Challenges to the Health and Safety of Women Undergoing Second and Third Trimester Abortion – The Case for State Oversight of Late Abortion Facilities

Overview of the problem

Conventional wisdom suggests that abortions are safe and there is little need for procedure specific regulations to ensure public health and safety. This is based on widely cited publications such as the National Academies Report entitled "The Safety and Quality of Abortion Care in the United States".[1] The problem with these assessments is that they don't differentiate risks based on gestational age or procedure type.

First trimester abortions are done almost exclusively using drugs or aspiration techniques. They represent approximately 90% of abortions in Colorado based on the latest CDPHE data from 2023. Second trimester abortions are primarily performed using Dilation and Extraction (D&E), which poses a substantially increased risk. Third trimester abortion commonly uses a variation of Dilation and Extraction (D&X) whose risks dissuade even most abortionists from attempting.

Since serious complications are uncommon in first trimester abortions, a global quantification of abortion risk will systematically understate the risk posed by second and third trimester abortions. According to the CDC, for each additional week of gestation beyond 8 weeks, the risk of dying from abortion increases by 38%.[2] The mortality from an abortion performed at 21 weeks or more is 77 times higher than the mortality from an abortion at 8 weeks or less based on data from the CDC between 1988-1997.[2] The latest CDC abortion mortality research encompassed data from 1998-2010 and confirmed the earlier findings and emphasized that gestational age was the best predictor of mortality.[3] Reviews of abortion safety commonly miss the vital fact.

One commonly repeated assertion is that "the risk of death associated with childbirth is 14 times higher than with abortion".[33] This ignores the reality that when incorporating gestational age into the determination, the risk of dying from a second trimester abortion at 18 weeks is nearly twice as high as the risk of dying from natural childbirth.[3, 34] For abortions performed at 18 weeks or greater the mortality from abortion is 6.7 deaths/100000 abortions and the rate increases to 8.9/100000 at 21 weeks or greater.[2,3] The risk of dying during natural childbirth is only 3.6/100000.[34]

Another pertinent comparison is the risk relative to ambulatory surgical centers. The mortality rate at ambulatory surgery centers certified by AAAASF is 2/100000 based on a study from the US.[6] A survey of accredited Canadian ambulatory surgical centers indicates an even lower rate of 1/100000.[7] This suggests that late abortions are 4-8 times more

deadly than these ambulatory surgeries. Ambulatory surgical centers are licensed, regulated and inspected in Colorado, but second and third trimester abortion clinics are not.

The increased danger of later abortions is not confined to mortality. Morbidity related to abortion increases exponentially by gestational age as well. Minor and major complications of D&E second trimester abortions are increased for each additional week of gestation.[4] For example, each one week increase in gestation has been associated with a 7.1% increase in mean estimated blood loss.[5] This is relevant since hemorrhage is the most common cause of death in the second trimester.[2]

Abortion advocates often compare the risk of abortion to other common medical procedures to make the case that abortions are safe. But they routinely compare global mortality rates rather than gestational specific rates.

Facilities that perform colonoscopies are not regulated but they pose 1/3 the risk of 21-week abortions.[1] Plastic Surgery poses only 8-19% of the risk of late abortion and are typically performed in regulated facilities.[1] Adult tonsillectomies pose 32-70% the risk of late abortion and are performed in either a hospital or ambulatory surgical center.[1]

Assessments of abortion safety also suffer from a lack of reliable statistics since the US doesn't have a national health registry to accurately correlate pregnancy outcomes with maternal morbidity or maternal deaths. Submission of abortion data to the CDC is voluntary and consequently incomplete. To identify abortion related deaths the CDC relies on the Pregnancy Mortality Surveillance System (PMSS) that is based on death records, media reports, and case reports from public health departments and state maternal mortality review committees. This has been shown to underestimate abortion-related mortality when compared to countries such as Finland with robust national health registries.[8] In contrast to the US, Finland has universal health coverage and can identify abortion related deaths through a comprehensive health registry that allows linkage between pregnancy, abortion, and death. If Finland relied on death records alone, which is the primary source in the US, 73% of maternal deaths from abortion would be missed.

The other common problem with publications exploring the risk of abortion is that they often rely on large medical claim databases which systematically underestimate the number of patients who have had an induced abortion and inadequately quantify complications for those that did.[9] Even with the methodological limitations of these studies, the risks of second trimester abortions are markedly higher than the risks of first trimester abortions.[10]

Second and third trimester abortion practice represents an opportunity for both prolife advocates and abortion rights advocates to find common ground. Those who follow a prolife ethic are motivated by an abiding love for both the woman and her preborn baby. They abhor abortion and don't want to see women harmed by the procedure. Abortion rights supporters want what is best for women and don't want access to abortion to override their concerns for the health and safety of women. Evidence-based regulation of second and third trimester abortion facilities to protect women's lives is consistent with both ideologies.

Specific Risks of Second and Third Trimester Surgical Abortions

There were 1220 second trimester abortions and 137 third trimester abortions reported to the CDPHE in 2023. This represented 8.3% and 0.9% of all abortions in Colorado. Abortions performed after the lower limit of fetal viability numbered 468 - which represents 3.2% of all abortions. Since 2023 additional 2nd/3rd trimester abortion facilities have opened in Colorado which suggests the numbers may be considerably higher.

While prospective double-blind placebo-controlled trials are considered the gold standard in establishing objective assessments of clinical risk, they aren't feasible for abortion since it would be unethical to submit women seeking abortion to different clinical procedural arms. Consequently, to understand the specific procedure and gestational age specific risks of late abortion, the best evidence is obtained from large retrospective case series from abortion centers across the US.

The largest series of second trimester D&E abortion complications was reported from the University of California San Francisco which is recognized as the premier center for abortion research in the country.[4] They demonstrated a 9.8% risk of any complication including cervical laceration, *hemorrhage*, uterine atony, *anesthesia complications*, *uterine perforation*, disseminated intravascular coagulation, and retained products of conception in over 4500 D&E procedures. There was a 1.7% incidence of serious, life-threatening complications including those requiring hospitalization, transfusion, or further surgical intervention.

Second trimester surgical abortion was associated with a 37% risk of greater than 500 ml hemorrhage and 8% risk of greater than 1000 ml in lower volume abortion centers in South Carolina.[5] (For reference, a whole unit of blood is 450 ml). Blood transfusion was administered to 3.73% of patients.

A study from our own University of Colorado demonstrated a 5.6% risk of cervical injury and a 4.2% risk of hemorrhage of greater than 500 ml in women undergoing suction D&C and D&E abortion in the second trimester.[11] There was a 2% risk for hospitalization.

Pregnancies sometimes involve complex comorbidities in the women or placental abnormalities with the fetus. This can further raise the risk from induced abortion which may not be recognized in unregulated clinic settings.

In a large high volume referral abortion clinic in New York's, 14.2% of patients undergoing D&E abortion from 15 to 24 weeks gestation had placenta previa (PP) by ultrasound.[12] Second trimester surgical abortion was associated with a 1.3% risk of major hemorrhage requiring transfusion in those without PP but in 3.4% of those with PP. Hemorrhage greater than 500 ml was observed in 4.2% of normal patients but 12.6% of women with PP. This would be prohibitively risky in an unregulated, lower volume second or third trimester abortion clinic in Colorado.

Specific Risks of Second and Third Trimester Medical Abortions

Medical abortion into the second and third trimester is also legal in Colorado, although this represents an off FDA label use of many abortion drugs. They may be performed in unregulated abortion clinics although prudent clinicians would choose a hospital setting. They pose additional risks to the women undergoing this procedure.

Second trimester medical abortions are associated with a 33% risk of any complication and a 6% rate of serious complication based on a study from Northwestern and Rush Universities in Chicago. [13] There is a 16% risk of hemorrhage and a 2.2% risk for hemorrhage requiring transfusion. There is a 0.5% risk for ICU admission, 12% risk for retained placenta requiring surgery, and a 12% risk of infection requiring antibiotics. If there is a history of one or more prior C-sections, these risks are substantially increased – 56% risk of any complication and 19% risk of serious complication.

A study from Perth, Australia using mifepristone/misoprostol during the second trimester didn't quantitate all complications but cited a 4.3% risk of hemorrhage greater than 1000 ml, a 1.7% risk for blood transfusion, a 19% risk of placental retention requiring intervention, and a 0.3% risk for uterine rupture.[58]

A second study from Rush University suggested that second trimester medical abortion was associated with a 1% risk of major hemorrhage requiring transfusion, 13% risk of hemorrhage greater than 500 ml, 17% risk of suspected infection requiring antibiotics, 6% risk of retained placenta, and overall complication rate of 17%.[14]

Another second trimester medical abortion study performed at Thomas Jefferson University Hospital in Philadelphia demonstrated a 1.6% incidence of severe hemorrhage requiring transfusion, 14% had retained tissue requiring D&C and 9.5% chorioamnionitis requiring antibiotics.[15]

A small outlier study from the Medical College of Wisconsin showed no statistically different rate of complications from D&E compared to medical induction abortions in the second trimester.[16]The complication rate ranged from 1.3 to 7% and included hemorrhage, retained tissue requiring manual or D&C removal.

C-sections performed during an earlier pregnancy markedly increase the risk from induced abortions. In a scoping review of the literature, a women with one prior C-section had a 0.5% chance for uterine rupture while a woman with 2 previous C-sections had a 2.2% risk for uterine rupture.[59] Another study suggested an overall uterine rupture rate of 1.24%.[60] Previous C-section was also found to be a moderate risk for retained placenta requiring further surgical intervention.

There is little data on the risk of third trimester abortions since they are rare outside a handful of states that permit them, including Colorado.

Third trimester abortions (like many later second trimester abortions) involve the injection of a feticide which carries its own independent risk for adverse events.[17]Because third trimester abortions in Colorado incorporate surgical instruments as well as drugs to extract the fetus, it can be anticipated that there is substantial risk to the woman – akin to instrument augmented deliveries.[18]

Risk Beyond the Aborted Pregnancy

There are risks to women that extend beyond those which are manifest immediately post abortion. Abortion facilities still have a vital role to play by ensuring comprehensive informed consent and mitigating these more latent risks.

It is well established that women who seek abortion have a much higher antecedent history of mental health disorders than women who give birth.[22] However, it is also now clear that women seeking abortion are at increased risk for exacerbations of mental illness post abortion.

Abortion advocates primarily point to survey-based studies to bolster their claims that abortion is neutral, or even positive with regards to mental health outcomes.[21-22,] However, even studies using this methodology point to a markedly increased incidence of substance abuse post abortion.[21]

The Turnaway study is most often cited by national media to dismiss concerns about the harm to women's mental health caused by abortion.[35] It shows no negative mental health effects of abortion up to 5 years post procedure. This study is fatally flawed (like most other survey-based studies) because of its small sample size, excessive dropout, and obvious susceptibility to selection bias, response bias, reporting bias, and social responsibility bias.[36] Women with the most negative abortion experience are the least likely to participate in abortion survey-based research which predictably skews the results.

To better establish the impact of abortion on women's mental health, national registry studies and large cohort studies that evaluate "hard" outcomes like mental health diagnoses/visits, mental health and substance abuse hospitalization, and mental health related deaths are more credible.

A large study from Canada, which was adjusted for confounding variables, showed a marked increased risk for hospitalizations for psychiatric disorders (increased 81%), substance abuse disorders (increased 157%), and suicide attempts (increased 116%) in those who had abortions rather than other pregnancy outcomes.[37] While those with an antecedent mental health disorder were most dramatically impacted, the effect was also seen in those women without a history of mental health issues. The Canadian study built on research from multiple other countries, including the US, that demonstrated that women who had abortions were at greater risk for mental health problems and death.[38-41.]

In addition to concerns for mental health, there is a growing body of literature which attests to the deleterious effects of abortion on future pregnancies.

Individual studies[42-44] and meta-analysis[45-47] have demonstrated that surgical abortions are associated with premature birth in subsequent pregnancies. One of the most recent meta-analysis points to a 4.08 times increased risk for cervical insufficiency – leading to premature birth - in women who undergo surgical abortions.[48] This is important because premature birth is associated with both increased maternal and infant mortality.[49]

Induced abortion (and spontaneous abortion) has also been shown to result in abnormalities in the placement/depth of the placenta in the uterus.[50] The suspected common theme is sharp curettage and the resulting damage to the uterine wall in surgical abortions (and other uterine surgical procedures).

Studies suggest a marked increase in placenta previa and placenta accreta spectrum disorders – anywhere from a 36% increase to as much as a 190% increase.[51-55] The relationship between surgically induced abortion and placental abnormalities is significant because both are associated with markedly increased maternal and infant morbidity and mortality.

The other impact on future pregnancies may be an increased need for C-section – which was increased 44% in one study.[56] It shouldn't be surprising that C-section rates might increase in whole or partly related to the impact of surgical abortion and sharp curettage on placental abnormalities.

Finally, although the literature is mixed, there is some concern that the scourge of infertility in our country and beyond could be partially related to the impact of surgically induced abortion.[57]

Reducing Reproductive Age Women's Morbidity and Mortality is a Priority in Colorado

Maternal mortality, which includes abortion-associated and abortion-related mortality, is a scourge in our nation and in the state of Colorado. Maternal mortality includes death from any cause within one year of pregnancy. Pregnancy can end by live birth, miscarriage, stillbirth, or abortion. Pregnancy-related deaths are a subset of pregnancy associated deaths and are due directly to a complication of pregnancy/abortion or a chain of events initiated by pregnancy/abortion. These could include suicide and overdose, or the aggravation of an unrelated condition exacerbated by the physiological effects of pregnancy or abortion. As in the rest of the United States maternal mortality in Colorado disproportionately impacts people of color, individuals living in poverty, those with less than a high school education, those over the age of 40 and those living in "frontier" areas.[19]

Maternal mortality is the "tip of the iceberg" since maternal morbidity is a much larger problem. For every woman that dies as a result of her pregnancy, it is estimated that 20 or 30 more will experience significant life-long complications.[20]

The Colorado Maternal Mortality Prevention Program (MMPP) aptly states that "every person has the right to a safe and healthy pregnancy". Unsafe second and third trimester abortion clinics are a direct challenge to this basic right.

The Colorado Maternal Mortality Review Committee (MMRC) reported 174 pregnancy-associated deaths and 80 pregnancy-related deaths between 2016 and 2020.[19] These numbers include abortion associated and abortion-related deaths – but abortion related deaths aren't separately identified. This may give the false impression that maternal mortality is simply related to "wanted" pregnancy complications. In fact, abortion-related mortality may be playing a significant role.

There has been significant progress made in delivery-related mortality, which is an important component of pregnancy-related mortality. There has been a uniform decrease in delivery related mortality across all racial and ethnic groups, age groups, and modes of

delivery between 2008 and 2021.[20]This has been attributed to national and state strategies focused on improving maternal quality of care using evidence-based bundles during delivery related hospitalizations.

There has not been a similar national or state strategy to institute evidence-based bundles for second and third trimester abortion clinics. While some conscientious facilities may institute these best practices on their own, this represents an opportunity for the legislature to have a significant role in reducing maternal morbidity and mortality by instituting a licensing, regulatory, and an inspection regimen under the auspices of CDPHE for these clinics.

The MMRC has recommended that "health care facilities should implement evidence-based safety bundles".[19] They add "there should be a specific focus on implementing bundles that address supporting patients with substance abuse disorders and mental health challenges." A second recommendation is that "all health care providers should use evidence-based screening tools (e.g., PHQ-9, EPDS, C-SSRS) for mental health, substance use, suicidality, intimate partner violence, and social determinants of health including social support, housing, and barriers to care."

These recommendations from the MMRC are particularly pertinent to abortion care since women who seek abortions have significantly more mental health disorders compared to women who seek childbirth.[21] One high quality registry study suggested that women seeking an abortion were 4 times more likely to have a mental health disorder than women before a normal delivery.[22] They are much more likely to suffer from an anxiety disorder, mood disorder, substance use disorder, and suicidal ideation. Furthermore, abortion is twice as likely to trigger a substance use disorder as compared to childbirth.[21]

Colorado has the second highest percentage (19.4%) of pregnancy-associated deaths from suicide in the country.[23] Significantly, 19.4% of Colorado's pregnancy-associated deaths are from drug overdose and 10% from homicide. Besides standardizing the approach to anticipated complications of second and third trimester abortions (such as hemorrhage, infection, and anesthesia complications), there is a huge opportunity for abortion clinics to improve outcomes if they employ proper screening techniques and have access to a multidisciplinary team that addresses mental health, substance use disorders and domestic violence.

What requirements should the state emphasize when exercising oversight of second and third trimester abortion clinics?

There is a range of premorbid conditions and specific abortion procedures that necessarily entail increased risk, and the state should determine which can safely be performed in an out-patient setting and which require hospital care.

Since hemorrhage is the most urgent and life-threatening complication of a second trimester abortion, the state CDPHE should develop regulations and an inspection schedule that ensures abortion patients have access to care that minimizes the risk of hemorrhage and affords prompt treatment options. Studies suggest that actual blood loss is twice as high as estimated blood loss and therefore hemorrhage can quickly result in a critically ill woman or exacerbate any antecedent medical conditions.[24-25]

Each clinic should ascertain whether the patient has a prior uterine scar, the gestational age of the fetus, the quality of cervical preparation, body mass index, procedural experience, fetal demise, and what kind of anesthesia is appropriate.[27] These all can impact the magnitude of hemorrhage following a D&E. They should have access and protocols for use of methylergonovine, misoprostol, oxytocin, vasopressin, tranexamic acid, and other novel agents to prevent or mitigate hemorrhage. Protocols to transfer patients in need of tertiary treatments such as uterine artery embolization, laparoscopy, laparotomy, or hysterectomy should be developed.

A clinic should also be adept at administering anesthesia, including conscious sedation, and responding to anesthetic complications.

They should have protocols in place to address uterine perforation and infectious complications – even if these patients are more likely to present to an emergency department or urgent care center.

Procedures/protocols that minimize forceful dilation of the cervix using osmotic dilators and prostaglandins should be instituted and monitored to mitigate the increased risk for subsequent premature birth.

Mental health should be part of preprocedural screening performed at late abortion facilities. The risk for mental health exacerbations should be stratified to target specific postprocedural mental health interventions and support.   Screening should incorporate tools for domestic violence and substance abuse, besides mental health disorders.

Informed consent should reflect all the risks from late abortion – the immediate risks including hemorrhage but also the risks to the women's health and the health of their baby during future pregnancies.

Second and Third trimester abortion facilities should be required to follow clinical best practices and conduct quality review of all cases of severe maternal morbidity and mortality. The American Association of OB/GYNs (ACOG) recommends that clinicians "characterize the events, diagnoses, and outcomes involved; and to determine if an identified morbidity is judged to have been potentially avoidable and, thus, present opportunities for system change and improved future performance."[26]

Is a clinic regulation law simply a solution in search of a problem?

The abortion industry will argue that abortion is safe and that if there is a significant problem, it would already be obvious – despite the enumeration of the risks outlined above.

The reality is that because of the stigma from abortion, patients are unlikely to seek redress for significant complications. They may indicate (or be told to say) that they are having a miscarriage rather than an induced abortion when presenting to an emergency department with complications. And we know that even health departments and prestigious medical centers, will turn a blind eye to abortion complications in service to what they perceive as the greater good – unfettered access to abortion.

To understand the magnitude of the problem recognizing and reporting egregious public health and safety practices at abortion facilities, you simply have to peruse the details from the Grand Jury Report on Kermit Gosnell – the abortion provider currently serving time in prison for murder following decades of deplorable abortion practices.[27] The Pennsylvania Department of Public Health and Safety deliberately chose not to enforce law that would afford patients at abortion clinics the safeguards and assurances of quality care as patients of other medical providers. The Grand Jury stated that "the medical practice by which he carried out this business was a filthy fraud in which he overdosed his patients with dangerous drugs, spread venereal disease among them with infected instruments, perforated their wombs and bowels – and, on at least two occasions, caused their deaths." "Over the years, many people came to know that something was going on here. But no one put a stop to it.". Even the world class Hospital of the University of Pennsylvania and the Presbyterian Hospital turned a blind eye to women who presented with life-threatening complications from Gosnell's clinic.

Gosnell is not an isolated rogue actor, since there are dozens of examples of gross medical negligence at abortion clinics from New Jersey to Florida, and from Pennsylvania to Indianna/Michigan and California. If robust Department of Public Health and Environment licensing, regulation, and inspections were in place, none of these regrettable tragedies would happen.

Here in Colorado, Mediatrackers first drew attention to the lack of regulation at abortion clinics in Colorado in 2013.[28] This was prompted by a malpractice lawsuit against Planned Parenthood of the Rocky Mountains that alleged malpractice and health standard violations. They found that Planned Parenthood abortion clinics were not held to the same standards as other facilities which are regulated by CDPHE. Planned Parenthood's only state oversight consists of the licensure of physicians, nurses and pharmacists who must maintain the requirements of the Colorado State Board of Health, the Board of Nursing, and the Board of Pharmacy. They also operate within the constraints of OSHA (Occupational Safety and Health Administration) and CLIA (Clinical Laboratory Improvement Amendments). *There is no state licensing, regulatory, or inspection requirements for public health and safety at abortion facilities in Colorado despite receiving millions of dollars of direct aid from the state.*

Another factor which is underappreciated is the fact that 29% of the abortions reported to CDPHE in 2023 were performed on out-of-state residents. Colorado is obligated to ensure quality care for these women so that don't suffer severe complications after they return home. This could delay appropriate care, worsen the severity of the complication, and have implications for their long-term health. Out-of-state women probably assume that the State of Colorado has their back with appropriate, evidence-based licensing, regulation, and inspections.

Finally, the truth is that there is a global shortage of abortion providers and few OB/GYNs wish to include abortion in their practices.[29] There is a negative public perception of abortion providers, even if the public broadly supports abortion rights. According to a recent survey conducted by KFF after the Dobbs decision, only 7% of OB/GYNs offer telehealth abortions, 14% in-person drug induced abortions, 13% aspiration abortions, and 12% D&E abortions.[30]

Dr. Warren Hern, the prominent second and third post-viability abortionist who until recently practiced (at age 86) at the Boulder Abortion Clinic acknowledges the problem of maintaining and recruiting quality abortion providers in his recent book *Abortion in the Age of Unreason*.[31] He lamented that there were two kinds of abortion providers. There are those motivated by "altruistic" concerns to help women and sacrifice much to deliver that care in a hostile environment. The second kind of abortion provider is the "commercial" provider who "cuts corners on patient care" and which is the "choice of many abortion providers".

Even Planned Parenthood which has 11 clinics in Colorado isn't immune from allegations of putting the abortion "mission" above the health and safety of women.[32] The expose reported that "Planned Parenthood has enjoyed a fund-raising boom …but little of it goes to

the state affiliates to provide health care at clinics. Instead, under the national bylaws, most of the money is spent on the legal and political fight to maintain abortion rights." They went on to observe that "employees at various affiliates said it was common to run out of over-the-counter pain medication and I.V. flushes. Salaries are so low that it is not unusual for staff members to qualify for Medicaid and federal food assistance." As a result of high staff turnover, they say that "they did not receive adequate training for patient intake, blood draws and other tasks." "Dozens of current and former employees also said that their complaints were met with reminders that they were in a "mission moment," meaning a time of crisis for reproductive rights so urgent that it overshadowed their concerns." In this kind of environment would-be whistleblowers remain silent. Women's health and safety is a secondary consideration because as one employee observed, "we're afraid of damaging the mission".

Given the risks, there is a compelling argument to be made why the state must act now to ensure the health and safety of women pursuing second and third trimester abortions in Colorado. Not only is there a large risk to women who undergo late abortion in the best of circumstances, but Colorado's proabortion environment sets the stage for poorly qualified bad actors to come to the state to pursue remuneration for abortion services without regard for the women they may injure or even kill through their negligence.

In 2025 alone, there has been at least one death of a young woman post abortion and numerable reports of emergent ambulance transfers from second/third trimester abortion facilities suggesting severe complications. There is no way to differentiate anticipated complications from a procedure known to be high risk from medical negligence/malpractice without state oversight.

Conclusion:

Amendment 79 enshrined access to abortion at any time for any reason in the state constitution. Colorado voters could not imagine at the time that they might be casting a vote to undermine the health and safety of women.

Second trimester D&E abortions have a 10% complication rate and at least a 1.7% risk of severe, life-threatening complications such as severe hemorrhage and uterine perforation. At lower volume centers or using different techniques, or with underlying comorbidities and/or placental abnormalities, the complication rate can be as high as 56%. Hemorrhage is the greatest short-term risk and can be rapid and massive. Second and third trimester abortion clinics should be adequately prepared to minimize the risk for hemorrhage and mitigate its severity once established. They should be required to maintain a robust

quality/peer review process. There is also an important role for screening tools given the high incidence of mental health and substance abuse disorders in abortion patients.

Oversight should not be limited to direct procedural regulations. Since late abortion not only poses an immediate risk to the health of a woman but also to the prospects of any future pregnancy and wanted child, review of the informed consent process is also crucial.

It is past time for Colorado to have CDPHE establish basic licensing, regulatory, and inspection authority over second and third trimester abortion facilities. CDPHE already has jurisdiction for other medical facilities with markedly less risk for significant morbidity and mortality. To do otherwise poses an unacceptably high risk to the women of Colorado.

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