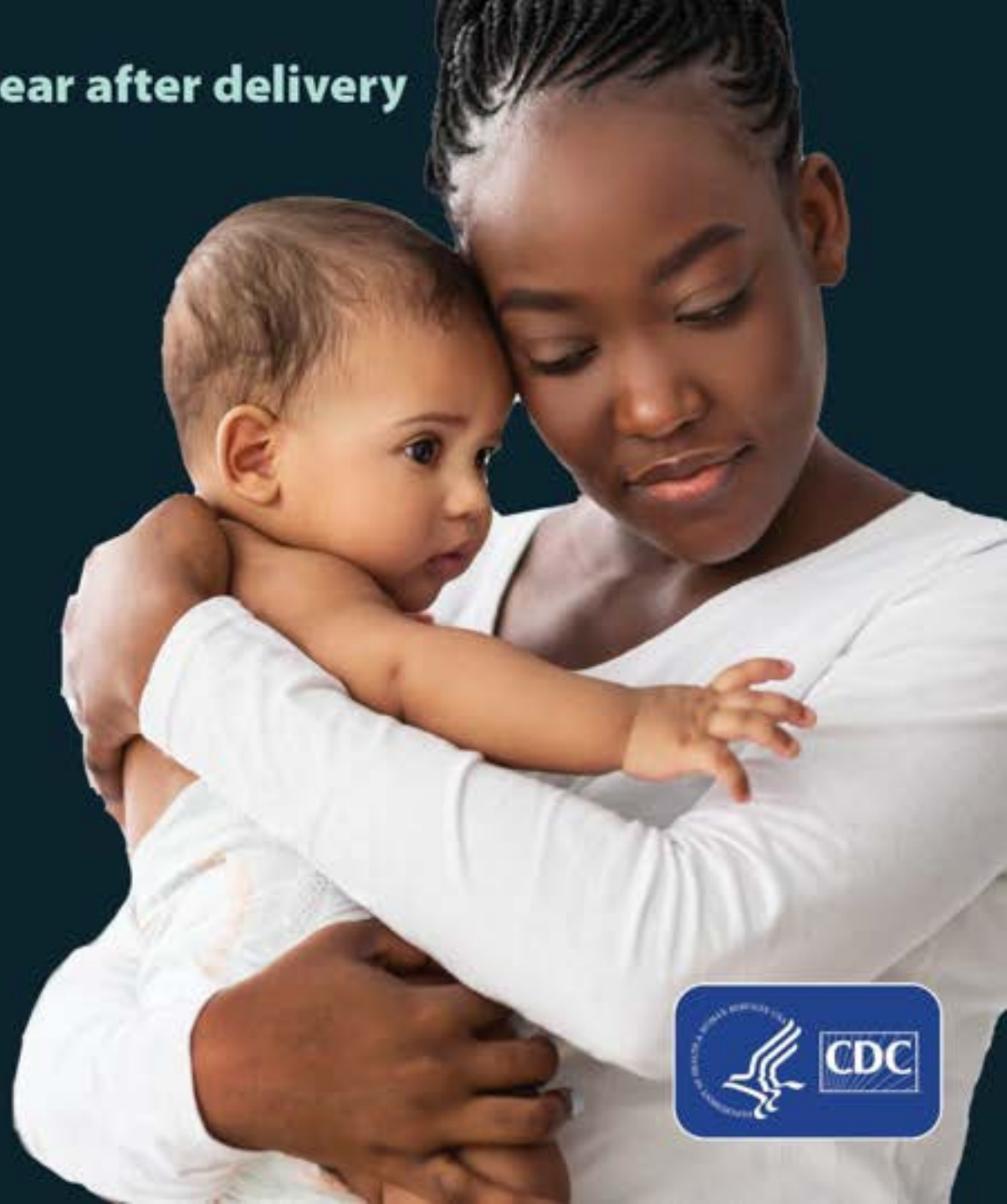
Abortion Safety in Perspective



Mortality of induced abortion, other outpatient surgical procedures and common activities in the United States. Contraception. 2014

Pregnancy-related deaths can happen up to year after delivery





HEAR
HEAR HER CONCERNS

CDC

Back to Basics: Pregnancy Outcomes

1. Ectopic pregnancy/miscarriage/fetal death
2. Abortion
3. Live birth

Abortion Semantics

- Spontaneous abortion
- Therapeutic abortion
- Induced abortion
- Missed abortion
- Incomplete abortion
- Elective Abortion
- Pregnancy Termination
- Augmentation of labor
- Completion of inevitable miscarriage
- Compassionate early delivery

What's in a name?

- ACOG – An intervention intended to terminate a pregnancy so that it does not result in a live birth.

- State of Utah - the ***intentional termination or attempted termination of human pregnancy after implantation of a fertilized ovum*** through a medical procedure carried out by a physician or through a substance used under the direction of a physician;

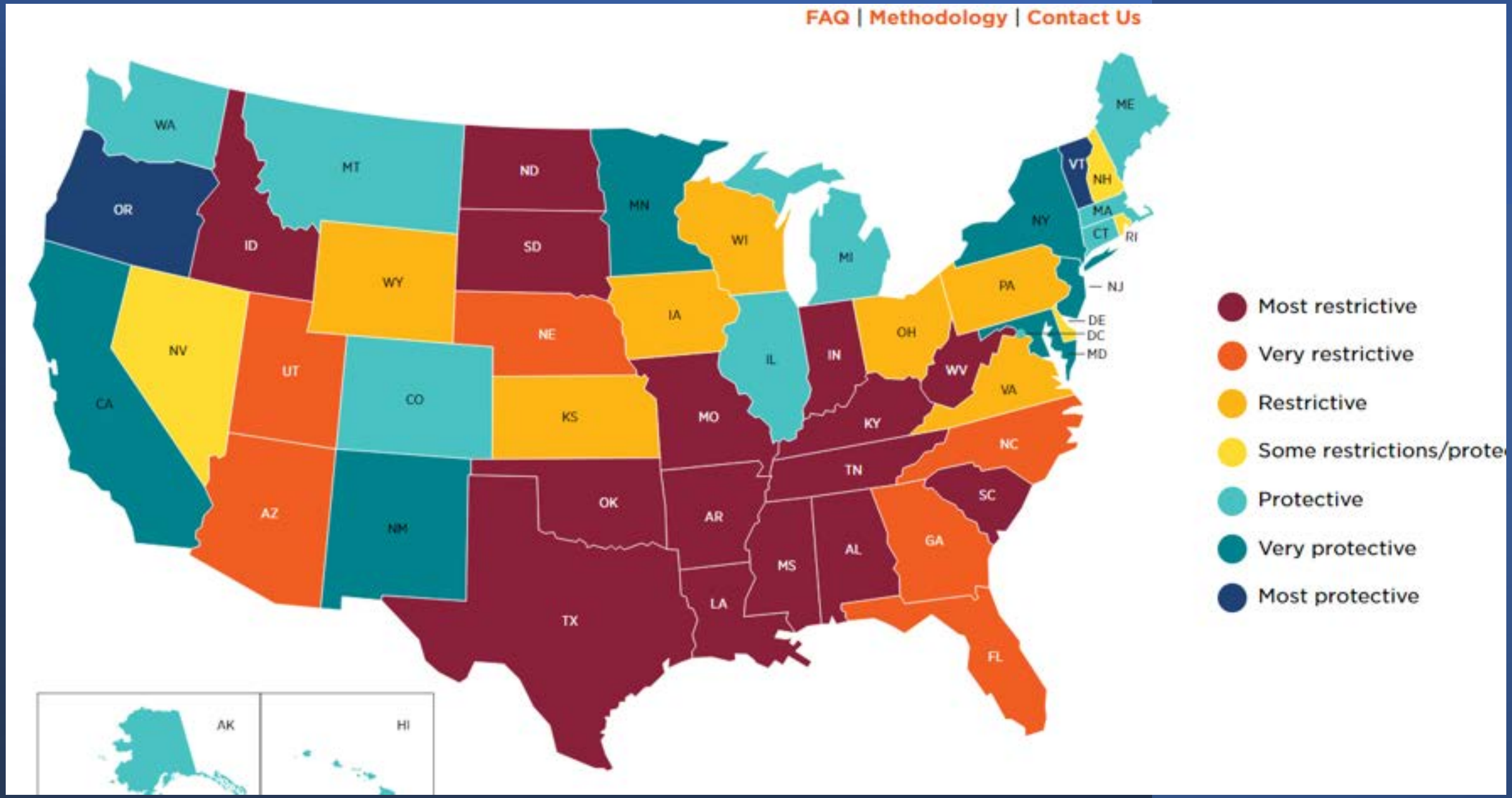
Consider…

- 39 yo G1 at 21w with antiphospholipid syndrome presents with early onset HELLP syndrome. Delivery is recommended by induction or labor of dilation and evacuation (surgical termination). The patient asks: Is this an abortion? Is this an indicated delivery?

- 22 yo at 19 weeks gestation with moderate but non emergent vaginal bleeding for three weeks leading to anemia requiring blood transfusion. Delivery is recommended for chronic previable abruption. Is this an abortion? An indicated delivery?

The Landscape

- Legislative interference with medical decision making
  - Restrictive States across the US seeing increased maternal morbidity and mortality
- Restricted access to abortion is altering the landscape of domestic violence
  - Reproductive coercion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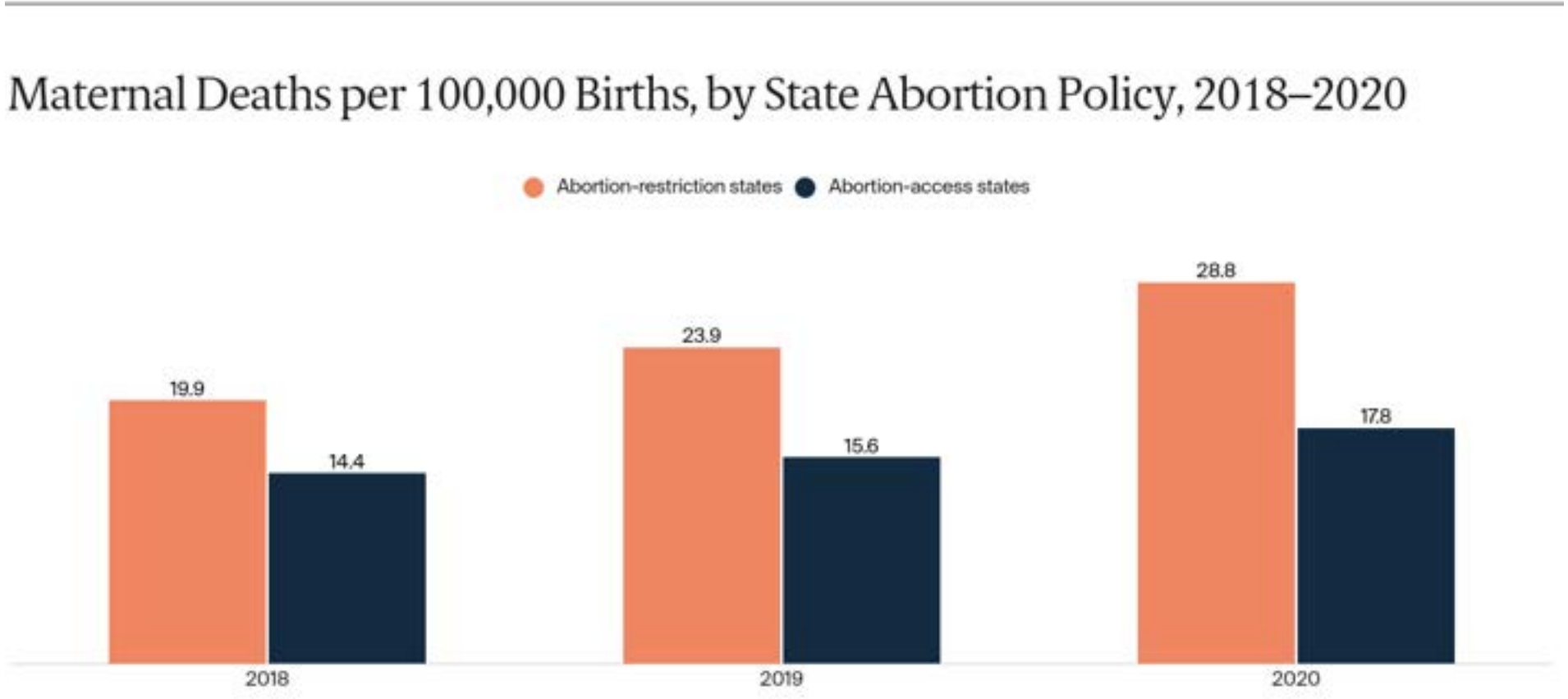
MATERNAL MORTALITY



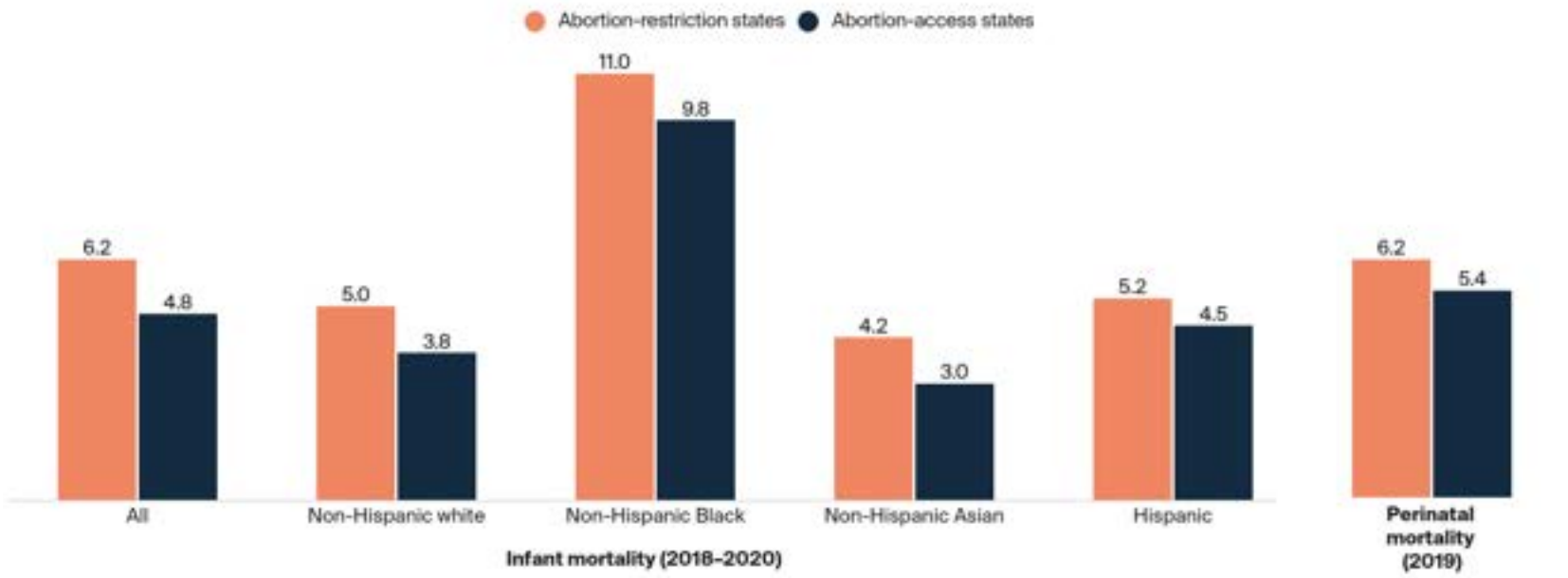
Data: Centers for Disease Control and Prevention, "National Center for Health Statistics Mortality Data on CDC WONDER," last updated Dec. 22, 2021.

Source: Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions* (Commonwealth Fund, Dec. 2022). https://doi.org/10.26099/z7dz-8211

INFANT/PERINATAL MORTALITY

EXHIBIT 7

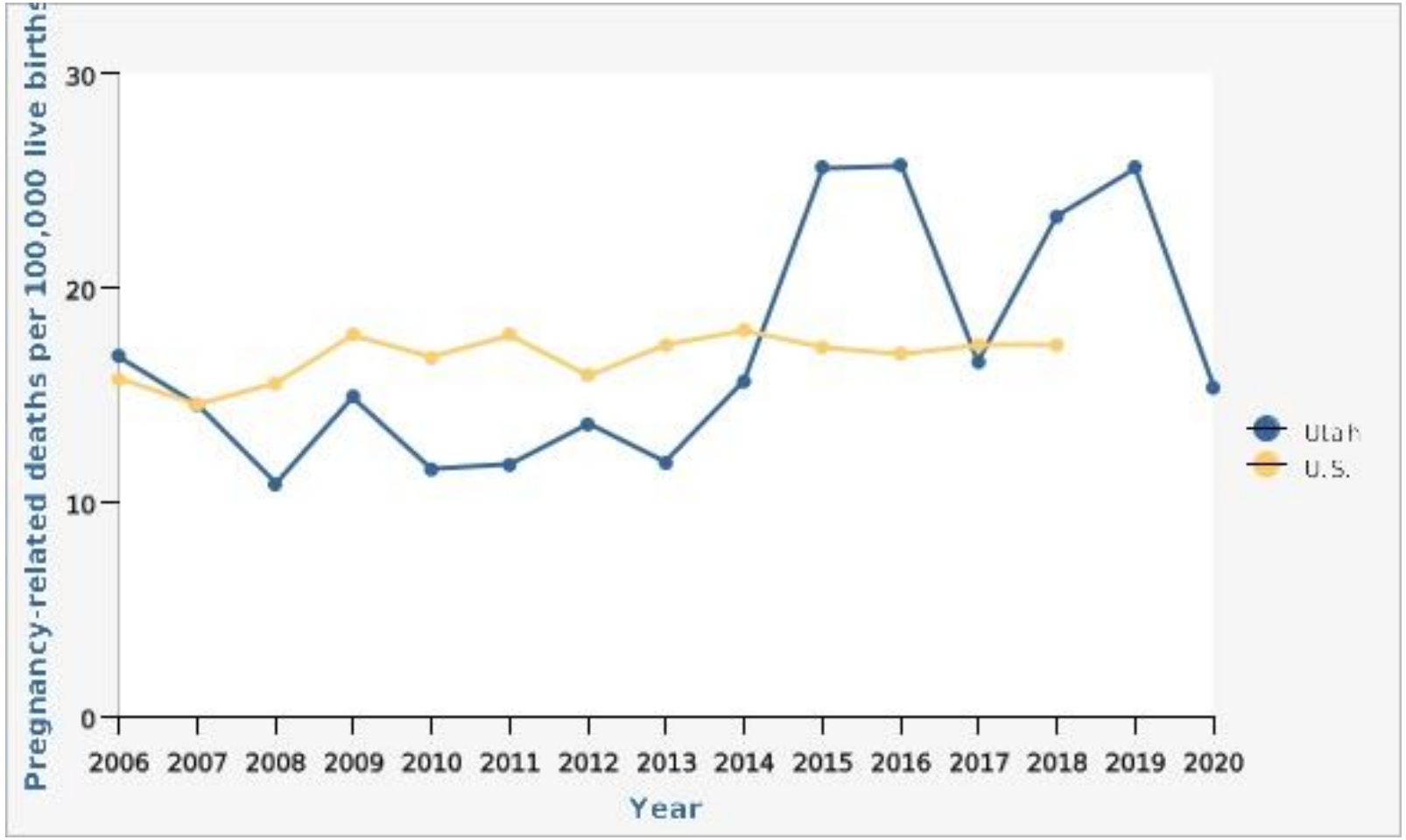
State Infant and Perinatal Mortality Rates per 1,000 Births, by Race/Ethnicity and Abortion Policy, 2018–2020



Data: *Mortality* – Centers for Disease Control and Prevention, CDC WONDER (database), "Underlying Cause of Death, 1999–2020," accessed Sept. 30, 2022; *Perinatal mortality* – Claudia P. Valenzuela, Elizabeth C.W. Gregory, and Joyce A. Martin, *Decline in Perinatal Mortality in the United States, 2017–2019*, NCHS Data Brief no. 429 (National Center for Health Statistics, Jan. 2022).

Source: Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions* (Commonwealth Fund, Dec. 2022). https://doi.org/10.26099/z7dz-8211

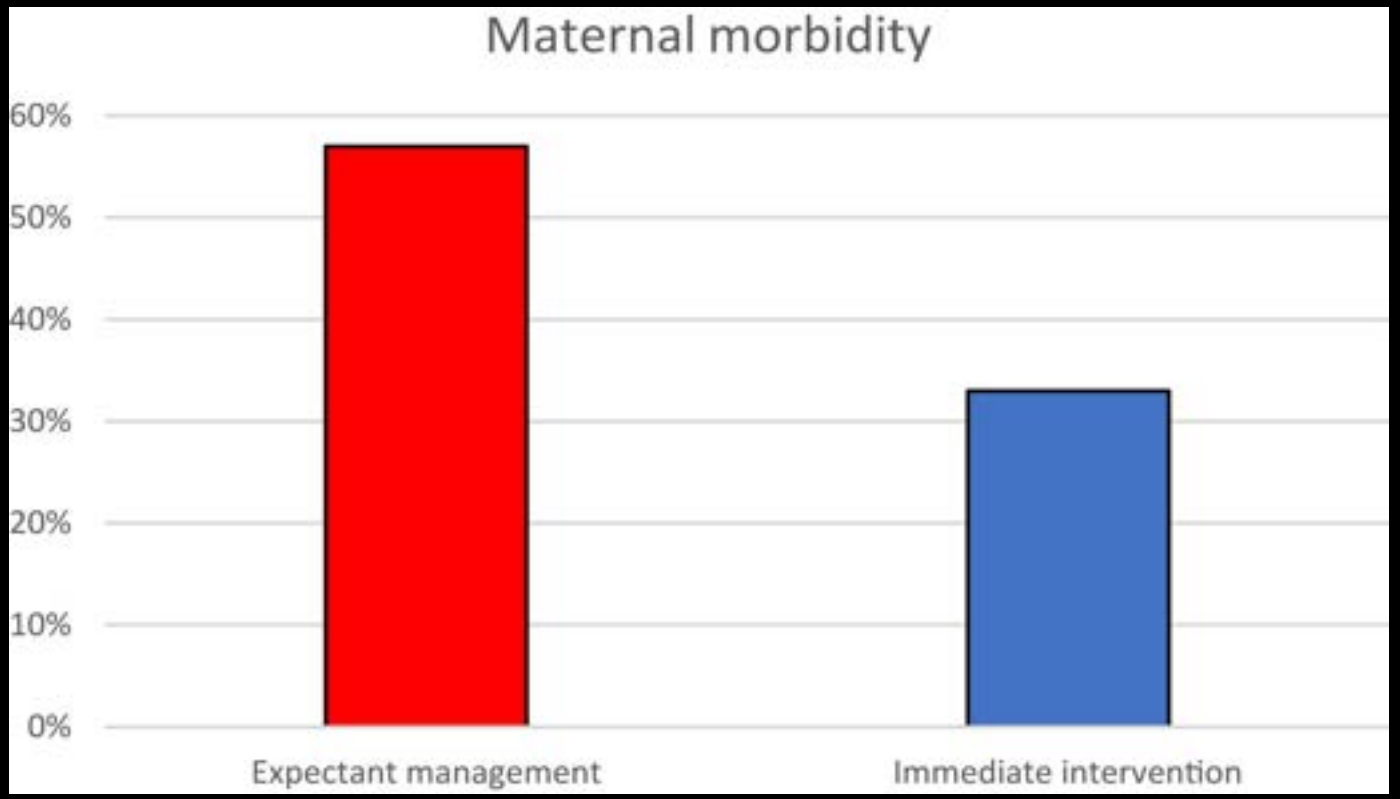
Utah Maternal Mortality



Maternal morbidity and fetal outcomes among pregnant women at 22 weeks' gestation or less with complications in 2 Texas hospitals after legislation on abortion

Anjali Nambiar, MD

American Journal of Obstetrics & Gynecology
Volume 227 Issue 4 Pages 648-650.e1 (October 2022)
DOI: 10.1016/j.ajog.2022.06.060



Anecdotal Expert Evidence

- Dramatic rise in patient transports from Idaho facilities to obtain abortion care in Utah
  - Previable preterm premature rupture of membranes
  - Sepsis
  - Bleeding
  - Second trimester preeclampsia
  - Maternal heart failure
  - Lethal fetal abnormalities (anenecephaly, trisomy 18, others)
- Some have required intensive care admission
- Some have required hysterectomy and lost their future fertility as a direct result
- Some have ended up on dialysis
- Many have simply had ***standard of care*** treatment (abortion) and done well
  - at tremendous personal expense (financial and emotional), systemwide resource utilization, and diversion of transport services for standard medical care that should have been provided at the referring center

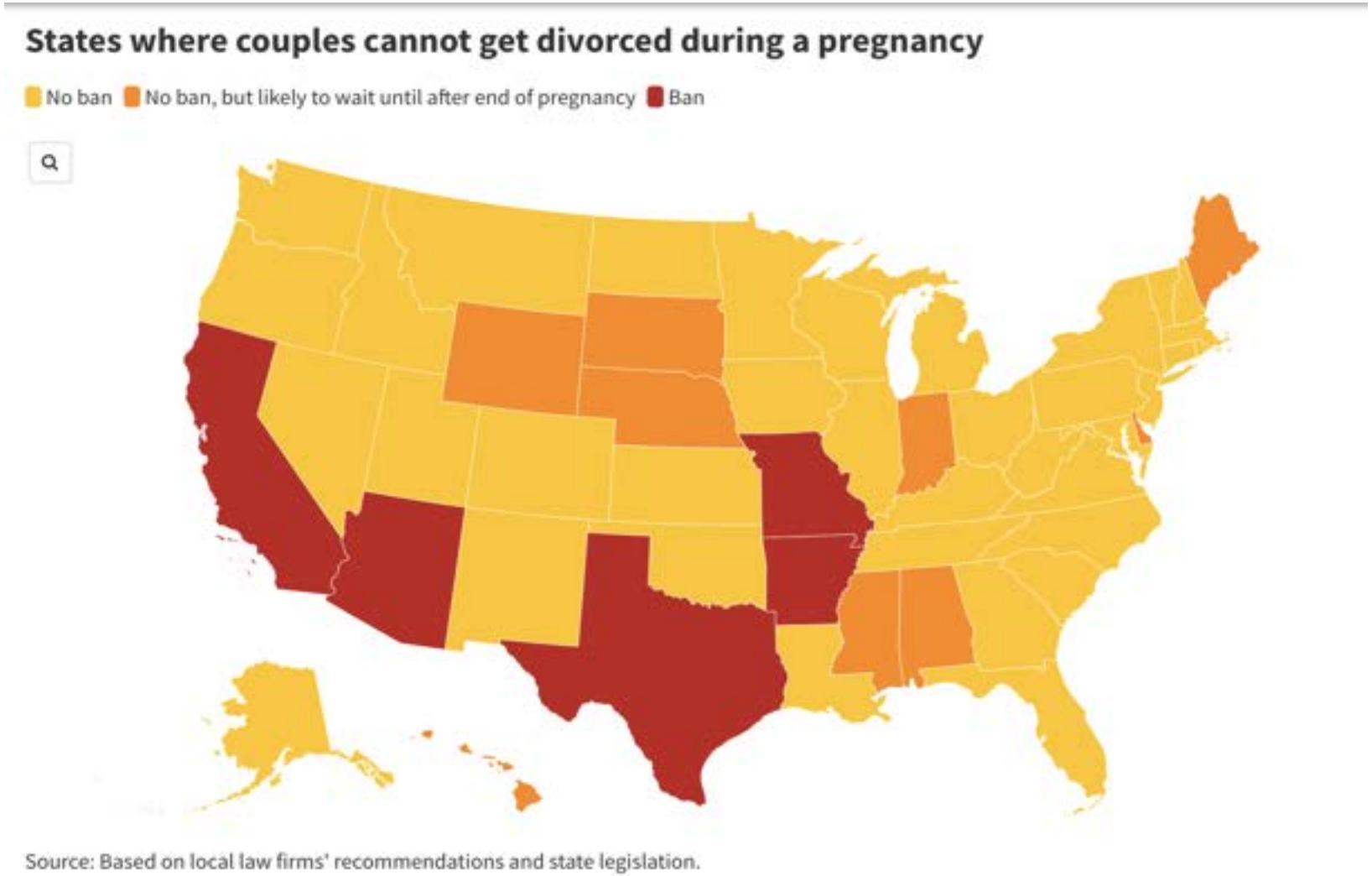
Reproductive coercion: Individual

- Purposefully control a woman's reproductive decision making through contraceptive sabotage, contraceptive refusal, emotional/psychological/financial/physical manipulation or abuse to unduly influence reproductive outcomes (to ***become*** pregnant, to ***continue*** a pregnancy, to ***end*** a pregnancy)

Reproductive Coercion: Societal/System Level

- Legal, institutional, structural factors that can exert undue influence on decision making
  - Medicaid 30-day consent for sterilization (good intentions gone awry)
  - Restrictive laws about abortion that selectively impact vulnerable populations (women of color, those with limited financial means)
  - Arbitrary institutional policies that influence provision of care (contraception, abortion access)
  - Systematic reductions in healthcare access to obtain contraception/prevent pregnancy
  - Polarizing groups pressuring women to end or continue a pregnancy
  - State restrictions barring or limiting divorce during pregnancy (Texas, Missouri, Arkansas, Arizona)

Reproductive Coercion – Pregnancy and Divorce



https://www.newsweek.com/map-shows-us-states-where-pregnant-women-cant-get-divorced-1874139

Sexual Coercion

- Sexual coercion is unwanted sexual activity that occurs when someone is pressured, tricked, or forced in a non-physical way. This includes psychological or emotional pressure, psychological or physical threats, intimidation, manipulation, and blackmail. This can also include using drugs or alcohol to manipulate a person into “consenting” to otherwise unwanted sexual activity.

Consider…

- A 39 yo mother of 3 has an abusive husband. They live in a State that does not allow abortion and does not allow divorce during pregnancy (*yes, there are several*). She has been threatening to leave and he hid her contraceptive pills and she became pregnant. How does reproductive coercion fit within the framework of reproductive autonomy?
- 16 yo G1 at 8 weeks gestation pregnant after “consensual” sex with a 17 yo who threatened to release nude photos and a sex tape online if she didn’t have sex with him on demand. Is sexual coercion rape? Is physical restraint and forced penetration the only definition of rape?

Abortion is Healthcare
Women are safer when abortion is legal

ACOG and AMA Joint Statement with 75 HCOs

"Abortion care is safe and essential reproductive health care. Keeping the patient–clinician relationship safe and private is essential not only to quality individualized care but also to the fabric of our communities and the integrity of our health care infrastructure. As leading medical and health care organizations dedicated to patient care and public health, we condemn this and all interference in the patient–clinician relationship."

-July 7, 2022

Legislative History

Legal Access to Contraception

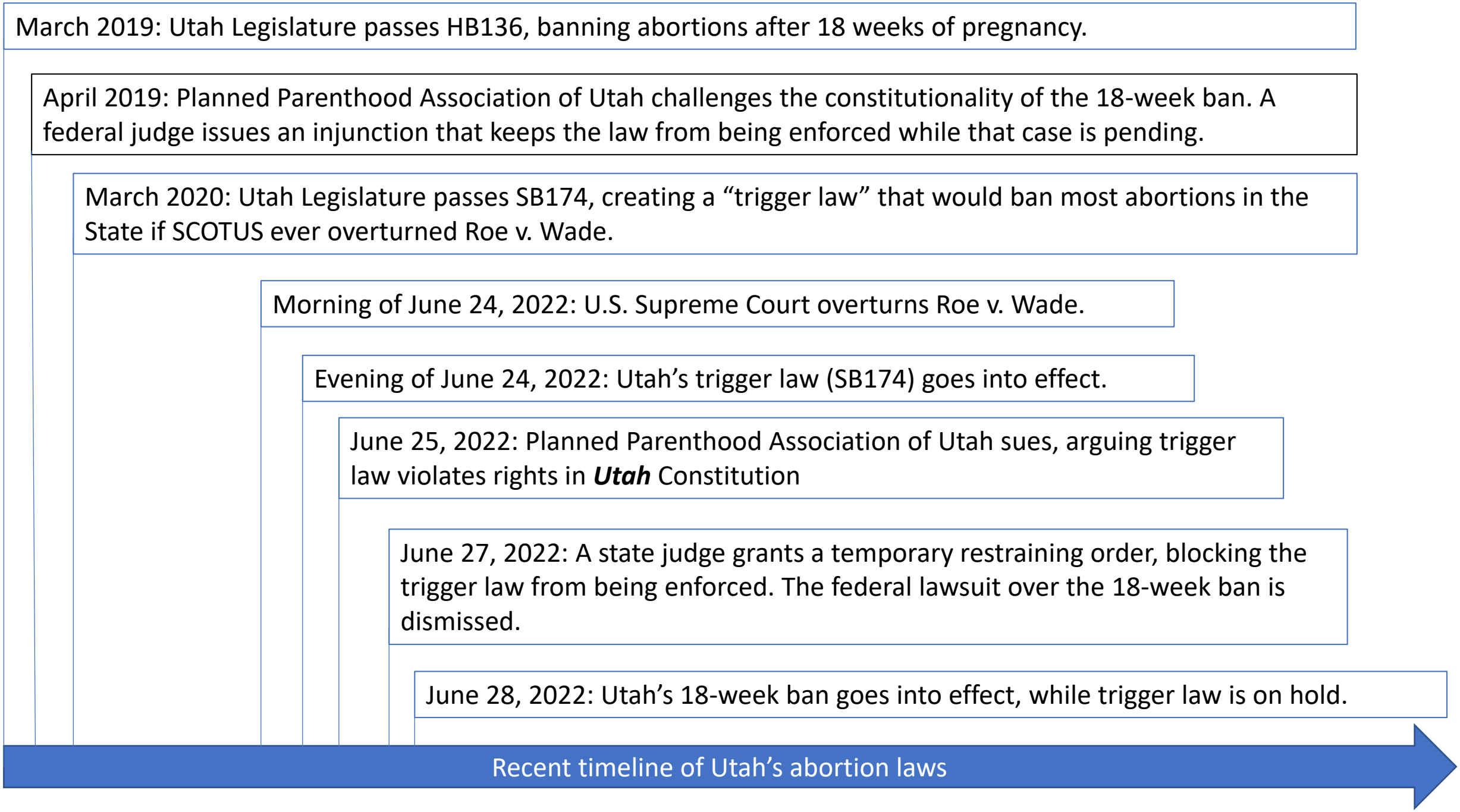
- Most of 19th century, contraception legal in the US
- **1870** Comstock Act and various State "Comstock Laws"
  - outlawed the distribution of information on safe sex and contraception
- **1965** SCOTUS decision **Griswold v. Connecticut**
  - Connecticut law prohibiting the use of contraception by married couples unconstitutional based on the ***RIGHT TO PRIVACY*** implicit in US Constitution (*this forms future legal basis of Roe*)
- **1975** SCOTUS decision **Eisenstadt v. Baird**
  - Massachusetts law prohibiting the use of contraception *per se* violates a single person's rights under the 14th Amendment's Equal Protection Clause "*the rights must be the same for the married and the unmarried alike*"

Judicial History: Abortion

- **1973** SCOTUS **Roe v. Wade**
  - US Constitution protects a woman's right to an abortion prior to third trimester ("viability")
  - The case involved a Texas statute that prohibited abortion except when necessary to save the life of the pregnant woman
- **1992** SCOTUS **Planned Parenthood v. Casey**
  - Upheld Roe (mostly, some important caveats)
    - Viability vs Roe's Trimester framework
    - Concept of "Undue Burden"

2022 **Dobbs v. Jackson**

- **2018** law enacted by the Mississippi Legislature
  - Bans abortions if “the probable gestational age of the unborn human” was determined to be more than 15 weeks
  - Included narrow exceptions for medical emergencies or “a severe fetal abnormality.”
- *Upheld with SCOTUS decision June 24, 2022*


March 2019: Utah Legislature passes HB136, banning abortions after 18 weeks of pregnancy.
April 2019: Planned Parenthood Association of Utah challenges the constitutionality of the 18-week ban. A federal judge issues an injunction that keeps the law from being enforced while that case is pending.
March 2020: Utah Legislature passes SB174, creating a “trigger law” that would ban most abortions in the State if SCOTUS ever overturned Roe v. Wade.
Morning of June 24, 2022: U.S. Supreme Court overturns Roe v. Wade.
Evening of June 24, 2022: Utah’s trigger law (SB174) goes into effect.
June 25, 2022: Planned Parenthood Association of Utah sues, arguing trigger law violates rights in ***Utah*** Constitution
June 27, 2022: A state judge grants a temporary restraining order, blocking the trigger law from being enforced. The federal lawsuit over the 18-week ban is dismissed.
June 28, 2022: Utah’s 18-week ban goes into effect, while trigger law is on hold.
Recent timeline of Utah’s abortion laws

June 28, 2022: Utah's 18-week ban goes into effect, while trigger law is on hold.

May 3, 2023: ***HB 467 Abortion Changes*** modifies maternal and fetal exception language from original 18w ban after productive meeting between MFM providers and Bill Sponsor

March 14, 2024 - ***HB 560 Licensing Modifications*** – abortion can only be performed in a certified abortion clinic or hospital

Recent timeline of Utah's abortion laws

Abortion banned after implantation

Defined as the beginning of pregnancy

UTAH STATE LEGISLATURE

S.B. 174 Abortion Prohibition Amendments

Bill Text

Status

Hearings/Debate

Bill Sponsor:

Sen. McCay, Daniel

Floor Sponsor:

Rep. Lisonbee, Karianne

UTAH STATE LEGISLATURE

Information

Last Action: 28 Mar 2020, Governor Signed

Last Location: Lieutenant Governor's office for filing

Effective Date: 12 May 2020

Session Law Chapter: 279

Currently Active “18 week ban”

Information

Last Action: 25 Mar 2019, Governor Signed

Last Location: Lieutenant Governor's office for filing

Effective Date: 14 May 2019

Session Law Chapter: 208

Amendments: 2023 HB 467 & 2024 HB 560

- Amended original language for maternal and fetal indications
  - From risk of "*substantial and irreversible*" to ***"substantial"*** impairment of major bodily function
  - From "*uniformly diagnosable and uniformly lethal*" and/or "*severe brain anomalies*"
    to "***likely incompatible with life***"
- Rape is NO LONGER an exception for abortion after 18w
- In cases of lethal fetal anomalies, the physician must provide verbal and written information on hospice as an alternative to abortion
  - Of course, we have always done this as ethical medical practice in the context of unbiased, comprehensive patient counseling
- Abortions may only be performed in a hospital or certified abortion clinic
  - **Including** medication abortion prescribing and the preoperative preparation for surgical abortion after 14 weeks

Current Utah State Law

Index Utah Code
Title 76 Utah Criminal Code
Chapter 7 Offenses Against the Family
Part 3 Abortion
Section 301 Definitions. *(Effective 5/3/2023)*

"Abortion" means:

- The act, by a physician, of using an instrument, or prescribing a drug, with the intent to cause the death of an unborn child of a woman known to be pregnant

"Abortion" does NOT include:

- Removal of a dead unborn child
- Removal of an ectopic pregnancy
- Killing or attempted killing of an unborn child without the consent of the pregnant woman, not associated with a medical procedure
- Contraception, including emergency contraception

Criminal Homicide Caveat

Enrolled Copy **H.B. 462**

CRIMINAL HOMICIDE AND ABORTION REVISIONS

2010 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Carl Wimmer

Senate Sponsor: Margaret Dayton

LONG TITLE

General Description:

This bill amends provisions of the Utah Criminal Code to describe the difference between abortion and criminal homicide of an unborn child and to remove prohibitions against prosecution of a woman for killing an unborn child or committing criminal homicide of an unborn child.

Self managed abortion, regardless of gestational age, is considered criminal homicide in Utah.

Yes, we have seen patients reported to police for suspicion of self-induced abortion

Utah Abortion Law Summary

Index Utah Code
Title 76 Utah Criminal Code
Chapter 7 Offenses Against the Family
Part 3 Abortion
Section 302 Circumstances under which abortion authorized. *(Effective 5/3/2023)*

CURRENTLY ACTIVE

UNDER JUDICIAL REVIEW IN SCOUT

	HB 136 with HB 467 Amendments	SB 174 (Pending)
Any Reason	< 18 weeks	**Total Ban (as of implantation)**
Exceptions	≥ 18 weeks	
Maternal Medical	To avoid: • Death of the woman • "Serious physical risk of substantial impairment of a major bodily function of the woman"	To avoid: • Death of the woman • "Serious physical risk of substantial impairment of a major bodily function of the woman"
Fetal Medical	Two MFM physicians concur that the fetus • has a defect that is "in the physician's reasonable medical judgement incompatible with life"	Two MFM physicians concur that the fetus: • has a defect that is "in the physician's reasonable medical judgement incompatible with life"
Rape/Incest/Age<14y	Must be reported**, not allowed at ≥ 18w**	Must be reported, unsure of GA limits)
Penalties for providers	Second degree felony for the provider	Second degree felony for the provider

Other requirements

Complete State mandated informed consent module (print and video) at least 72 hrs prior to procedure*

72 hr waiting period after consent, before procedure*

Unmarried minors must inform parent/guardian

Court order if unsafe/not possible

Insurance limitations (coverage in maternal exception circumstances but often not for fetal indications)

DOH *Report of Induced Termination of Pregnancy* form for every case regardless of indication

*Module and 72h waiting period requirements can be omitted in certain circumstances

Non-Urgent Cases – Maternal substantial risk

Referral to MFM for consultation is NOT required

- By law, any provider can make this determination for their patient

We encourage and welcome MFM consultation for cases of non-urgent maternal indication to consider pregnancy termination

- **801-321-BABY** for MFM on call for informal consultation or to arrange expedited formal consultation with the patient

A detailed provider note in the medical record (iCentra) is required to document the risk!

- We recommend the following attestation to add to the bottom of your note in iCentra

Maternal Indication Attestation

I counseled the patient about Utah State law regarding pregnancy termination. Termination of pregnancy is legal in cases wherein abortion is necessary to avert the death of the pregnant person or to avert a physical risk of substantial impairment of a major bodily function. Ms. XXX has [condition] and pregnancy presents a significantly increased risk for [death] or [physical risk of substantial impairment of a major bodily function]. As such, her condition meets the legal requirements within the State of Utah for legal pregnancy termination based on maternal risk.

Urgent/Non-emergent Cases– Maternal risk

- Obstetrical complications in the previable period that present risk of substantial harm, even if the risk may not be immediate, warrant consideration of pregnancy termination
  - **Preterm premature rupture of membranes**
    - Risks include infection, sepsis, abruption, DIC, hysterectomy
  - **Previable chorioamnionitis**
    - Risks include sepsis, hysterectomy
  - **Significant second tri bleeding/previable significant or chronic abruption**
    - Risks include massive hemorrhage, DIC, need for transfusion, hysterectomy
  - **Previable preeclampsia**
    - Risks include stroke, cardiac events, death
- DOH *Report of Induced Termination of Pregnancy* required

Emergent Cases– Maternal risk

- We encourage you to continue to ***practice standard of care***
  - Do not hesitate to provide appropriate, emergency gynecologic care for women, including abortion care
- ***Do not delay care to seek consultation if you would have proceeded with uterine evacuation/pregnancy termination prior to these laws***
  - Providers are protected from liability under these laws for emergencies
- Do not delay care for documentation but attest to maternal risk in your subsequent documentation
- DOH *Report of Induced Termination of Pregnancy* form required

Provider Liability Fears

- “If this is a self managed abortion in progress, am I complicit?”
  - The circumstances prior to presentation do not preclude or affect the need to provide standard of care medicine based on the patient’s condition

Cases of Rape or Incest

- Documentation requirements:
  - Before the procedure, the provider "*verifies that the incident… has been reported to law enforcement*"
    - What does "verify" mean?
    - Intermountain uses an attestation form
      - Patient asked for a case ID# as evidence of reporting. This form will be signed by the patient and the provider to (hopefully) meet due diligence in verification.
  - DOH *Report of Induced Termination of Pregnancy*

HB 67: Disposition of Fetal Remains

- Prohibits medical incineration of ***any* fetal remains *at any GA***
  - Includes products of conception (POC) before a visible embryo is identified
    - **EXCEPTION**: if pathology exam and/or genetic studies planned*
- Women experiencing miscarriage <20w *OUTSIDE A HEALTH CARE FACILITY* may bring the tissue/fetal parts to the MD and request such disposition services

*Think targeted regulation of abortion providers.

HB 67: Disposition of Fetal Remains

- Fetal Remains >20w gestation by LMP (regardless of fetal size) require mortuary disposition
  - Patient must independently choose a mortuary, call and coordinate care for burial or cremation

Fetal Death, Abortion, Miscarriage <20w*

- Requires offering patient the following choices for disposition
  - ***Hospital coordinated disposition***
    1. Routine hospital disposition/medical incinceration (***if pathology/genetic testing planned***)
    2. Hospital assisted mortuary disposition (through contractual relationship)
       - If NO pathology/genetics, MUST go to a mortuary at hospital's expense
       - If patient *wants* mortuary disposition specifically, hospital must comply at no cost to patient
  - ***Mortuary coordinated*** - patient selects a specific mortuary for burial or cremation
  - ***Patient coordinated disposition –*** burial transit form to release remains

Collateral Damage: some outpatient surgical centers have stopped allowing MDs to do simple D&Cs for miscarriage due to cost and logistics burden of managing POCs!!!

Guiding Principles

- Continue to practice evidence-based medicine
- Treat ectopic pregnancies (including cesarean scar ectopics) per standard of care
- Circumstances preceding patient presentation (i.e. suspected self managed abortion) do not preclude provision of care or implicate the physician in assisting with abortion

Preventing Unplanned/Undesired Pregnancy

Back to Basics

- Assume your patients may be sexually active and counsel /offer ALL PATIENTS contraception
- Part of chronic disease management and care of patients on teratogenic medications is to address contraception – NEVER assume they "can't get pregnant"….
- Offer referral of medically complex women to Intermountain MFM's PREPPARE (PREgnancy Prevention, Preparation, And Risk Evaluation) Clinic
- Offer emergency contraception Rx to all sexually active young women
  - EC is NOT abortifacient, it prevent ovulation (pills) and/or implantation (IUD)
  - They are **progestin only** and there are no absolute contraindications. Any theoretical risks for a medically complex patient are typically orders of magnitude lower than pregnancy related risks!

Plan B and others

- Prevents pregnancy up to 5 days after unprotected sex – but it works better the sooner you take it.
- You don't need a prescription from a doctor.
- You can get it at most. drugstores or online.

ella

- Prevents pregnancy up to 5 days after unprotected sex.
- More effective than Plan B.
- You need a prescription from a nurse or doctor. You can also get it online.

ParaGard IUD (or Mirena IUD)

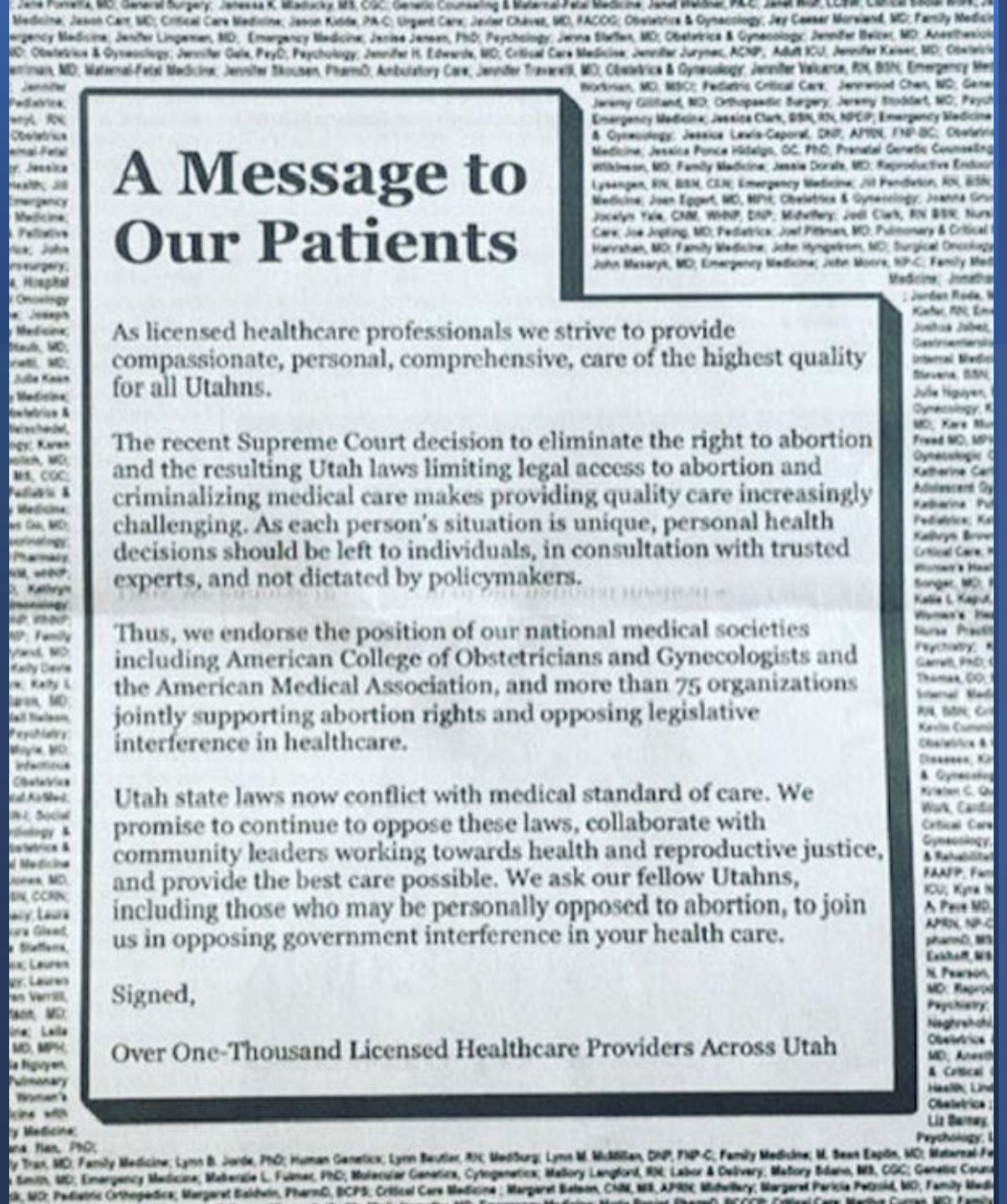
- Prevents pregnancy 99% of the time when you get it within 5 days of unprotected sex.
- A nurse or doctor puts it in your uterus.
- You can keep using it as birth control for up to 12 years.

Good **Better** **Best**

Provider Advocacy Efforts

Ways to get involved

- Physicians as respected community leaders speaking up to advocate for access to essential healthcare
- Twitter follow @acog, @ACOGAction, @mysmfm
- Check on/support trainees
- Contact UMA
- Contact your elected officials and vote in midterms for national and state races



A Message to Our Patients

As licensed healthcare professionals we strive to provide compassionate, personal, comprehensive, care of the highest quality for all Utahns.

The recent Supreme Court decision to eliminate the right to abortion and the resulting Utah laws limiting legal access to abortion and criminalizing medical care makes providing quality care increasingly challenging. As each person's situation is unique, personal health decisions should be left to individuals, in consultation with trusted experts, and not dictated by policymakers.

Thus, we endorse the position of our national medical societies including American College of Obstetricians and Gynecologists and the American Medical Association, and more than 75 organizations jointly supporting abortion rights and opposing legislative interference in healthcare.

Utah state laws now conflict with medical standard of care. We promise to continue to oppose these laws, collaborate with community leaders working towards health and reproductive justice, and provide the best care possible. We ask our fellow Utahns, including those who may be personally opposed to abortion, to join us in opposing government interference in your health care.

Signed,

Over One-Thousand Licensed Healthcare Providers Across Utah

Resources

Local

- Rapid Access Clinic (RAC) for contraception
  - Intermountain Health

    801-507-7070
  - University of Utah

    Care Navigation 801-213-9500
- Planned Parenthood
  - https://www.plannedparenthood.org/planned-parenthood-utah/utah-patients
  - 801-532-1586
  - ***>95% of what they do is NOT abortion care!!***

Unexpected Early Pregnancy Resources

- Refer patient to their primary OBGYN when possible for early evaluation
- University of Utah Early Pregnancy Evaluation Clinic (EPAC)
  - Comprehensive, non-judgmental, NON DIRECTIVE early pregnancy care
    - Pregnancy dating, options counseling, evaluation of bleeding/pain, mgmt and follow up of early pregnancy loss (miscarriage or abortion)

Consultation Resources

Maternal Fetal Medicine

- Intermountain Health 801-507-7400
- University of Utah 801-581-8452

Medically Complex Patient Counseling

- Intermountain PREPPARE Clinic 801-507-7400
  - contraception ***AND*** pregnancy risk counseling
- U of U Complex Contraception Clinic 801-213-4989

Reaching MFM Urgently

801-321-BABY