Women’s Access to Health Care:

THE FACTS ABOUT ABORTION CARE IN WEST VIRGINIA

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EXECUTIVE SUMMARY

Physicians and other health care professionals, including those who provide abortion services, are subject to a significant amount of regulation intended to protect the health, safety and welfare of the citizens of West Virginia. All health care providers should be held to the highest safety standards. This is achieved in West Virginia by the following:¹

- Licensure requirements established by professional boards to ensure all health care professionals are highly qualified
- Protection from negligent and/or incompetent health care providers through the disciplinary authority of the West Virginia Board of Medicine, the Board of Osteopathic Medicine and the Board of Examiners for Registered Professional Nurses, as well as other professional boards, to investigate complaints and take appropriate disciplinary action, including suspension or revocation of licenses
- Protection from negligent health care providers through the Medical Professional Liability Act that establishes a system whereby members of the public can sue for medical negligence

Health care professionals who provide abortion care in West Virginia are duly regulated, despite claims that abortion clinics in West Virginia are “neither regulated nor certified.” Medical regulations should be based on legitimate health and safety needs. There has never been a medical malpractice judgment or disciplinary action taken against physicians or other health professionals related to abortion services in West Virginia. Abortion is a safe medical procedure. When compared to other office-based procedures, abortions have as low or lower rates of complications. Abortion services in West Virginia are particularly safe. A review of 2012 emergency room data from Charleston Area Medical Center Women and Children’s Hospital found only two women presented with complications associated with legally induced abortions. Additionally, a review of 2013 emergency room data for women presenting at Thomas Memorial Hospital in South Charleston, WV found that no complications were associated with legally induced terminations of pregnancy.

In November 2013, a statewide poll of West Virginia voters found most do not support more regulations intended to restrict access to abortion clinics.²

In addition to a lack of need and lack of support, the cost to state governments to implement laws based on invalid safety concerns is high. Many of the laws passed in other states have been struck down in court and/or are being litigated. Kansas has spent over

$900,000 defending its new anti-abortion laws and that figure is expected to increase.$^3$ South Dakota’s attorney general estimates it will cost the state $1.75 million – $4 million to defend their new anti-abortion laws.$^4$ In addition to the legal costs, there are costs to state departments of health to enforce new and unnecessary regulations.

In the absence of evidence of a health or safety need, there is no legitimate basis for targeting abortion care for further regulation.

“Abortion is one of the safest medical procedures performed in the United States” according to the American Medical Association and the American College of Obstetricians and Gynecologists.$^3$

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INTRODUCTION

Recently, West Virginia Attorney General Patrick Morrisey claimed that two women’s health clinics providing abortion services “are neither licensed nor regulated by the State.” Such claims are misleading and only serve to alarm and generate publicity.

All physicians and physician assistants in West Virginia are regulated pursuant to the West Virginia Medical Practice Act. Moreover, other health care professionals, such as registered nurses and advanced practice nurses are licensed and regulated in accordance with state law and regulations. Health care professionals who provide abortion care are no different. They are subject to the same licensing and regulation requirements as all other West Virginia health care professionals working in the state.

Medical regulations should be based on legitimate health and safety needs. No one disputes that all healthcare providers should be held to the highest safety standards—and health care providers who provide abortion care are no exception. However, in the last few years states across the country have singled out abortion providers for new and onerous regulations that have little, if anything, to do with protecting women’s health or safety and far more to do with politically motivated efforts to restrict access to abortion services. If regulations are truly necessary to address legitimate health and safety concerns, one would apply the regulations to all providers doing similar -- and sometimes more risky -- types of procedures in their offices. Instead, abortion opponents target professionals providing abortion, a medical procedure known to be very safe.

Abortion is one of the safest medical procedures performed. The best way to ensure a woman’s safety is to keep abortion care accessible. By burdening providers with extensive regulations, abortion services will become more difficult and more expensive to obtain. This will produce the opposite effect of protecting women’s health and safety.

A 2011 analysis in the New England Journal of Medicine concluded that restrictions aimed at shutting down providers had little or no effect on demand for abortion. The health care economist who authored the study predicted that “making access to abortion unnecessarily costly (through unnecessary and burdensome regulation) will probably result in...
clandestine abortions and unintended childbearing among families with the least resources and the fewest options.”

This report provides an overview of abortion care in West Virginia and the nation, demonstrates that women’s health providers in West Virginia are regulated and meet standards of safety, and examines existing legislation and its impact on access to care.

ABORTION CARE IN WEST VIRGINIA

Abortion has been performed throughout recorded history. Although it continues to be an emotionally charged topic in some areas of the United States, abortion is a common experience. Almost one in three American women will have had an abortion by the time she reaches 45 years of age.

Since 1973 when the U.S. Supreme Court recognized that the constitutional right to privacy includes safe and legal abortion, 50 million legal abortions have occurred. Once legalized, morbidity and mortality from unsafe abortions decreased dramatically; in 1970 there were 40 abortion-related deaths per million live births; six years later that statistic had dropped to eight deaths per million live births. Today, abortion is considered one of the safest medical procedures performed in the United States.

National and state data regarding characteristics of abortion care are similar. For the majority of women who have an abortion, it is a one-time occurrence. Most women in both the U.S. and in West Virginia are in their twenties when they get an abortion. Most women who have an abortion are mothers. About 61% of abortions in the U.S. are obtained by women who

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10 Brief of Amici Curiae American College of Obstetricians and Gynecologists and the American Medical Association in support of Plaintiffs-Appellees and in support of Affirmance, Filed 12/19/2013 in the United States Court of Appeals for the Fifth Circuit, Case: 13-51008, Document: 005-12477474, p. 2
have one or more children,\textsuperscript{12} which is similar for those women in West Virginia who obtain abortions (about 65\% in 2010).\textsuperscript{13}

Sixty-four percent of the women in West Virginia who had an abortion in 2010 had never had one before. Similar data is reported to the CDC for those states that report this information.\textsuperscript{14}

Most abortions in West Virginia and throughout the United States are provided early in pregnancy. During 2010 in West Virginia, nearly 60\% of all abortions occurred before 9 weeks and 90.7\% occurred in the first trimester. (These figures have been very consistent in the last five years.)\textsuperscript{15} Most abortions are done by a surgical method in the U.S. and in West Virginia (about 80\% and 90\% respectively). However, due to pharmaceutical advancements, the number of medically induced abortions (those done via medication) has increased both nationally and in West Virginia. From 2001 to 2010, medically induced abortions increased approximately 400\% in the U.S. (from 3.4\% of abortions in 2001 to 17.2\% in 2010).\textsuperscript{16} Although only about 10\% of the abortions performed in West Virginia in 2010 were medically induced, this figure may have risen more in the last few years.\textsuperscript{17}

Despite being an “integral component of women’s reproductive health services,”\textsuperscript{18,19} access to abortion care is severely limited. The number of abortion providers has decreased in

\begin{footnotesize}
\begin{enumerate}
\item Ibid.
\item Recent information from Women’s Health Center of West Virginia indicates that about 20\% of the abortions they provide currently are medical. (Information provided by executive director, December 9, 2013.)
\end{enumerate}
\end{footnotesize}
the last 20 years.\textsuperscript{20} In 2008, 87\% of U.S. counties had no abortion provider; 35\% of women lived in these counties. Access is even more restricted in West Virginia. Many women in the state can only access abortion services at the two clinical sites located in Charleston, Kanawha County. Only 10\% of West Virginia women of child-bearing age live in Kanawha County, making these services geographically challenging for most West Virginia women.\textsuperscript{21}

In 1996, concerns about abortion access and the limited opportunity for education and training in abortion care led the Accreditation Council for Graduate Medical Education (ACGME) to issue new program standards requiring abortion training of obstetrics and gynecology (ob/gyn) residents. These standards require that “experience with induced abortion must be part of residency training.” Residency programs in ob/gyn must provide their residents the opportunity for abortion training either in-house or at an outside facility. Residents may opt out of the training, but they must receive training in management of abortion complications. As noted by the American College of Obstetricians and Gynecologists: \textit{Training in abortion offers many skills which are applicable for the obstetric and gynecology practice, including early gestational sizing through the use of examination and ultrasonography, pain management, and the use of manual vacuum aspiration for incomplete and missed abortions}.\textsuperscript{22}

While some terminations may be done in hospital or private physician office settings, there are only two abortion clinic providers in West Virginia: Women’s Health Center of West Virginia and Kanawha Surgicenter. Both are located in Charleston and both adhere to best practices and evidenced-based standards of care of the National Abortion Federation. To become a member of the National Abortion Federation, providers must remain compliant with these standards of care. The certification process includes an initial site visit, annual reports, and periodic site visits to retain certification and membership.

\textbf{The Women’s Health Center of West Virginia} is a non-profit comprehensive women’s health care center. It was founded in 1976 and offers a full range of gynecological services, many of which are offered on a free or sliding fee scale. Some of the health care services, in addition to abortion, that are provided at Women’s Health Center, are:

- Family planning, including birth control counseling and supplies
- Breast and cervical cancer screening
- Depression screening
- Pregnancy support services


The Women’s Health Center (WHC) is staffed by a variety of health care personnel that reflect the broad array of health care services they provide. All appropriate medical personnel have met licensing requirements to practice in the state. (This process is discussed in detail in Section IV.) Many have additional education and certifications. The staff includes:

- Medical Doctors, including board certified ob/gyns and physicians from other specialties with specialized abortion training
- Registered Professional Nurses (RNs) who also have additional licensure and certifications, including Public Health Nurse Physical Assessment Training Certifications, Obstetrical Ultrasound, Point of Care Technician, and Basic Life Support
- Certified Registered Nurse Anesthetists (CRNAs) with advanced cardiac life support certification
- Master’s Level Nurse (MSN) Family Nurse Practitioner with prescriptive authority and other certifications, including Obstetrical Ultrasound, Point of Care Technician, and Basic Life Support
- Master’s level therapist
- Licensed Social Workers (LSWs)
- License Practical Nurses (LPNs)
- Medical Assistants with Point of Care Technician licensure

Both surgical and medical abortions are offered at Women’s Health Center. Kanawha Surgicenter is a private clinic, owned and operated by a board certified ob/gyn. Kanawha Surgicenter provides surgical abortions.

In addition, to the medical doctor, health care personnel at Kanawha Surgicenter include:

- Certified Registered Nurse Anesthetist (CRNA)
- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Technicians

Abortion is a common and safe medical procedure. Although access to abortion care is limited, especially in West Virginia, demand for services is relatively consistent. In fact, the only thing that seems to affect the number of abortions is the availability and use of effective contraception. Despite calls for more restrictions on abortion care, such legislation historically has not resulted in a reduction in the number of abortions. International surveys show that abortion occurs at about the same rate whether you are in a region where it is legal or highly restricted. For example, Latin America and Africa have some of the highest abortion rates despite the fact many countries in these areas have highly restrictive abortion laws. (Unfortunately, women who live in countries where abortion is banned or highly restricted are forced to seek out unsafe abortions. This comes at a high societal price. It is estimated that 70,000 women die and five million develop complications from unsafe abortions every year.)
contrast, the world’s lowest abortion rates are in Western Europe, where the procedure is legal and widely accessible—and where effective contraceptive use is high and unintended pregnancy rates are low.\textsuperscript{23}

THE SAFETY RECORD: ABORTION AND OTHER MEDICAL PROCEDURES

“Abortion is one of the safest medical procedures performed in the United States” according to the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG). A thorough review of studies published in peer reviewed scientific and medical journals during the last two decades demonstrate the accuracy of this fact. Although as with any medical procedure, there are risks; complications from abortions are rare. Moreover, nearly all of the complications that do occur are minor and can be treated in an outpatient setting. Significant adverse effects from abortions are very rare and hospital care is required in less than 0.3% of the cases.

The safety record for abortion services provided in West Virginia is as stellar as that of the rest of the U.S. A review of 2012 emergency room data for women presenting at Charleston Area Medical Center Women and Children’s Hospital (one of the busiest in the state and located in the same city as the two abortion clinics) found only two complications associated with legally

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24 Brief of Amici Curiae American College of Obstetricians and Gynecologists and the American Medical Association in support of Plaintiffs-Appellees and in support of Affirmance, Filed 12/19/2013 I the United States Court of Appeals for the Fifth Circuit, Case: 13-51008, Document: 005-12477474, p. 2
25 Examples of medical studies accessed from the U.S. National Library of Medicine, National Institutes of Health, National Center for Biotechnology Information Institute, Pubmed.gov include these conclusions:

- “Complications of medication and aspiration procedures occurred at a low rate, and most were minor and managed without incident.” (Bennet, Ian et al. [2009] Early abortion in family medicine: clinical outcomes. *Annals of Family Medicine*, 2009 November 7 (6): 527-533)
- “Legal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion. Similarly, the overall morbidity associated with childbirth exceeds that with abortion.” (Raymond and Grimes. [2012] The comparative safety of legal induced abortion and childbirth in the United States. *Obstet Gynecol*. 2012 Feb; 119(2 Pt 1)

27 Brief of Amici Curiae American College of Obstetricians and Gynecologists and the American Medical Association in support of Plaintiffs-Appellees and in support of Affirmance, Filed 12/19/2013 I the United States Court of Appeals for the Fifth Circuit, Case: 13-51008, Document: 005-12477474, p. 2
induced terminations of pregnancy\textsuperscript{29}. A review of 2013 emergency room data for women presenting at Thomas Memorial Hospital (also located in the same city as the two abortion clinics) found that no complications were associated with legally induced terminations of pregnancy\textsuperscript{30}.

Advances in medical technology have resulted in higher quality and improved care.\textsuperscript{31} First trimester surgical abortions (which represent the vast majority of abortions performed in West Virginia)\textsuperscript{32}, have a very low risk of a major complication.\textsuperscript{33} Medical abortions (which are limited to 9 weeks gestation) are also very safe.\textsuperscript{34} Only 0.6% of medical abortions result in a significant adverse event.\textsuperscript{35} According to the World Health Organization, in an article published by \textit{The Lancet}, “By contrast [to illegal abortion], legal abortion in the industrialized nations has emerged as one of the safest procedures in contemporary medical practice....”\textsuperscript{36}

Although there have been allegations that abortions may be linked to serious long term adverse health problems, there is no evidence to support this. In 1988 President Ronald Regan asked Surgeon General C. Everett Koop to prepare a report focusing on the psychological and physical effects of abortion on women. The report was never released because Koop found that such a study could not “withstand scientific and statistical scrutiny.”\textsuperscript{37} Since that time numerous studies have found that abortion is a very safe procedure with no long term effects.\textsuperscript{38}

\begin{itemize}
\item \textsuperscript{29} Weber, S.A., Vice President/Administrator, CAMC Women and Children’s Hospital letter dated January 16, 2014 to Patricia White, Charleston, WV.
\item \textsuperscript{30} Dexter, S.P., CEO, Thomas Health System’s letter dated February 17, 2014 to Patricia White, Charleston, WV.
\item \textsuperscript{32} Ibid.
\end{itemize}
Comparisons to Other Office-based Medical Procedures

Abortions are just one of many medical procedures performed in private office practice and clinical settings. According to the American Society of Anesthesiologists, there has been rapid growth in the number of surgeries being performed in doctors’ offices (rather than in hospitals or ambulatory surgical centers). Over a ten-year period from 1995 to 2005, the number of office-based procedures doubled; in 2010 ten million procedures were performed in physician offices. These procedures include things as simple as the removal of a mole to more significant procedures, such as vasectomies, breast augmentation/reduction, liposuction, hernia repairs, or knee arthroscopies. Moreover, there are a growing number of gynecological procedures now performed in an office-based setting. When examining rates of complications, abortion compares favorably with other medical procedures done in a doctor’s office, and has significantly lower adverse effects than many procedures.

Operative hysteroscopies, one of many procedures done in ob/gyns’ offices, are minimally invasive surgical procedures used for numerous reasons, including voluntary sterilization. “Nearly 500,000 women have been sterilized using this method and an increasing number of physicians are now performing this procedure in the office setting.” The infection rate for this procedure (1.15%) is similar to that of a surgical abortion (0.1%-2%).

Dilation and curettage (D&C) procedures are performed in doctors’ offices to diagnose or treat uterine conditions such as heavy bleeding or to clear the uterine lining after a spontaneous abortion. The procedure has a similar safety record as that of abortions.
Complications, such as perforation, infection, and damage to the cervix are very rare, just as with abortions.\textsuperscript{45, 46}

Medical procedures to remove abnormal tissue are also commonly performed in physician offices. Loop electrosurgical excision procedure (LEEP) is used to treat abnormal cells in the cervix, pre-cancers, and noninvasive cancer cells. Rates and types of complications are similar to abortion with 1-4% of patients having a complication that may include excessive bleeding and infection.\textsuperscript{47, 48} Another complication of LEEP is the increased risk for preterm delivery (4.6%). Repeat LEEP is associated with an almost threefold risk for preterm delivery.\textsuperscript{49}

Global endometrial ablation is a minimally invasive procedure performed in a physician office to treat abnormally heavy or prolonged menstrual bleeding. (This procedure is often preferred over the more serious and invasive hysterectomy procedure.) The incidence of uterine injury is reported to be 0.3% - 2.5%.\textsuperscript{50} (Abortion has a less than 0.4% rate of uterine perforation.\textsuperscript{51} The infection rate with all endometrial ablation techniques is approximately 1%.\textsuperscript{52} (As noted, infection from surgical abortions occur between 0.1-2%).

In addition to the gynecological procedures discussed above, there are a number of other procedures done in private practice offices and clinics. For example, oral and maxillofacial procedures are commonly performed in dental offices, and they are not without risks. Infection rates from third molar extractions (wisdom teeth) vary from 0.9 – 4.3%.\textsuperscript{53} The overall complication rate is 4.6%.\textsuperscript{54} Overall complication rates from abortion are about 3%.\textsuperscript{55}

\textsuperscript{49} Heinonen, A., Gissler, M., MPolSc; Riska, Annika MD, PhD; Paavonen, Jorma MD, PhD; Tapper, Anna-Maija MD, PhD; Jakobsson, Maija MD, PhD (2013, May) Loop Electrosurgical Excision Procedure and the Risk for Preterm Delivery. Obstetrics & Gynecology. 121(5):1063-1068.
\textsuperscript{52} Ibid.
\textsuperscript{54} Ibid.
Other types of procedures such as those for cosmetic reasons or to correct vision problems have higher rates of complications, some significantly higher, than those from abortion. Analyses of Florida data consistently have shown high rates of complications from cosmetic procedures performed in office-based settings. The majority of the deaths and the complications that required transfer to a hospital were associated with liposuction, abdominoplasty (tummy tucks), or bundled procedures — when multiple procedures were done together.\footnote{See, for example: Coldiron B, et al. (2004) Patient injuries from surgical procedures performed in medical offices: three years of Florida data. \textit{Dermatological Surgery}. 30(12 Pt 1): 1435-43; Coldiron, B et al. (2005) Adverse event reporting: lessons learned from 4 years of Florida office data. \textit{Dermatologic Surgery}: 31(9Pt 1): 1079-92; discussion 1093 and Starling, J et al. (2012) Determining the Safety of office-based surgery: what 10 years of Florida data and 6 years of Alabama reveal. \textit{Dermatologic Surgery}. 38(2):171-7.u}

Complications from lasik surgery (to correct vision problems) vary from more than 10% (hazy, blurry vision, glare, etc.) to less than 1% (disabling vision loss, optic-nerve problem, infection).\footnote{Consumer Reports. (2013, Feb). Lasik eye surgery, Will you really get rid of your glasses? \textit{Consumer Reports}, 2006-2014. Retrieved from http://www.consumerreports.org/cro/2013/02/lasik-eye-surgery/index.htm}

REGULATION OF HEALTH CARE PROVIDERS IN WEST VIRGINIA

State government plays an important role in the protection of public health and safety. States accomplish this through a variety of laws and regulations, including laws that assure the provision of high quality health care throughout the medical profession.

In West Virginia, state laws govern the licensing, scope of practice, and training of health care professionals. Health care providers practicing in offices in which abortion is performed are subject to the same licensure and credentialing requirements of all providers practicing in the state.

West Virginia, like the majority of states, does not have a special “abortion clinic” designation any more than it has a special “ob-gyn clinic,” “lasik clinic” or “podiatry clinic” designation. Instead, providers who perform abortions are regulated like any other provider performing a medical procedure in his or her office or clinic. Although the West Virginia Department of Health and Human Resource’s Office of Health Facilities Licensure and Certification (OHFLAC) has regulatory authority over a number of health care facilities, including hospitals, behavioral health programs, nursing homes, hospices and ambulatory surgical centers, it does not license or certify those who work in private physician offices or clinics. OHFLAC certifies many of these facilities on behalf of the federal government, but private practice offices and clinics are not required to meet the federal certification regulations. The West Virginia Department of Health and Human Resources does not have licensing and disciplinary authority over the providers working in the offices and clinics that provide a variety of medical procedures; instead that regulatory function is maintained by the Professional and Occupational Boards established in the State Code.

Professional and Occupational Boards Provide Oversight and Authority

Chapter 30 of the West Virginia Code establishes the various boards that govern professions and occupations in the state. As stated in law, the “fundamental purpose of licensure and registration is to protect the public....” The boards are responsible for making

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62 Information obtained from website and discussion with OHFLAC personnel. http://www.wvdhhr.org/ohflac/
rules and regulations that are necessary to do this. There are about 40 professions and occupations named in this section of the law.

Article 1 of Chapter 30 outlines the general provisions that apply to all state boards that examine and/or license professionals. Members of the boards are appointed by the Governor and approved by the West Virginia Senate. In order to protect the public’s health and safety, the boards decide who is qualified to practice in their respective profession. All professional and occupational boards are required to establish rules pertaining to the requirements that must be met in order to obtain a professional license to practice, promulgate rules on how to apply for and renew the license, and establish what continuing education requirements are needed in order to maintain licenses. Boards have the authority to grant and deny licenses.

Another important role that is crucial to public safety is the professional and occupational boards’ duty to investigate and resolve complaints against those holding professional licenses. Boards are granted investigative powers, including the authority to “compel the attendance of witnesses, to issue subpoenas, to conduct investigations and hire an investigator and to take testimony and other evidence.”

Boards have a “duty to report violations of individual practice.” In addition, any person licensed by the professional board must report violations of his/her professional peers. The boards have the authority to revoke or suspend professional licenses for those who have been “convicted of a felony or who has been found to have engaged in conduct, practices, or acts constituting professional negligence or a willful departure from accepted standards of professional conduct.” The boards, in the course of investigations, may enter into Consent Decrees, reprimand, put on probation and/or levy fines.

The following discusses the specific health care providers who may work in clinics where abortion services are provided and how their professions are regulated, as well as some of the other federal and state certifications and regulations to which these health care providers are subject.

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63 West Virginia Code. Professions and Occupations. SS30-1-5(b)
64 West Virginia Code. Professions and Occupations. SS30-1-5 (d)
65 West Virginia Code. Professions and Occupations. SS30-1-8(a)
Regulation of Medical Doctors

The West Virginia Board of Medicine, established in the West Virginia Medical Practice Act, is the state agency that regulates all allopathic physicians in the state. The West Virginia Medical Practice Act is found in Chapter 30, Article 3 of the West Virginia Code. The Act’s purpose is to protect the public interest and to encourage the delivery of quality medical services.

The Board of Medicine is the “sole authority for the issuance of licenses to practice medicine and surgery, to practice podiatry, and to practice as a physician assistant for a medical doctor in the state of West Virginia.” In addition to its licensing authority, the West Virginia Board of Medicine is the disciplinary body for all providers licensed by the Board.

In order to practice medicine in West Virginia, a physician must be licensed by the Board of Medicine. To obtain a license, one must meet the following requirements:

- Be a graduate of a medical school approved by the LCME (Liaison Committee on Medical Education which accredits medical education programs in the US and Canada) or by the Board;
- Provide a statement from a fellow physician that he/she is of good moral character;
- Complete at least one year of postgraduate clinic training from an accredited graduate medical program; and
- Pass an accepted national licensing exam.

Once obtained, a medical license is valid for two years. To renew the license, the medical doctor must complete a minimum of 50 hours of continuing medical education. At least 30 hours of the education must be related to the physician’s area or areas of specialty, and beginning May 1, 2014, a minimum of three hours of the education must include training on drug diversion and best practices prescribing of controlled substances.

In addition to regulating who can practice medicine, the Board of Medicine protects the public interest by disciplining medical doctors, podiatrists and physician assistants who have violated the West Virginia Medical Practice Act or rules of the Board. (Examples of some of the rules include fraud, forgery, abuse of alcohol or controlled substances, unethical behavior, etc.).

67 Ibid.
This is done through a complaint process. Complaints against an individual physician can be made by any person, medical peer review committee, firm, corporation, member of the Board of Medicine, or public officer.

In addition to the complaint process, the Board of Medicine also reviews the malpractice status of physicians who have a certain number of judgments and/or settlements against him/her in a five-year period.

The Board of Medicine decides and enforces appropriate disciplinary action. Such action may include probation, suspension or revocation of license, fines, or other actions the Board feels is necessary to ensure good medical practice.

As a state entity the West Virginia Board of Medicine makes an annual report to the West Virginia State Legislature and maintains on a public website information on licensed medical doctors as well as disciplinary actions, including settlements and judgments, against individual physicians. Through this oversight, the Board ensures the protection of the patients these providers serve.

**Regulation of Doctors of Osteopathy**

The West Virginia Board of Osteopathic Medicine, established in 1923 is the state agency that licenses osteopathic physicians and osteopathic physician assistants. The Osteopathic Physicians and Surgeons Act is found in Chapter 30, Article 14 of the West Virginia State Code. Similar to the West Virginia Board of Medicine, the West Virginia Board of Osteopathic Medicine is responsible for protecting the citizens of West Virginia by licensing qualified osteopathic physicians, surgeons, and osteopathic physician assistants, and by investigating all complaints made against these professionals and determining the disciplinary action necessary to address the complaint.

Like the West Virginia Board of Medicine, members of the West Virginia Board of Osteopathic Medicine determine the requirements for obtaining a license to practice and issues licenses to qualified applicants. Requirements include:

- Graduate of accredited osteopathic college;
- Completion of at least one year of approved post-doctoral, clinical training; and
- Documentation of passage of a standard, national examination.

Like medical doctors, osteopathic doctors must renew their licenses every two years. To renew a license the physician must complete 32 hours of continuing medical education. He or she must also complete a three-hour course on pain prescribing best practices and drug diversion.

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68 All information obtained from the West Virginia Board of Medicine website.
69 Information obtained from the West Virginia Board of Osteopathic Medicine website. Retrieved from https://www.wvbdomed.org/
As noted, the West Virginia Board of Osteopathic Medicine is responsible for disciplining its members who violate state code for Osteopathic Medicine or the rules of the Board. The disciplinary role is very similar to that of the Board of Medicine, including the complaint process, the right of the Board to enforce disciplinary action, the right to a public hearing, and the establishment of a liability committee to investigate patterns of malpractice judgments and settlements.

Regulation of Registered Professional Nurses

The West Virginia Board of Examiners for Registered Professional Nurses (RN Board) is the agency responsible for regulating registered professional nurses and dialysis technicians. Its authority is established in Article 7 of Chapter 30 of the West Virginia Code. In addition to licensing and disciplinary authority, the RN Board is authorized to accredit and prescribe standards for educational nursing programs in the state. The Board regulates all professional registered nurses, including advanced practice nurses.

Like doctors of medicine and osteopathy, in order to practice in the state, registered professional nurses must be granted a license through their professional board. To receive a license, applicants must pass the national council licensure examination. In order to qualify to take the exam, the applicant must complete an accredited nursing program and complete a state and national criminal history records check.

Nurses’ licenses must be renewed on an annual basis. Twelve contact hours of continuing education are required to renew.

Like the medical boards discussed above, the RN Board has the right to deny, revoke, or suspend any license to practice registered professional nursing.

Regulation of Advance Practice Nurses

An Advanced Practice Registered Nurse (APRN) is “a registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to independently provide direct and indirect care to patients.” Examples of specialties with APRN licenses include Nurse Anesthetists, Nurse Midwives, Clinical Nurse Specialists and Nurse Practitioners. APRNs may specialize in certain populations and receive national and board certification in that field, such as a Women’s Health certification.

As noted, advance practice nurses are regulated by the Board of Examiners for Registered Professional Nurses. They are subject to the same licensing requirements, but also must provide the RN Board with additional educational and national certification documentation.

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The following requirements must be met to receive an APRN license:

- Graduation from a graduate program accredited by a nurse accrediting body that is recognized by the U.S. Department of Education and/or the Council for Higher Education Accreditation, and
- Pass national certification examination in the appropriate APRN role and population specialty consistent with educational background.

In order to renew an APRN license, the APRN must complete at least 24 contact hours of continuing education every two years. Twelve of the contact hours must be in pharmacotherapeutics, 8 of which may be used for renewal of Limited Prescriptive Authority, and 12 hours in the clinical management of patients.

The RN Board has disciplinary authority to investigate APRNs when complaints are made to determine if they have violated standards of practice and subsequently decide what disciplinary action is needed.

In their FY 2013 Annual Report, the RN Board reported that 2049 of the 30,643 registered nurses in West Virginia (6.7%) are APRNs. The following discusses some of the additional authority and responsibility of APRNs who work in private practice offices or clinics where abortion services may be provided.  

Certified Registered Nurse Anesthetists (CRNA) are specialty Advanced Nurse Practitioners regulated by the RN Board. As authorized in SS30-7-15 of the West Virginia Code CRNAs can administer anesthetics in the presence and under the supervision of a physician or dentist if, in addition to a professional registered nurse’s license, the CRNA has completed an accredited educational program of a school of anesthesia and passed a national certification examination. In addition to the contact hours required to renew their licenses, CRNAs must maintain current certification by a national professional certification organization.

APRNs may also be given limited prescriptive authority. As provided in SS30-7-15a (a) of the West Virginia Code, the RN Board may grant APRNs authorization to prescribe certain prescription drugs if they are in a collaborative relationship with a West Virginia-licensed physician. There must be a written agreement filed with the RN Board and copies of the collaborative agreement sent to the appropriate medical, osteopathic and pharmacy boards. In addition to a professional registered nurse’s license, the advanced practice nurse must complete 45 hours of an approved educational program in pharmacology and clinical management of drug therapy to qualify for this authority. The RN Board, in collaboration with the Board of Pharmacy, decides which substances can be prescribed by APRNs.

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71Information obtained from West Virginia Board of Examiners for Registered Professional Nurses website. Retrieved from http://www.wvrnboard.com/
APRNs who have prescriptive authority must renew their licenses every two years and show that they have received at least 8 contact hours of pharmacology continuing education.

The RN Board reported that 902 of the 2049 registered professional nurses in advanced practice (44%) have prescriptive authority in their FY 2013 Annual Report.

Certified Nurse Midwives (CNMs) are also regulated by the West Virginia Board of Registered Professional Nurses. Article 15 of Chapter 30 of the West Virginia Code details some of the requirements and authority granted to CNMs in the state. In addition to the meeting the requirements for licensure required of all professional nurses, the certified nurse midwife must:

- Be a graduate of a nurse-midwifery education program approved by the American College of Nurse-Midwives and
- Be certified by the American College of Nurse-Midwives.

Certified nurse midwives are required to practice in a collaborative relationship with a licensed physician (either a Family Practice physician, an ob/gyn, or a primary care physician directly responsible for obstetrical and gynecological care).

Certified nurse midwives may be granted prescriptive authority by the RN Board. Like the other APRNs who have prescriptive authority, the midwife must have a collaborative relationship in writing with a West Virginia-licensed physician and complete 45 contact hours of education in pharmacology and clinical management of drug therapy. Verification of the written agreement must be filed with the RN Board by the nurse midwife. The RN Board determines which drugs fall under this prescriptive authority. Nurse midwives may also prescribe a 72 hour supply of a Schedule III substance. Prescriptive authority must be renewed every two years. The midwife must have 8 contact hours of pharmacology during this time to receive renewal.

Regulation of Licensed Practical Nurses

The West Virginia State Board of Examiners for Licensed Practical Nurses is the state agency (established in SS30-7A of the West Virginia Code) that regulates practical nurses. In addition to the licensing of these health care workers, the Board issues accreditation to educational programs preparing practical nurses. To receive a license, the applicant must:

- Be of good moral character;
- Have at least a 10th grade education;
- Completed a course of study in an accredited program of practical nursing;
- Pass national licensure examination; and
- Have criminal history records check.

Licenses must be renewed annually. Every two years, LPNs are required to complete 24 contact hours of continuing education (at least 3 of which must be in substance abuse) and engage in 400 hours of LPN practice. Like the other boards, the West Virginia State Board of Examiners for Licensed Practical Nurses has the authority and duty to revoke or suspend the licenses of practical nurses, or otherwise discipline them, if needed.\(^{72}\)

**Regulation of Social Workers**

The West Virginia Board of Social Work is the state agency that regulates social workers through its licensure and disciplinary authority (established in SS30-30 of the West Virginia Code). The Board awards four levels of licensure.\(^{73}\) The four licensure levels consist of:

- **Level A Social Worker (LSW)** – must have a Bachelor's degree in Social Work from a Council on Social Work Education (CSWE) accredited social work program and passed the Association of Social Work Boards (ASWB) Basic level state social work examination;
- **Level B Graduate Level Social Worker (LGSW)** – must have a Master's degree in social work (MSW) from a Council on Social Work Education (CSWE) accredited social work program and passed the Association of Social Work Boards (ASWB) Intermediate level state social work exam;
- **Level C Certified Social Worker (LCSW)** – must have a Master's degree in social work (MSW) from a Council on Social Work Education (CSWE) accredited social work program, completed two years post-masters social work practice experience, and passed the Association of Social Work Boards (ASWB) Advanced Generalist level state social work exam;
- **Level D Independent Clinical Social Worker (LICSW)** – must have a Master's degree in social work from a Council on Social Work Education (CSWE) accredited social work program, and/or a Ph.D. or DSW degree in social work from a university that is accredited by the CSWE and passed the Association of Social Work Boards (ASWB) Clinical level examination. Additional requirements, include:
  - Supervised clinical field placement at the graduate level, or post-master's clinical training that is found by the board to be equivalent;
  - Graduate course in either psychopathology or abnormal psychology or other course found equivalent by the Board;

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\(^{72}\) Information obtained from the West Virginia State Board of Examiners for Licensed Practical Nurses website. Retrieved from http://www.lpnboard.state.wv.us/

\(^{73}\) Information obtained from the West Virginia Board of Social Work website. Retrieved from http://www.wvsocialworkboard.org/
- At least two years of post-graduate clinical experience.

All licenses to practice social work in West Virginia must be renewed every two years. To renew, the social worker must earn 40 hours of continuing social work education hours.

Like the other professional boards, the West Virginia Board of Social Work is given the authority and responsibility to investigate complaints and take disciplinary actions for those it licenses.

**Regulation of Clinical Labs and Lab Technicians**

The West Virginia Department of Health and Human Resource’s Office of Laboratory Services is responsible for administering the program that regulates clinical laboratory services. In 1988, the U.S. Congress passed the Clinical Laboratory Improvement Act (CLIA) establishing quality standards for all clinical laboratories. The Centers for Medicare and Medicaid Services (CMS) is the federal agency given oversight of the CLIA program. The Office of Laboratory Services administers the program following the federal guidelines.

CLIA requires all facilities that perform even one test, on “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings” to meet certain federal requirements. The Office of Laboratory Services certifies labs in West Virginia. The CLIA certification given is dependent upon the complexity of the tests performed by the lab.

One of the regulatory functions of the CLIA program is to provide physicians and the general public with specific information that is useful in evaluating the performance of laboratories. Information provided to the public includes:74

- A list of laboratories that have been convicted, under Federal or State laws relating to fraud and abuse, false billing, or kickbacks;
- A list of laboratories that have had principal sanctions imposed; their CLIA certificates suspended, limited, or revoked, and the reasons for the adverse actions;
- A list of persons who have been convicted of violating CLIA requirements;
- A list of laboratories on which alternative sanctions have been imposed;
- A list of laboratories whose accreditation has been withdrawn or revoked and the reasons for the withdrawal or revocation;
- All appeals and hearing decisions;
- A list of laboratories against which CMS has brought suit and the reasons for those actions; and

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• A list of laboratories that have been excluded from participation in Medicare or Medicaid and the reasons for exclusion.

Civil settlements reached with clinical laboratories are also noted. Specific information regarding laboratories can be accessed at the Centers for Medicare and Medicaid Services website.\(^75\)

In addition to certifying clinical labs under CLIA, DHHR also issues licenses to clinical laboratory personnel.\(^76\)

Licenses of Clinical Laboratory Technicians and Technologists are renewed annually. Clinical Laboratory Technicians and Technologists must obtain at least 10 contact hours each year to renew their license.\(^77\)

**Federal Regulations Affecting Physician Offices and Clinics**

In addition to meeting CLIA certification, there are other federal regulations that private physician offices and clinics must adhere to. These include OSHA and HIPAA rules.

In 1991, the **Occupational Safety and Health Administration (OSHA)** promulgated the Occupational Exposure to Bloodborne Pathogens Standard. West Virginia is one of 26 states covered entirely by the federal OSHA program. OSHA rules impact various aspects of medical/infectious waste, including management of sharps, requirements for containers that hold or store medical/infectious waste, labeling of medical/infectious waste bags/containers, and employee training. The Bloodborne Pathogens Standard has numerous requirements, including the development of an Exposure Control Plan and includes rules specific to certain types of wastes generated at healthcare facilities.\(^78\)

The **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 protects individuals’ health information. All physicians and those working with the physician must comply with the requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information.\(^79\)

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\(^75\) Specific laboratory registry information can be found at [http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Laboratory_Registry.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Laboratory_Registry.html)

\(^76\) West Virginia Division of Health Legislative Rule governing Clinical Laboratory Technicians and Technologist Licensure and Certification ([64 CSR 57](http://www.wvdhhr.org/labservices/compliance/licensure/index.cfm)) became effective August 1, 1997. The rule covers laboratories performing clinical laboratory testing of moderate or high complexity as defined by CLIA.


Additional/Voluntary Regulatory Bodies

Many abortion providers go above and beyond what is mandated by state and/or federal regulations. The two providers who specialize in abortion care in West Virginia are members of the National Abortion Federation (NAF). NAF sets the standards for abortion care in the U.S. and Canada. Every year, NAF publishes Clinical Policy Guidelines (CPGs), the only evidence-based guidelines for abortion practice in North America. The guidelines are developed based on rigorous review of the relevant medical literature and known patient outcomes. NAF’s Clinical Services Department works to ensure compliance with the Clinical Policy Guidelines by conducting Quality Assurance and Improvement (QAI) site visits during which each guideline is addressed. This site visit must be completed prior to becoming an approved member and on an on-going basis to maintain membership.\(^8^0\)

Conclusion

Physicians and other health care professionals, including those who provide abortion services, are subject to a significant amount of regulation intended to protect the health, safety and welfare of the citizens of West Virginia. They must be licensed and adhere to quality standards of care established by the Boards that govern their respective professions. They must adhere to a number of state and federal regulations, including those that license clinical laboratory workers and certify clinical labs. In addition, there are a number of state and local building and fire codes that physician’s offices and clinics must adhere to.\(^8^1\) They must meet OSHA and HIPAA regulations. Moreover, the two abortion providers in the state are certified by the National Abortion Federation and are subject to even more regulation and oversight intended to ensure quality services and safe care.


\(^8^1\) While these regulations and codes are not discussed in this report, codes include, but are not limited to, those located at the regulatory and licensing division, Office of State Fire Marshall, http://www.firemarshal.wv.gov/rldivision/Pages/BuildingCodecert.aspx
FURTHER OVERSIGHT OF HEALTH CARE PROFESSIONALS:
MEDICAL MALPRACTICE AND COMPLAINT AND DISCIPLINARY PROCESSES IN WEST VIRGINIA

As written in the West Virginia State Code, “citizens of this state are entitled to the best medical care and facilities available…. (H) ealth care providers offer an essential and basic service which requires that the public policy of this state encourage and facilitate the provision of such service to our citizens.”

There are a number of ways in which the state facilitates the provision of high quality health care. Protection from incompetent or negligent health care providers is important in assuring quality care; this protection is available through two avenues. When it is suspected that health care does not meet professional standards, a patient can either file a lawsuit for medical negligence or he/she can file a complaint with the professional board that licenses the health care provider. Both systems allow for a check on the professional conduct of health care providers. The malpractice process involves litigation and may result in compensation for the injured party, while the professional boards’ disciplinary processes involve a formal complaint process, investigation and disciplinary actions that may result in probation, suspension or revocation of the professional license, if necessary.

Moreover, additional oversight of health care providers comes from the Health Care Quality Improvement Act (HCQIA) of 1996, the National Practitioner Data Bank, as well as reviews of medical charts and records by insurance companies. These systems use peer review processes to ensure that incompetent physicians are identified and reported to appropriate officials.

If there were persistent and serious safety problems with abortion care provided in West Virginia, one would expect to see complaints and disciplinary actions taken against physicians and/or successful medical negligent cases brought by injured parties. According to the West Virginia Board of Medicine, as of August 2013 it had taken 229 disciplinary proceedings since 2008. Not one of those was related to abortion. No medical malpractice

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82 West Virginia Code. Medical Professional Liability. §55-7B-1
verdict or other judgment has ever been entered in West Virginia against an abortion provider.\textsuperscript{84}

The following describes in detail these checks on the professional conduct of health care providers.

**Medical Negligence**

In West Virginia, a malpractice lawsuit can be filed against a health care provider for medical negligence. This is commonly called medical malpractice. Medical negligence occurs when a patient is injured or dies as a result of the provision of sub-standard health care. Any person or entity licensed to provide medical services is considered a health care provider and may be held liable for medical negligence. This includes, but is not limited to, physicians, nurses, hospitals, clinics, and medical group practices.

Medical malpractice claims must be filed within two years of the alleged negligent act or, if the injury is not discovered until later, two years from the date it is found (or reasonably should have been found). There are exceptions for minors.\textsuperscript{85}

In a medical malpractice case, compensatory damages (both economic and noneconomic, e.g., pain and suffering), as well as punitive damages may be awarded. However, punitive damages are only awarded if there is evidence that a defendant acted with wanton, willful, or reckless conduct or criminal indifference to civil obligations affecting the rights of others to appear or where the legislature so authorizes.\textsuperscript{86} There are caps on the amount of noneconomic damages that can be awarded.\textsuperscript{87}

There are a number of processes to follow and deadlines to meet when filing a medical malpractice lawsuit. These include sending a “notice of claim” at least thirty days (before filing the lawsuit) to each health care provider against which a suit is being brought. This notice must include information regarding the liability “upon which a cause of action may be based” and “a list of all health care providers and health care facilities to whom notices of claim are being sent.” A signed document from a medical expert, called “a screening certificate of merit” must also be sent with the notice or within 60 days.\textsuperscript{88} The certificate of merit must include the following information: (1) the expert’s familiarity with the applicable standard of care; (2) the expert’s qualifications; (3) the expert’s opinion as to how the applicable standard of care was breached; and (4) the expert's opinion as to how the breach of the applicable standard of care

\textsuperscript{84} Conversations with Paul Sheridan, former interim executive director of American Civil Liberties Union of West Virginia, Nancy Tolliver, former executive director of Women’s Health Center of West Virginia, and Sharon Lewis, current executive director of Women’s Health Center of West Virginia.

\textsuperscript{85} West Virginia Code. Medical Professional Liability. §55-7B-4

\textsuperscript{86} Karpacs-Brown v. Murthy, 224 W.Va. 516, 686 S.E.2d 746 (2009)

\textsuperscript{87} Physicians must carry policies that cover them for $1 million in order for these caps to apply. Insurance does not cover punitive damages.

\textsuperscript{88} A certificate of merit is not necessary if no expert testimony is needed because the liability is considered to be well-established.
resulted in injury or death. The expert cannot have a financial interest in the lawsuit, but he/she may participate as an expert witness in any judicial proceeding.\textsuperscript{89}

The health care provider is entitled to pre-litigation mediation within forty-five days.\textsuperscript{90}

Medical malpractice cases may settle or may go to trial. Typically when a case settles, no fault or liability is established. Many settlements contain confidentiality clauses. Liability insurance companies may choose to settle to avoid the cost of going to trial. For this reason and others, settlement of a case is not proof a provider has been professionally negligent.

Trials to determine medical professional liability are decided by a lay jury and almost always involve the testimony of expert witnesses. Testimony by expert witnesses is necessary to establish whether the health care provider failed to meet the standard of care, and whether that breach proximately caused injury to the plaintiff. Expert witnesses must meet certain qualifications, including having professional knowledge and expertise about the applicable standard of care, having a current medical license, and having experience and/or training in diagnosing or treating injuries or conditions similar to those of the patient.\textsuperscript{91} These and other rules ensure that the jury can trust the testimony of the witnesses and have reasonable expectations of their knowledge and expertise surrounding the details of the case.

West Virginia averages 265 medical malpractice claims per year. Over the last twenty years, 30% of the malpractice claims have been dismissed.\textsuperscript{92} The majority of claims for malpractice are settled (62%); only about 8% go to trial.

**Complaint Process and Disciplinary Responsibility of Health Care Professional Boards**

As discussed in Section IV of this report, professional boards (including the Board of Medicine, the Board of Osteopathic Medicine, the Board of Examiners for Registered Professional Nurses, and the Board of Social Workers), have a duty to license qualified health professionals to practice in West Virginia. The Boards set standards, ensure applicants meet all requirements and issue licenses to those who are qualified. All health care professionals must have a valid license to practice in West Virginia.

Professional boards are responsible for protecting the public’s health, welfare and safety, and in order to do so, the boards must ensure that the health care professionals that they license provide appropriate and quality care. This critical regulatory role is accomplished through their disciplinary process. All boards have a formal complaint process and have the duty to investigate and take disciplinary action against a professional who violates standards of care. A complaint can be filed by the patient or any other member of the public. In addition, health professionals have a duty to lodge a complaint against one of their peers when they are

\textsuperscript{89} West Virginia Code. Medical Professional Liability. §55-7B-6
\textsuperscript{90} Ibid
\textsuperscript{91} West Virginia Code. Medical Professional Liability. §55-7B-6d
\textsuperscript{92} Medical Malpractice Report. Provided by the West Virginia Insurance Commissioner: November 2013
aware of incompetent, unethical, or illegal behavior. The boards have broad investigative powers, including the authority to “compel the attendance of witnesses, to issue subpoenas, to conduct investigations and hire an investigator and to take testimony and other evidence.”

While there might be slight differences, the overall process for addressing complaints is very similar across the professional boards. All professional boards have a complaint committee made up of members of the board. The complaint committee is responsible for processing complaints. After reviewing a complaint, several things may happen. If there are insufficient grounds for probable cause, the committee will recommend that the complaint be dismissed. If after investigating the complaint, the committee finds probable cause, a recommendation to the professional board will be made to take disciplinary action. Disciplinary action may include: reprimands, probation, continuing education, suspension, or revocation of the professional license. The board and the licensed professional (about whom the complaint has been made) may enter into a Consent Decree/agreement. The Consent Decree acts as a settlement agreement in which the health care professional (who is being disciplined) agrees to the disciplinary action.

If the health care provider refuses to accept a Consent Decree, an administrative hearing is scheduled. These are held before a hearing examiner. The hearing examiner will provide findings of fact and make a recommendation to the board. The board then issues the final order.

The boards must give the public access to all complaints, decisions, and other information. All of the professional boards make available to the public (typically easily accessible on the board’s website):

- Complaint forms and instructions;
- A description of the complaint process, including possible disciplinary actions taken;
- Other information regarding process, such as timelines for resolution, responsibilities of the board, etc.; and
- Board disciplinary actions. This information is updated on a regular basis.

In addition to reviewing complaints made by patients, physicians, or other entities, the Board of Medicine and the Board of Osteopathic Medicine may also initiate their own investigation. Both boards receive notice of malpractice claims filed against members. A certain number of malpractice judgments and settlements in a prescribed period of time will trigger an investigation by the Professional Liability Committee. The Professional Liability Committee reviews the medical records, including hospital records, records from other appropriate entities, insurance documents, etc., to determine if the physician should be referred to the complaint committee. Through this mechanism, they have the authority and responsibility to recommend to the board if the pattern of malpractice is indicative of

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93 West Virginia Code. State Administrative Procedures Act. Article 5. Contested Cases. SS30-1-5(b)

JANINE BREYEL, BA, AND NANCY TOLLIVER, RN, MSIR
professional conduct that warrants a suspension or revocation of the member’s professional license or if other disciplinary action is needed.

**Conclusion**

Protecting patients from negligent and/or incompetent health care providers is an important public safety issue. The opportunity to sue for medical negligence and the administrative authority of professional boards to take disciplinary action against those health care professionals who do not meet standards of care, are two important ways the state ensures the provision of safe health care. The two clinics providing abortion services in West Virginia have never had a malpractice judgment for medical negligence against them or a disciplinary action taken against a physician or nurse related to abortion care. As noted by Nancy Tolliver, the former executive director of Women’s Health Center of West Virginia: “Other than a recent suit filed in June 2013, there have been no serious medical or nursing complaints related to abortion against the Women’s Health Center of West Virginia in 37 years. The Center has a stellar record for medical safety; a record any medical institution would give everything to replicate.”

“Other than a recent suit filed in June 2013, there have been no serious medical or nursing complaints related to abortion against the Women’s Health Center of West Virginia in 37 years.”
OVERVIEW OF STATE LEGISLATION IMPACTING ABORTION ACCESS

Since the U.S. Supreme Court’s 1973 landmark ruling establishing a woman’s constitutional right to an abortion, states have passed a number of laws regulating the access and availability of abortion services. Not every state law decreases access to care. California passed legislation that expands the group of medical professionals who can provide abortions, allowing nurse practitioners, physician assistants, and nurse midwives to perform first-trimester procedures.94

There is no evidence that more restrictive abortion laws improve women’s health or lower the incidence of abortions. Moreover, most of the restrictive legislative actions have been challenged in court and ultimately may be overturned.

Legislation Affecting Private Physician Offices and Clinics

Twenty-eight states have passed laws that impose regulations on the private physician’s office or clinic space. These new laws often are unrelated to, and do not ensure patients’ safety. Instead they focus on such things as room size and corridor width requirements. In eighteen of these states, the regulations apply to sites where only medical abortions are provided. Many of these regulations are modeled after those applying to surgical centers where more invasive and risky procedures are performed. The new laws typically apply solely to private physician offices and clinics where abortions are provided and not to physician offices and clinics where similar types of medical procedures are done.95

Other new state laws seek to regulate the relationship between local hospitals and physicians. One of the most restrictive of these laws is the requirement that physicians who perform abortions have hospital admitting privileges. A total of nine states have passed such legislation. Such laws have gone into effect in four of the states -- Kansas, South Dakota, Tennessee and Texas. In four other states, (Alabama, Mississippi, North Dakota, and Wisconsin) federal courts have blocked implementation of the law. Arizona’s law has not taken effect.96

The requirement that physicians who provide abortion services have hospital admitting privileges has drawn particular criticism and opposition from medical experts. The American

96 Ibid.
Congress of Obstetricians and Gynecologists released a policy statement in April 2013 opposing such a requirement.\textsuperscript{97} In states where such laws have passed, state medical societies and other health organizations have voiced opposition to the law. For example, in Wisconsin the law was opposed by the Wisconsin Medical Society, the Wisconsin Hospital Association, the Wisconsin Public Health Association, the Wisconsin Academy of Family Physicians, the Wisconsin Association of Local Health Departments and Boards, and the Wisconsin Alliance for Women’s Health.\textsuperscript{98} In Texas, the law has been opposed by American College of Obstetricians and Gynecologists, the American Medical Association, and the Texas Hospital Association.\textsuperscript{99}

In its statement, the Texas Hospital Association noted that “…[A] requirement that physicians who perform one particular outpatient procedure, abortion, be privileged at a hospital is not the appropriate way to accomplish” the goal that women “receive high-quality care.…”\textsuperscript{100} ACOG and the AMA stated that: “H.B.2’s privileges requirement does not serve the health of women in Texas” and the requirement does “nothing to protect the health of women and are incongruous with modern medical practice.”\textsuperscript{101} In Wisconsin, the federal judge in his ruling upholding an earlier ruling prohibiting the application of the admitting privileges law wrote: “As noted earlier, the state has presented no evidence (that)...Wisconsin is rife with serious complications from abortion and requiring admitting privileges to hospitals within short distances of abortion clinics is essential to preventing such complications.”\textsuperscript{102}

**Legislation on the Provision of Medical Abortion**

The U.S. Food and Drug Administration (FDA) approved the use of mifepristone for early non-surgical abortion in 2000. Since that time, more and more women have chosen this less
invasive form of abortion. However, several states have enacted restrictions targeting medical abortions. These are summarized below.¹⁰³

Thirty-nine states require clinicians who perform medical abortion procedures to be licensed physicians. (This is despite the fact that the World Health Organization and the National Abortion Federation recommend that midlevel practitioners can safely provide medical abortions.)

Two states require mifepristone to be provided in accordance with outdated FDA protocol rather than the simpler evidence-based protocol that has been proven to be safe and effective. (ACOG and AMA wrote in their *Amicus Brief* challenging this provision of the Texas law: “As a result of three decades of studies of various medical abortion regimens, a number of evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA over 13 years ago. .... It is common for medical practice to advance beyond what is described on FDA drug labels. The FDA allows “off-label” use of registered products...when existing medical evidence supports such use.”¹⁰⁴ Off-label prescribing is a common legal practice.¹⁰⁵

**Bans on Later Abortions**

Twenty-three states have passed laws that place unconstitutional limits¹⁰⁶ on abortion at specific gestational age. Lower courts in three of the states have struck down the law. The U.S. Supreme Court refused to hear Arizona’s appeal, so the lower court’s ruling will stand. The rulings in the other two states could be overturned on appeal.

Some of these laws that ban abortions in the second trimester and before viability are based upon a claim that fetuses can feel pain. However, findings demonstrate that the neural structures needed to feel pain are not present at that stage of fetal development.¹⁰⁷

Most of these bans include exceptions to save the life or physical health of the woman.¹⁰⁸

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¹⁰⁶States have the right to ban or limit abortions after the fetus is viable, but the U.S. Supreme Court has held that even after fetal viability, states may not prohibit abortions “necessary to preserve the life or health” of the woman and that it is only her physician who can decide if the fetus is viable and what constitutes “health.”
Effects of Legislation Limiting Abortion Access: Litigation, Interference in Patient-Physician Relationship, and Harm to Woman

As noted, many of the laws passed in states have resulted in lawsuits and appeals, and such litigation is expected to continue at great expense. Currently, a significant number of state laws are enjoined by court order and may not be put in effect pending final court decisions. Some laws have been found to be unconstitutional, but laws similar to those that have been struck down are in effect in other areas of the country. Many believe that provisions of the Texas law that are currently being challenged in U.S. Circuit Court will end up at the U.S. Supreme Court level.

Implementation of these new laws restricting access to abortion care has negatively impacted the provision of health care for countless women and families. Over 50 clinics (many of which provided critical services including cancer screening and family planning) have either closed or stopped performing abortions since 2010 when the passage of these types of laws began in earnest. While some of the closures are unrelated to the new requirements, the states that have lost the most clinics are the same ones that have passed new abortion restrictions and cut state family planning budgets. For example, nine clinics have closed in Texas and twelve in Arizona. Women in rural areas are disproportionately negatively affected. Women must travel over 150 miles in areas of Texas and Arizona now to obtain abortion care. Mississippi and North Dakota, two rural states with only one abortion clinic each, may soon not have any providers. The continued existence of each clinic in both states is in jeopardy awaiting court decisions.

After abortion services were made legal and access to safe care became available, the 1970s saw a reduction in abortion-related complications and deaths as American women no longer needed to resort to clandestine services. It is unclear what impact the closing of clinics will ultimately have if safer options are no longer accessible to women living in these states. However, we do know that restricting access has little to no effect on demand and, if we have learned anything from history both far and recent, restriction to safe and legal abortion care has resulted in too many incidents of harm and unsafe conditions for women.

Conclusion: Costly and Unnecessary Over-Regulation is Ineffective and Harmful

The last few years have seen an unprecedented amount of state legislation to restrict access to abortion care. While many of these laws were passed under the guise of protecting women’s health and safety, many medical professionals worry they may have the opposite effect. They have expressed concern that they interfere with patient care, medical decisions and the patient-physician relationship. ACOG’s Statement of Policy notes that such “legislative interference affects all physicians, not just obstetricians-gynecologists.” Instead of protecting women, passage of these and other laws seems to invite years of litigation in state and federal courts and prevent the most vulnerable of women from accessing a full range of reproductive services, including abortion care.

The costs to states, including the high price of litigation to fight challenges to the laws, the additional financial burdens on state departments of health to meet new licensure and certification obligations, and the increases in the number of unintended pregnancies as abortion becomes more expensive and more difficult to obtain, may in the end be very high.

Kansas has spent more than $913,000 to defend anti-abortion laws and such expenses appear likely to grow. Idaho has spent $1 million since 2000 defending its laws restricting abortions. South Dakota’s attorney general estimated the abortion law passed in 2011 will cost $1.75 million to $4 million to defend. In North Dakota, the attorney general requested $400,000 to defend the state’s abortion restrictions.

Unintended pregnancies cost taxpayers 11.1 billion dollars a year. In 2006, 43% of the births in West Virginia were unintended. Of those, 72% were publicly funded. At $10,999

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114 Ibid.
per birth, the costs of unintended pregnancy to the state are already alarmingly high.\textsuperscript{117} “Unintended births also have numerous undesirable consequences including low birth weight, a greater risk of physical abuse and mental illness, and high rates of poverty, unemployment and educational failure.”\textsuperscript{118} Clearly, restricting access to a safe, legal and relatively inexpensive procedure is not in the best interest of a woman who is not prepared, for whatever reason, to carry the pregnancy to term. Moreover, restricting access to abortion causes financial burdens, not only to individual families, but to the State.


WHAT DO HEALTH CARE PROVIDERS THINK?

Excellence in women’s health is an essential element of the long-term physical, intellectual, social and economic well-being of any society.

This is the fundamental doctrine of the American Congress of Obstetricians and Gynecologists (ACOG). Yet in recent years, ACOG has expressed concern that concerted legislative efforts directed at women’s reproductive rights are threatening the ability to ensure excellence in women’s healthcare. The following statements are supported by Dr. Stephen Bush, Chairman of West Virginia Section, District IV of ACOG and have been published by the national office.

ACOG is an advocate for women’s health. We work tirelessly at both the state and federal level to combat ill-conceived legislation intended to erode women’s reproductive rights. We maintain our position that decisions about an individual’s medical care are best made between the patient and his or her physician. Women should have access to all needed health care—ranging from mammograms to prenatal visits to reproductive care—that is based on scientific facts, not political ideology.119

The continuous onslaught of laws focusing exclusively on denying reproductive health care rights is a concerted campaign against women. These laws are not grounded in science or evidence-based medicine.120

As physicians for women’s health care, ob-gyns see firsthand the havoc that punitive ideology-based laws have on the health of women and their families. These ill-conceived laws are based on the pretext of protecting health, but they do anything but that.121

ACOG opposes any government interference that threatens communication between patients and their physicians or other health care providers. ACOG also objects to laws that interfere with the patient’s right to be counseled according to the best currently available evidence-based guidelines and the physician’s professional medical judgment.122

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121 Ibid.
ACOG opposes legislation or other requirements that single out abortion services from other outpatient procedures. For example, ACOG opposes laws or other regulations that require abortion providers to have hospital admitting privileges. ACOG also opposes facility regulations that are more stringent for abortion than for other surgical procedures of similar low risk.\(^{123}\)

ACOG President Jeanne A. Conry, MD, PhD said, “Given the relentless legislative assault on the patient-physician relationship that we’ve seen in the past few years - and unfortunately continue to see - we were compelled to issue a formal Statement of Policy. A disproportionate number of these types of laws are aimed at women’s reproductive rights and the physicians that provide women’s health care services.”\(^{124}\)

“We are speaking out not just on behalf of ob-gyns, but for all physicians and patients,” said Dr. Conry. “Many of these laws are dangerous to patients’ health and safety. As physicians, we are obligated to offer the best evidence-based care to our patients. Government should stay out of imposing its political agenda on medical practice.”\(^{125}\)

“ACOG opposes legislative interference, and strongly believes that decisions about medical care must be based on scientific evidence and made by licensed medical professionals, not the state or federal government,” said ACOG Executive Vice President Hal C. Lawrence, III, MD.\(^{126}\)

“Women’s reproductive rights have come under a nearly unprecedented attack, not only in Texas but throughout the United States,” says ACOG Executive Vice President Hal C. Lawrence, III, MD. “It’s a pivotal moment in time, and it’s critical that ACOG clearly and loudly stand up for the rights of women to make personal and informed choices about their health care in consultation with their physicians. Women must have access to quality care without interference from politicians. Anything less would be a disservice to our patients.”\(^{127}\)


\(^{125}\)Ibid.


Clearly, the professionals who specialize in providing women’s health care do not support restricting access through unnecessary regulation of abortion services.
WHAT DO WEST VIRGINIA VOTERS THINK?

In November 2013, a poll of West Virginia voters found most do not support more regulations intended to restrict access to abortion clinics.

According to the poll, 49 percent of voters in West Virginia oppose adding more restrictions to the state's abortion clinics. Only twenty-eight percent of people support more restrictions, while 23 percent are not sure.

The survey also found that more West Virginians disapprove of Attorney General Patrick Morrisey after hearing that he proposed more regulations for abortion providers in the state. After being told that Morrisey is proposing increased abortion clinic regulations and that "medical experts say that these are intended to make it more difficult and more expensive for the health centers to stay open, which could threaten women's access to medical care," 45 percent indicated that they disapproved of the job Morrisey is doing as attorney general, (compared to 32 percent who disapproved prior to learning he was trying to increase regulations that may restrict access), 32 percent approve, and 23 percent were not sure.

West Virginians are not in favor of more regulations intended to restrict access to abortion care.

According to a 2013 statewide poll of West Virginia Voters, West Virginians are not in favor of more regulations intended to restrict access to abortion care.

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CONCLUSION

Abortion is a safe medical procedure. Furthermore, despite claims to the contrary, all West Virginia health professionals, including those who work in private practice settings where abortion care is provided, are licensed and regulated. As discussed in this report, mechanisms in the form of medical negligence and the disciplinary authority of medical and health professional boards are in place that ensure oversight of all health care professionals. There has never been a malpractice judgment nor disciplinary action taken against physicians or other health professionals related to abortion services. A recent review of emergency room data revealed an extremely low number of women presenting with complications from abortions. In the absence of evidence of a health or safety need, there is no legitimate basis for further regulating this one procedure.
ABOUT THIS REPORT

This report was researched and written by Janine Breyel, a health policy consultant located in Morgantown, West Virginia and Nancy Tolliver, RN, MSIR. Developed with the help and guidance of many state and national experts, the information presented in the document was obtained through extensive literature reviews and through numerous phone calls and interviews with health professionals across the state. The authors are grateful for all the assistance they were provided by the many who offered their time and expertise.