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PRIORITIZING ABORTION ACCESS OVER ABORTION SAFETY IN PENNSYLVANIA

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This conference was prompted by the prosecution of Dr. Kermit Gosnell, who ran an abortion clinic in Philadelphia, Pennsylvania. Dr. Gosnell was convicted in May of 2013 of charges arising from the killing of viable infants born in his clinic, the negligent death of an adult patient, and the systematic disregard of regulations governing the performance of abortions in Pennsylvania.¹ One question proposed for our consideration is whether Dr. Gosnell is an “outlier,” a description offered by the National Abortion Federation following Gosnell’s indictment.²

Presumably, one might want to know whether Gosnell was typical of abortion providers because it could shed light on contested questions concerning the justification for new abortion regulations. If Gosnell is uncharacteristic of abortion providers, one might argue, then his prosecution does not suggest the need for additional oversight. In this short essay, on the other hand, I argue that whether or not we can currently identify more providers like Gosnell, and there may well be some,³ his dangerous medical practice was a foreseeable consequence of the unsupervised market for abortion services in which he operated.

Dr. Gosnell was able to routinely violate Pennsylvania law because Pennsylvania health officials decided access to abortion should be prioritized over monitoring compliance with regulations designed to ensure

1. Joseph A. Slobodzian, *Gosnell Guilty of Three Murder Counts*, PHILADELPHIA INQUIRER, May 15, 2013, available at http://articles.philly.com/2013-05-15/news/39258185_1_verdict-jury-gosnell-case; Sarah Hoye & Sunny Hostin, *Doctor Found Guilty of First-Degree Murder in Philadelphia Abortion Case*, CNN, May 14, 2013, 10:26AM, <http://www.cnn.com/2013/05/13/justice/pennsylvania-abortion-doctor-trial/>.

2. Press Release, National Abortion Federation, Open Letter to Patients from NAF President Vicki Saporta: Despite Recent Headlines, Quality Abortion Care is the Norm (Jan. 21, 2011), available at <http://www.prochoice.org/news/releases/20110121.html>.

3. See *Kermit Gosnell is Not an Outlier*, SUSAN B. ANTHONY LIST, <http://www.sba-list.org/negligence> (July 24, 2013) (last updated Sep. 11, 2013).

the safety of abortion procedures. Prioritizing access over safety is an ironic development in the history of abortion rights activism. A key argument for recognizing a constitutional right to abortion was that legalization would promote safety by ensuring that abortions were performed by licensed medical professionals subject to oversight by the state,⁴ a premise undermined by the laissez-faire practices of Pennsylvania officials.

Any concern that oversight of abortion clinics might unnecessarily restrict access can be adequately addressed through the familiar principle of general applicability. There should be no question that states can properly enforce against abortion clinics regulations applied generally to other medical facilities presenting comparable risks to health.

I

Numerous scandals in recent decades have been attributed to a combination of greed and lax regulation. A desire for wealth, an opportunity for profit that entails risks to others, and inattentive government officials can together produce significant social harm. Commentators have identified these conditions as root causes of the savings and loan crisis of the 1980s,⁵ the Enron scandal,⁶ and the financial crisis of 2008,⁷ to name a few. The investigation and trial of Dr. Gosnell suggest that the same elements of private avarice and minimal government oversight helped produce the dangerous clinic that Gosnell operated in Philadelphia.

4. See, e.g., Brief for Planned Parenthood Federation of America, Inc. and American Association of Planned Parenthood Physicians as Amici Curiae supporting Respondents, in *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973) (Nos. 70-18, 70-40) (“Planned Parenthood believes that since abortion is a medical procedure, it should be governed by the same rules as apply to other medical procedures in general when performed by properly qualified physicians with reasonable medical safeguards.”).

5. Gene R. Nichol, Jr., *Liberalism, Public Virtue and JFK*, 30 WM. & MARY L. REV. 893, 898 (1989) (“We face a massive crisis in the savings and loan industry—born of unbridled greed and creedal belief in deregulation.”).

6. Timothy P. Duane, *Regulation’s Rationale: Learning from the California Energy Crisis*, 19 YALE J. ON REG. 471, 471 (2002) (“[B]oth the California energy crisis and Enron’s collapse were caused by legislative and administrative failures to design regulatory institutions that adequately constrained opportunistic behavior.”).

7. Janice Kay McClendon, *The Perfect Storm: How Mortgage-Backed Securities, Federal Deregulation, and Corporate Greed Provide a Wake-Up Call for Reforming Executive Compensation*, 12 U. PA. J. BUS. L. 131 (2009); FINANCIAL CRISIS INQUIRY COMMISSION, FINAL REPORT OF THE NATIONAL COMMISSION ON THE CAUSES OF THE FINANCIAL AND ECONOMIC CRISIS IN THE UNITED STATES, at xv–xxv (2011), available at <http://www.gpo.gov/fdsys/pkg/GPO-FCIC/pdf/GPO-FCIC.pdf> (conclusions regarding causes of the financial crisis, focusing on excessive risks taken by profit motivated enterprises and failure of government regulators to act).

The grand jury that recommended charges against Gosnell prepared a lengthy report on his abortion clinic, concluding that the doctor “ran a criminal enterprise, motivated by greed.”⁸ A number of features of Gosnell’s abortion practice seemed designed to maximize his profit margin, often in ways that increased risks to patients. On the revenue side, Dr. Gosnell probably brought in tens of millions of dollars over the years through the performance of abortions. A 2005 price list shows prices ranging from 330 dollars for aborting a fetus at six to twelve weeks up to 1,625 dollars if the fetus was at twenty-three to twenty-four weeks, the legal limit for elective abortions under Pennsylvania statutes.⁹ However, Gosnell’s competitive advantage in the market for abortion services consisted of his willingness to perform abortions other clinics would not, including abortions illegal under the laws of Pennsylvania and surrounding states:

Gosnell was known as a doctor who would perform abortions at any stage, without regard for legal limits. His patients came from several states, including Delaware, Maryland, Virginia, and North Carolina, as well as from Pennsylvania cities outside the Philadelphia area, such as Allentown. He also had many late-term Philadelphia patients because most other local clinics would not perform procedures past 20 weeks.¹⁰

Employees testified that Gosnell sometimes charged 2,500–3,000 dollars for late-term abortions.¹¹

Based on conservative assumptions, the grand jury estimated that Gosnell would have taken in 1.8 million dollars a year performing abortions three nights a week, but “[i]n light of the testimony we heard that Gosnell performed the really late third-trimester abortions on Sundays, his take was likely much higher.”¹² The grand jury’s estimate did not include revenue from the extra amounts patients were invited to pay if they wanted higher-than-normal levels of sedation.¹³ Further, Dr. Gosnell was not particularly scrupulous about where the money came from. The grand jury found

8. In re Cnty. Investigating Grand Jury XXIII, Misc. No. 0009901-2008, 23 (Pa. Ct. C.P. Jan. 14, 2011), available at www.phila.gov/districtattorney/PDFs/GrandJuryWomensMedical.pdf.

9. *Id.* app. C. (showing that higher prices were charged if the patient was insured).

10. *Id.* at 27. See also *id.* at 3 (“Most doctors won’t perform late second-trimester abortions, from approximately the 20th week of pregnancy, because of the risks involved. And late-term abortions after the 24th week of pregnancy are flatly illegal. But for Dr. Gosnell, they were an opportunity. The bigger the baby, the more he charged.”).

11. *Id.* at 81, 88.

12. *Id.* at 88.

13. *Id.* app. C.

evidence that Gosnell defrauded an insurance company by convincing another doctor to bill for services performed by Gosnell's clinic, allowed a patient to pay for an abortion using her cousin's insurance card, and fraudulently tapped a Delaware abortion fund by falsely claiming that particular patients were from Delaware.¹⁴ One employee testified that when Dr. Gosnell performed second-trimester abortions before the 24-week limit, he would sometimes manipulate ultrasounds to make the fetus look bigger so he could charge more.¹⁵

On the cost side of the ledger, Dr. Gosnell took a number of steps to keep the expense of performing abortions low. For instance, he employed untrained and unqualified personnel who worked for less money:

- Gosnell “deliberately hired unqualified staff because he could pay them low wages, often in cash. Most of Gosnell’s employees who worked with patients had little or no remotely relevant training or education. Nor did they have any certifications or licenses to treat patients. Yet they did so regularly, and without supervision—in violation of Pennsylvania’s medical practice standards and the law.”¹⁶
- Untrained and unlicensed staff (including a 16-year-old high school student) administered drugs to patients without individualized medical evaluation and then monitored the medicated patients.¹⁷
- One of Gosnell’s patients, Karnamaya Mongar, died from medications administered by unlicensed and untrained staff.¹⁸ Dr. Gosnell had been told a year earlier that one of these staff members “did not know what she was doing and that she routinely overmedicated patients.”¹⁹
- Gosnell employed two individuals who had medical training but had not obtained medical licenses. They were referred to and acted like “doctors” whether or not Gosnell was present.²⁰

Dr. Gosnell also saved money on equipment and supplies:

- One of the drugs Gosnell’s staff routinely used to sedate

14. In re Cnty. Investigating Grand Jury, *supra* note 8, at 89, 177.

15. *Id.* at 81.

16. *Id.* at 32.

17. *Id.* at 51.

18. *Id.* at 117–35.

19. *Id.* at 119.

20. In re Cnty. Investigating Grand Jury, *supra* note 8, at 39–44.

patients had been out of favor for 10–15 years because safer alternatives had been developed, but Gosnell preferred the older drug because it was cheaper.²¹

- Apart from one non-functioning defibrillator, Gosnell’s clinic did not have the equipment and drugs required under Pennsylvania law for resuscitation of patients.²²
- Gosnell’s clinic had one old EKG machine for monitoring patient heart rate and pulse, but it had not worked for at least six years.²³ Even the death of a patient did not lead Gosnell to purchase the required equipment.²⁴
- The clinic had only one blood pressure cuff.²⁵
- “Several workers testified that Gosnell insisted on reusing plastic curettes, the tool used to remove tissue from the uterus, even though these were made for single use only.”²⁶

These cost-saving measures presumably resulted in a relatively high profit margin on the abortions performed by Gosnell and his unlicensed staff. Moreover, abortion was only one of Gosnell’s moneymaking endeavors. Gosnell’s illegal abortion practice came to light when he was being investigated for running a “prescription mill,” allowing customers to obtain controlled substances like the narcotic Oxycontin based on prescriptions pre-signed by the doctor.²⁷

II

Assuming the grand jury was correct that Gosnell was motivated by financial considerations, it should have been possible to deter some of the conduct harmful to his patients and the illegal abortions performed in his clinic. Assuming sanctions were significant enough and the perceived risk of imposition high enough, Gosnell might have adjusted course to stay on the right side of Pennsylvania law.²⁸ As it played out, however,

21. *Id.* at 7, 124–25.

22. *Id.* at 75–76.

23. *Id.* at 76.

24. *Id.* at 92–93.

25. *Id.* at 76.

26. In re Cnty. Investigating Grand Jury, *supra* note 8, at 49.

27. *Id.* at 2, 44, 141. *See id.* at 23, 88 (Gosnell was allegedly among the three top Oxycontin prescribers in Pennsylvania).

28. David A. Dana, *Rethinking the Puzzle of Escalating Penalties for Repeat Offenders*, 100 YALE L.J. 733, 740 (2001) (“The conventional economic model of deterrence assumes that individuals (and by extension, the entities they compose) have preferences and tastes independent

Pennsylvania officials gave Gosnell plenty of reason to believe that noncompliance with the law would be overlooked. Gosnell was the only doctor at his clinic at the time of a Department of Health (“DOH”) inspection in 1989.²⁹ That inspection noted that, among other deficiencies, Gosnell had no nurses on his staff, even though state law required patients recovering from surgery to be monitored by nurses.³⁰ Gosnell was nevertheless allowed to continue performing abortions. He was inspected again in 1992 and 1993, and the failure to hire nursing staff had still not been corrected.³¹ The 1993 inspection noted the problem, along with other violations, but DOH officials later inaccurately recorded that the deficiencies had been addressed.³² Thus, four years after the DOH noted Gosnell’s failure to hire nurses to monitor patients recovering from surgery, Gosnell was allowed to continue performing abortions even though he was still not in compliance.³³

In 1993, with the election of a pro-choice governor, the Pennsylvania Department of Health abruptly decided to stop performing regular inspections of abortion clinics.³⁴ Under the revised policy, the DOH did not visit Gosnell’s clinic for a period of over sixteen years.³⁵ In theory, the new policy called for inspection of abortion clinics in response to complaints.³⁶ In fact, the DOH did not visit Gosnell’s clinic: when attorneys’ offices contacted them in connection with malpractice claims, when a pediatrician complained that multiple teenage patients had been infected at Gosnell’s clinic with a sexually transmitted parasite, when a twenty-two-year-old patient died in 2002 due to complications from an abortion Gosnell performed, when a medical examiner reported that Gosnell had performed an abortion on a fetus at thirty-weeks’ gestation (well beyond the Pennsylvania limit of twenty-four weeks), or even when a second patient

of the content of legal prohibitions. Individuals will comply with a legal prohibition if the expected penalty—the expected cost to them of the violation—will exceed the gain they expect to derive from the violation. Two variables are relevant in assessing expected penalties: the magnitude of the formal sanction if the violation is detected (*p*) and the probability of detection (*pdet*), as perceived by the prospective violator.”); David C. Gray, *A Spectacular Non Sequitur: The Supreme Court’s Contemporary Fourth Amendment Exclusionary Rule Jurisprudence*, 50 AM. CRIM. L. REV. 1, 46 (2013) (“The basic deterrence formula describes a ratio between two functions: severity of punishment multiplied by risk of imposition, which is itself a function of risk of detection, certainty of conviction, and swiftness of process, compared to the value of reward multiplied by probability of success.”).

29. In re Cnty. Investigating Grand Jury, *supra* note 8, at 139–40.

30. *Id.* at 140.

31. *Id.* at 140–42.

32. *Id.* at 140–42.

33. *Id.* at 142.

34. *Id.* at 9, 147.

35. In re Cnty. Investigating Grand Jury, *supra* note 8, at 142–43.

36. *Id.* at 143.

died in 2009 from an abortion at Gosnell’s clinic.³⁷ The DOH did not return to Gosnell’s clinic until they were asked to accompany law enforcement officials investigating prescription drug abuses, and even then DOH officials grumbled about being “used” by law enforcement and “badgered” by the District Attorney to shut down Gosnell’s facility.³⁸

It was not just the Pennsylvania Department of Health, but also the state Board of Medicine, that overlooked or downplayed complaints about Gosnell’s clinic. In 2001, before any of Gosnell’s patients had died, one of Gosnell’s former employees informed the Board of Medicine of numerous problems at the clinic, including the use of unlicensed personnel to administer anesthesia, the filthy and unsterile conditions at the clinic, and the absence of licensed nurses to monitor patient recovery.³⁹ A Board employee conducted a cursory investigation that did not involve a visit to the clinic or interviews of any of the unlicensed clinic employees, though he did talk to Gosnell and another doctor who had performed abortions there.⁴⁰ The Board closed its investigation into the former employee’s allegations on the same day that it decided not to investigate the death of twenty-two-year-old patient Semika Shaw following an abortion by Gosnell.⁴¹ Nor did later complaints of malpractice or lack of insurance prompt the Board to take action with respect to Gosnell’s clinic.⁴²

III

The 1993 Department of Health decision to stop performing regular inspections of abortion clinics was motivated by pro-choice political considerations, specifically, the fear that such inspections could result in “putting a barrier up to women’ seeking abortions.”⁴³ Consideration was given to reinstating the inspections in 1999, but the Department concluded that “if they did routine inspections, that they may find a lot of these facilities didn’t meet [the standards for getting patients out by stretcher or wheelchair in an emergency], and then there would be less abortion

37. Randy Beck, *Overcoming Barriers to the Protection of Viable Fetuses*, 71 WASH. & LEE L. REV. __ (forthcoming 2014).

38. In re Cnty. Investigating Grand Jury, *supra* note 8, at 152.

39. *Id.* at 176–77.

40. *Id.* at 177–78.

41. *Id.* at 176.

42. Beck, *supra* note 37. The Philadelphia Department of Health also failed to act on reports about the unsanitary conditions at Gosnell’s clinic, filed by one of its employees monitoring the clinic’s participation in a city vaccine program. *See id.* (manuscript at __).

43. In re Cnty. Investigating Grand Jury, *supra* note 8 at 9, 147.

facilities, less access to women to have an abortion.”⁴⁴ The revised DOH policy effectively prioritized access to abortion over the safety of abortion facilities and compliance with the requirements of state law.

The decision of Pennsylvania health officials to prioritize abortion access over abortion safety is ironic in light of the history of pro-choice activism in this country. Pro-choice historical narratives often emphasize that many women had access to abortions before the Supreme Court recognized a constitutional right to abortion in *Roe v. Wade*, but that the procedures were frequently performed in unsafe conditions.⁴⁵ The brief Planned Parenthood submitted in *Roe* estimated that about one million illegal abortions were performed each year, but highlighted the high risk of death, infection, sterility or other complications that accompanied these illegal abortions, often performed by non-physicians.⁴⁶ The *Roe* Court took this argument to heart, noting that “[t]he prevalence of high mortality rates at illegal ‘abortion mills’” supported a state interest in regulating abortion clinics, particularly later in pregnancy:

The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. . . . The prevalence of high mortality rates at illegal “abortion mills” strengthens, rather than

44. *Id.* at 147. Sadly, Gosnell’s failure to comply with the requirements concerning emergency evacuation of patients contributed to the death of a patient named Karnamaya Mongar. *Id.* at 77 (“Another violation of Pennsylvania law proved significant the night Karnamaya Mongar died: Clinics must have doors, elevators, and other passages adequate to allow stretcher-borne patients to be carried to a street-level exit. Gosnell’s clinic, with its narrow, twisted passageways, could not accommodate a stretcher at all. And his emergency street-level access was bolted with no accessible key. Any chance Mongar had of being revived was hampered by the time wasted looking for keys to the door.”).

45. *Roe*, 410 U.S. at 150 (“The prevalence of high mortality rates at illegal ‘abortion mills’ strengthens . . . the State’s interest in regulating the conditions under which abortions are performed.”).

46. *Supra* note 4. According to this brief:

It has been estimated that about one million illegal abortions are performed each year. While some of these illegal abortions are performed by physicians, the often tragic consequences of clandestine abortions, many of them self-induced, or performed by non-physicians, have created a serious state and national health problem. The most serious consequence of bungled illegal abortion is, of course, the death of the pregnant woman. It is estimated that abortion-related mortality is under-reported by as much as fifty percent. Earlier estimates were that between 5,000 and 10,000 women died each year because of bungled illegal abortions. However, the number of deaths from criminal abortion has decreased in recent years as a result of several factors including the advent of antibiotics, so that a figure of 500 to 1,000 such deaths per year is probably a more reliable national estimate. Despite the fact that the death rate from illegal abortion has decreased, the adverse side effects of such abortions, including severe infection, permanent sterility or other serious complications are still epidemic.

weakens, the State's interest in regulating the conditions under which abortions are performed. Moreover, the risk to the woman increases as her pregnancy continues. Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy.⁴⁷

Planned Parenthood takes the position that promoting the safety of abortion procedures is the key benefit of the *Roe* decision: "The most important benefit [of *Roe*] was the end of an era that supported the proliferation of 'back alley butchers' who were motivated by money alone and performed unsafe, medically incompetent abortions that left many women dead or injured."⁴⁸

Planned Parenthood may be correct that legal abortions tend to be safer than the illegal abortions performed in the years before *Roe*. But if so, this is in large part a function of government oversight of the persons and facilities offering abortion services. In Pennsylvania, where government officials adopted a hands-off policy regarding abortion clinics, the result was Dr. Gosnell's clinic, where two patients lost their lives, countless others were subjected to high risk medical procedures, and hundreds of viable fetuses and newborn infants were killed in violation of Pennsylvania law.

IV

The Gosnell grand jury recommended that abortion clinics in Pennsylvania be inspected and regulated in the same manner as other facilities offering comparable surgical procedures: "We recommend that the Pennsylvania Department of Health plug the hole it has created for abortion clinics. They should be explicitly regulated as ambulatory surgical facilities, so that they are inspected annually and held to the same standards as all other outpatient procedure centers."⁴⁹ This idea of subjecting abortion clinics to generally applicable regulations was endorsed by the Supreme Court in *Akron v. Akron Center for Reproductive Health*, where the Court acknowledged that "[a] State necessarily must have latitude in adopting

47. *Roe*, 410 U.S. at 150.

48. *Medical and Social Health Benefits Since Abortion was Made Legal in the U.S.*, PLANNED PARENTHOOD (Jan. 2013), http://www.plannedparenthood.org/files/PPFA/Medical_Social_Benefits_Abortion.pdf.

49. In re Cnty. Investigating Grand Jury, *supra* note 8, at 16.

regulations of general applicability in this sensitive area.”⁵⁰

General applicability is a test that has often been employed in contexts where courts are concerned with preventing excessive regulation targeted at particular persons or activities. An early example can be found in *McCulloch v. Maryland*, where the Court struck down a Maryland tax that targeted the operations of a federally-chartered bank, but indicated that its decision would not prevent collection of “a tax paid by the real property of the bank, in common with the other real property within the state, nor to a tax imposed on the interest which the citizens of Maryland may hold in this institution, in common with other property of the same description throughout the state.”⁵¹ The Court was concerned that Maryland might be tempted to use targeted taxes to cripple the federal bank, perhaps as a favor to its own state-chartered banks,⁵² but presumably thought this risk was minimized in the context of a generally applicable tax on real estate or stock holdings that applied to Maryland citizens and did not single out non-citizens. Similar strategies have been deployed in other contexts. For instance, the federal government has been prevented from adopting regulations that commandeer state officials,⁵³ but it has been permitted to subject states to regulations that apply generally to large employers.⁵⁴ Governments may not target religious conduct for regulation,⁵⁵ but the Court has decided that the Free Exercise Clause permits application of generally applicable laws to religious individuals.⁵⁶ Likewise, even though the Free Press Clause might protect news organizations from being singled out for regulation, they must comply with generally applicable rules that bind a broad array of citizens.⁵⁷

50. 462 U.S. 416, 434 (1983). The Court in *Akron* struck down as medically excessive an ordinance requiring all second-trimester abortions to be performed in a hospital. *Id.* However, the Court seemed receptive to the idea that abortion clinics performing second-trimester abortions could be subjected to minimum standards applicable to “free standing surgical facilities.” *Id.* at 437.

51. 17 U.S. 316, 436 (1819).

52. *Id.* at 432.

53. *Printz v. United States*, 521 U.S. 898, 935 (1997); *New York v. United States*, 505 U.S. 144, 186–87 (1992).

54. *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 555–56 (1985) (holding that Congress could apply Fair Labor Standards Act to local transit employees); *Reno v. Condon*, 528 U.S. 141, 151 (2000) (upholding statute regulating use of personal data concerning drivers where it was generally applicable in that it applied to both public and private vendors of such information).

55. *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520 (1993).

56. *Emp’t Div., Dept. of Human Res. v. Smith*, 494 U.S. 872 (1990).

57. *Compare Minneapolis Star & Tribune Co. v. Minnesota Comm’r of Revenue*, 460 U.S. 575, 592–93 (1983) (striking down tax on paper and ink that only applied to some press organizations), *with Cohen v. Cowles Media Co.*, 501 U.S. 663, 670 (1991) (newspaper could be sued under generally applicable theory of promissory estoppel where it allegedly breached promise of confidentiality made to a source).

For many forms of health regulation, this general applicability principle could be deployed to promote the safety of abortion procedures, particularly in the second trimester, when the risks of abortion increase significantly.⁵⁸ The fact that a particular regulation is applied to a range of different outpatient facilities, not just abortion clinics, would give courts confidence that the regulation was genuinely designed to promote patient health. At the same time, subjecting abortion clinics to the regime of inspections and enforcement applicable to other surgical facilities would give patients confidence that public health officials were not sacrificing abortion safety in the pursuit of abortion access.

V

The experience in Pennsylvania leading up to the prosecution of Dr. Gosnell underlines the critical role played by public health officials in protecting the health of women undergoing abortions, as well as the lives of the unborn and the newborn. The willingness of public officials to vigorously enforce the laws governing abortion will play a significant role in determining whether Dr. Gosnell is in fact an outlier.

58. Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 *OBSTETRICS & GYNECOLOGY* 729, 729 (2004) (“Compared with women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes.”).