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Testimony before Pennsylvania Senate

Public Health & Welfare Committee

regarding

Regulations of Abortion Clinics

April 13, 2011

Thank you for inviting me to testify today. I come before this committee to present my testimony regarding the regulation of abortion clinics from the perspective of a board-certified obstetrician/gynecologist whose primary concern is the safety and well-being of all patients. My comments are limited to my personal experience and opinions in regard to surgical prudence within my specialty.

I practice general obstetrics and gynecology in a suburb of Philadelphia, caring for both low risk and high risk pregnant women as well as non-pregnant women of all ages. I perform both major and minor surgical procedures in a surgicenter, local ambulatory surgical facility (ASF), and a main operating room in the hospital. I also perform a very limited number of minor surgical procedures in my office.

The most common procedure performed in abortion clinics throughout the country is a Dilatation and Evacuation, known as a D&E. During this procedure, the pregnancy is evacuated from the uterus. In the first trimester, up to 13 weeks gestational age, this is done with a suction device, while in many second trimester abortions, instruments are used to grasp the tissue and remove it. In early pregnancies, the rate of complication is small, but as a gestation reaches the end of the first and into the second trimester, these complications increase.

The D&E is a procedure I perform frequently. I do not perform abortions; however miscarriages are not uncommon and can be managed with a D&E. Since most miscarriages occur early in the first trimester, I frequently schedule these in the office. For later gestation miscarriages, those after nine weeks, the surgicenter is the more prudent location. D&Es in later pregnancies can be complicated by hemorrhage and uterine injury. Additionally, I.V. sedation or general anesthesia are often used after 10 to 12 weeks. The surgicenter provides the necessary access to emergency modalities and mechanisms for transfer to the hospital if appropriate.

The decision of whether to bring the patient to the office or the surgicenter is based on the length and complexity of the surgery, the type of anesthesia needed and the type and length of recovery to follow. Later gestation D&Es, especially those requiring more that local anesthesia, should be performed in an Ambulatory Surgical Facility.

With my type of medical practice, minor procedures performed in a physicians' office where surgeries are not regularly scheduled, I am not mandated to comply with the regulations applicable to an ASF. However, because of my concern for patient safety, I applied common sense and the concept of "best practices" into the design of my suite where no specific methodology was mandated. Design specifications of room size, room and building access and fire code requirements meet requirements for an ASF. Procedural compliance, such as emergency equipment, transfer agreements and staff privileges to a local hospital are maintained. All of the above establishes an environment to manage each patient in the safest way possible.

And here in lies the most important function of the state. These procedures can be complicated by problems. The state has regulatory standards in the statute for Ambulatory Surgical Facilities that would create a safe environment for women who are having D&Es. These standards should be extended to every clinic functioning like an ASF. It creates a dangerous double standard to decline to apply the same regulation to abortion clinics that already apply to other Ambulatory Surgical Facilities. With these regulations applied to abortion clinics, we could all say we are doing everything we can to ensure safety to women seeking abortion.

Bills requiring inspections for abortion clinics are a step in the right direction. Regulating minimal standards for clinics is better. The best practice, however, would be to simply apply the existing ASF regulations to abortion clinics. Thank you.