ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

District XI
1001 Congress, Suite 340
Austin, TX 78701
512.473.2264 (o)
512.473.2267 (f)
info@tx.acog.org

Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9347

Sent via email to WRTK@dshs.state.tx.us

March 14, 2013

RE: SOLICITATION OF STAKEHOLDER INPUT, AND NOTICE OF ANNUAL REVIEW PROCESS FOR "A Woman's Right to Know Information Material" BOOKLET

To Whom It May Concern:

On behalf of the Texas District of the American Congress of Obstetricians and Gynecologists, I write with suggestions for proposed changes to the "Woman's Right to Know Information Packet". Our organization has significant concerns with some of the material and how it is presented. We are thankful for the opportunity to offer input on revision.

We strongly urge you to ensure an open process for updating the WRTK information. This material is viewed by thousands of women every year. We believe the revision process must be transparent and open for all interested parties, without the undue influence of those who want to limit the medical decisions of women seeking a legal procedure. In the absence of an open process, we encourage DSHS to share with ACOG and others all the primary sources used for the revisions.

When physicians, including ob/gyns, provide counseling and information to our patients, we endeavor to be "non-directive" in our counseling. The purpose of the counseling is to provide education so that a patient can understand her condition and the risks, benefits, and alternatives of care. The "Woman's Right to Know" materials does not fulfill these aims. The information in the brochure is biased and the risks presented are primarily the risks of abortion (pp. 9-17). The section that outlines the risks to a woman's life from carrying a pregnancy (the alternative) is much more limited (pp.17-19). Any medical procedure comes with risks, yet this is the one procedure where the state mandates the development and dissemination of a particular scripted document.

Specific concerns with the wording in the "Woman's Right to Know" packet include:

- The use of "unborn child" instead of the clinical standard term "fetus" is not scientific and sends an ideological message. We do not find the term "unborn child" used in other DSHS materials. The proper term for the second to eighth week is "embryo." The embryo becomes a fetus at 10 weeks. The term "fetus" is the correct term to use until birth.

- On page 5: Fetal pain: there is a reference to "some experts have concluded that the unborn child is probably able to feel pain" in the description of the fetus at 20 weeks gestational age. There is no credible, current medical evidence that fetuses are sufficiently neurologically developed to perceive pain before 24 weeks; indeed, there is significant evidence to the contrary. [Lee; RCOG] The language is unnecessarily inflammatory, putting forth an ideological rather than scientific perspective and should be removed.

- On page 10: The risks of abortion are less than the risks of carrying a pregnancy to term and delivering. This should be conveyed to women considering the risks, benefits, and alternatives.

- On page 12: The information on dilation and evacuation is unnecessarily graphic in its description. The reference to "scraping" the uterus is unnecessarily charged. We suggest the following description: "The contents of the uterus are removed by a suction device that is inserted into the uterus. It also may be called vacuum curettage."

- On page 14: The information on dilation and extraction is unnecessarily graphic in its description of a procedure that is not performed or needed for termination up to 23 weeks. Dilation and evacuation is the procedure normally performed for emptying uterine content greater than 13 weeks and less than 23 weeks.

- On page 15: "Former Surgeon General C. Everett Koop and the Physician's Ad Hoc Coalition for Truth stated in 1996 that this type of procedure … is never medically necessary to protect a mother's health or her future fertility. On the contrary, this procedure can pose a significant threat to both.'" This quote should be removed. Ending a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Dilation and extraction is one of the methods available in some of these situations and may be the best or most appropriate procedure in a particular circumstance. Only the doctor, in consultation with the patient based upon the women's particular circumstances can make this decision. With this procedure, it is more likely that a fetal autopsy can be performed and/or tissue or genetic samples can be obtained.

- On page 16: The information about emotional responses is poorly presented and not based on scientific evidence. "Some women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks, and substance abuse. These emotions may appear immediately after an abortion, or gradually over a longer period of time." These are also emotional responses that can occur in women after a miscarriage, and even after a healthy delivery. This information should be removed.

- On page 17: The statement pointing to an "increased risk of developing breast cancer after an induced abortion…" is not consistent with current and relevant science. Both the National Cancer Institute and the American College of Obstetricians and Gynecologists (ACOG) conclude in position statements that induced abortions have not been shown to increase a women's chance of developing breast cancer. [ACOG; NCI]

- On page 17: References to adverse pregnancy outcomes. Many studies have found little to no negative effect of induced abortion on future pregnancy outcomes and this information should be included in the brochure. [Raatikainen, Parazzini, Virk, Kara]

TX-ACOG is encouraged that the Department has taken a step forward by reviewing the current "Woman's Right to Know" materials with the intent to make revisions. Thank you for the opportunity to provide our input. ACOG stands firm that information we are compelled to provide to our patients on behalf of the State of Texas must be scientifically based and medically accurate.

ACOG is happy to be a resource to the Department as it goes through this review process. Please do not hesitate to contact me.

Sincerely,

Lisa M. Hollier, MD, MPH, FACOG
Chair, Texas District American Congress of Obstetricians and Gynecologists

Lee et al., Fetal Pain: A Systematic Multidisciplinary Review of the Evidence, 294 JAMA 947 (2005).

Royal College of Obstetricians and Gynaecologists, Fetal Awareness: Review of Research and Recommendations for Practice (Mar. 2010)

National Cancer Institute, "Abortion, Miscarriage, and Breast Cancer Risk Fact Sheet"
http://www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage

American College of Obstetricians and Gynecologists Committee Opinion No. 434, "Induced Abortion and Breast Cancer Risk" (2009).
http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Gynecologic%20Practice/co434.pdf?dmc=1&ts=20120304T0707314206

Raatikainen K, Heiskanen N, Heinonen S. Induced abortion: not an independent risk factor for pregnancy outcome, but a challenge for health counselling. Annals of Epidemiology 2006;16(8):587-92.

Parazzini F, Ricci E, Chiaffarino F, Cipriani S, Tozzi L, Fedele L. Does induced abortion increase the risk of preterm birth? Results from a case-control study. Gynecol Obstet Invest. 2010;69(1):40-5. Epub 2009 Nov 1.

Virk J, Zhang J, Olsen J. Medical Abortion and the Risk of Subsequent Adverse Pregnancy Outcomes. N Engl J Med 2007; 357:648-653Aug. 16, 2007.

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