HB1075 - Health - Informed Consent (Woman's Rights to Know Act)
Presented to the Hon. Shane Pendergrass and
Members of the House Health and Government Operations Committee
March 8, 2019 at 1:00 p.m.

POSITION: OPPOSE

NARAL Pro-Choice Maryland **urges the House Health and Government Operations Committee an unfavorable report on HB1075,** Health - Informed Consent (Woman's Rights to Know Act), sponsored by Delegate April Rose.

Our organization is an advocate for reproductive health, rights, and justice. As part of our efforts to protect reproductive freedom for all Marylanders, we work to ensure every child-bearing individual has the right to decide if, when, and how to form one's family, as well as to parent in good health, in safety, and with dignity. We honor pregnancy in all its complexity. As advocates for reproductive rights, we are deeply concerned about HB1075.

HB1075 would mandate that an abortion cannot be induced or performed on a patient seeking abortion care until the physician has done the following: obtained consent from the patient to perform an abortion, shared the medical risks of performing an abortion, shared the medical assistance or legal liabilities for carrying a fetus to term, performed an ultrasound on the pregnant patient, describe in great detail the characteristics of the fetus(es) as well as determining whether or not the fetus has a detectable heartbeat. Additionally, this legislation establishes a burdensome 24 hour waiting period on patients, defines "abortion," using loaded language, as a practice used to "intentionally kill the unborn child of a woman known to be pregnant." The establishment of information website is also included; yet, this website includes no information on abortion care services provided within the state, but does provide detailed information on alternatives to abortion as well as public and private agencies or services to assist individuals through pregnancy and childbirth. If these requirements and were not enough, HB1075 criminalizes abortion care by stating that violations of this legislation result in a felony and/or misdemeanor.

Abortion care is legal, common, and one of the safest forms of medical care for women in the United States. Less than 0.05% of women obtaining abortion care experience a complication.[1] One in four women will have an abortion at some point in her life.[2] With many individuals utilizing services and facilities within the state, it is essential to uphold the rights these patients have to make the medical decisions that best fit their needs. Yet, this legislation creates arbitrary limits to this decision-making process.

Provisions mandating "informed consent" and the 24-hour waiting period introduce unnecessary hurdles to accessing abortion care while intruding on the relationship and trust developed between patients and medical care providers. Waiting additional days for abortion care burdens individuals, particularly single parents and low-income individuals, with making multiple trips to clinics. As a result, patients may be forced to miss days

[1] Weitz TA et al.,(2013) Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver, *American Journal of Public Health*, 103(3):454–461.
[2] Jones, R. K., & Jerman, J. (2017). Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014. *American Journal of Public Health*, 107(12), 1904-1909. http://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042

at work and allocate extra funds to make travel arrangements or childcare. This ultimately leads many to have abortions later into their pregnancies (increasing the costs) or seek abortions elsewhere[3,4]. Extensive "informed consent" protocols such as those outlined in this legislation are also deterrents for patients seeking abortion care as well as a waste of state resources. Like other nonemergency medical procedures, consent and information about the procedures, risks, benefits, and alternatives are already discussed with patients prior to the procedure.[5] HB1075 only seeks to spread misinformation regarding abortion care. It states, in §20-217, that physicians discuss the "medical risks associated with the procedure…including, when appropriate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility." These "risk" factors are common myths centered on abortion that have little to no reliable data to support such claims. Researchers at the National Cancer Institute, the American Cancer Society, the American College of Obstetricians and Gynecologists, the World Health Organization, and major universities say that the most reliable studies show no increased risk of breast cancer in individuals who have had an abortion. [6,7,8] Little to no evidence suggests that abortions performed under safe medical environments cause infertility or danger to future pregnancies.[9, 10]

Legislation like this is used as an effort to reduce or end abortion care access. Rather than eliminating abortion, it can effectively intensify the challenges and oppression faced by those struggling financially, experiencing domestic violence, or facing housing instability while taking care of themselves and any children tthey may have.[11 12] In the end, abortion restrictions such as these are ineffective and do not deter women from seeking abortion care. In fact, studies conducted in states with similar policies or regulations (i.e. Wisconsin's mandatory ultrasound legislation) have determined "the majority of women were certain of their abortion decision and the law did not change their decision."[13] HB1075 sends a message that the state does not trust the reproductive decision-making of women and girls. Like all other forms of healthcare, the decision to receive abortion care should made in the privacy and safety of a doctor's office, not by members of the Maryland General Assembly. Legislation like HB1075 is not about protecting women's health and wellbeing. As seen in many other states, it is about advancing a political and ideological agenda that pushes any and all individuals seeking to exercise the right to abortion care to the shadows. We support and advocate for the ability for individuals to make sexual and reproductive healthcare decisions that best fit the needs of their families and themselves. This bill attempts to restrict these rights and freedoms which were solidified under U.S. Supreme Court 1973 *Roe v Wade* ruling and codified in the State of Maryland under the 1992 ballot referendum Question 6. **Therefore, NARAL Pro-Choice Maryland urges an unfavorable report on HB1075.** Thank you for your time and consideration.

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[3] Boonstra H.D., Nash E., (2014) A surge of state abortion restrictions puts providers—and the women they serve—in the crosshairs, *Guttmacher Policy Review*, 17(1):9–15, https://www.guttmacher.org/gpr/2014/03/surge-state-abortion-restrictions-puts-providers-and-women-they-serve-crosshairs.

[4] Karasek, D. et al. (2016) Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-visit 24-hour Mandatory Waiting Period Law. *Women's Health Issues*. 26(1). 60-66.

[5] Gold, R., Nash, E. (November 8, 2007). *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*. Guttmacher Institute. 10(4). https://www.guttmacher.org/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent

[6] American Cancer Society. (2013). *Is Abortion Linked to Breast Cancer?* http://www.cancer.org/cancer/breastcancer/moreinformation/is-abortion-linked-to-breast-cancer.

[7] American College of Obstetricians and Gynecologists. (2009). *Committee Opinion: Induced Abortion and Breast Cancer Risk*. Washington DC: ACOG Committee Opinion No. 434

[8] Planned Parenthood Federation of America. (2013) *Myths About Abortion and Breast Cancer*. https://www.plannedparenthood.org/files/9613/9611/5578/Myths_About_Abortion_and_Breast_Cancer.pdf

[9] Government of Southern Australia. (2012) *SA Health: Myths and facts about abortion.*

[10] Grimes DA (2006) Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991to 1999. *American Journal of Obstetrics and Gynecology*,194, 92-94.

[11] Finer LB and Zolna MR, (2016) Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 374(9):843–852, http://www.nejm.org/doi/full/10.1056/NEJMsa1506575.

[12] Jones RK, Darroch JE and Henshaw SK, (2002) Patterns in the socioeconomic characteristics of women obtaining abortions in 2000–2001, *Perspectives on Sexual and Reproductive Health*, 34(5): 226-235

[13] Upadhyay, U. D et al.. (2017). Evaluating the impact of a mandatory pre-abortion ultrasound viewing law: A mixed methods study. *PloS one*, *12*(7), e0178871. doi:10.1371/journal.pone.0178871