AAPLOG

AAPLOG Policy Statement

The Women's Health Protection Act of 2021

Pregnancy is not a disease and abortion is not healthcare. Despite what proponents of the procedure may claim, elective abortion carries no maternal benefit and ends the life of a pre-born human being. As demonstrated by hundreds of studies and years of data collection, abortive procedures carry several deleterious effects for women, with a statistically greater impact on minority populations. The effects of abortive procedures are harmful to women throughout their lifespan, and are the catalyst for a myriad of fertility and health issues for women across demographics and social strata.

Abortion guarantees the ending of the life of one of our patients – and severely threatens the life and health of the other. Science is clear that a new, distinct, and living human being comes into existence at the moment of fertilization - thus I have two patients I'm caring for. Dr. Ward Kischer, the author of one of my medical school textbooks, said this: "Every human embryologist in the world knows that the life of the new individual human being begins at fertilization…It is a scientific fact."[1] Abortive procedures are more than detrimental to the life of the pre-born child, though - they are also dangerous to the mother both in the short and long-term.

Abortion proponents often claim that women are dying because they can't readily access abortion and that by increasing access, we will lower maternal mortality rates. Extremely poor

[1] Kirscher, C. W. (2020, July 17). *When Does Human Life Begin? The Final Answer*. American Life League. https://www.all.org/learn/stem-cells/when-does-human-life-begin-the-final-answer/.

data collection on maternal deaths and their causes in the United States has led to claims that abortion is safer than childbirth.[2] These claims, like so many others from pro-abortion advocates, are based on inaccurate and poorly collected data.

One argument posed by those in favor of the Women's Healthcare Protection Act centers upon the need for increased access to abortion for minority communities. In taking a closer look at the these claims, it is clear that this argument is not only disproven by science - it serves to further target minorities by creating even higher rates of elective abortion and will lead to greater rates of maternal mortality – something that is already unacceptably high in the US. It is noteworthy that there are significant differences in birth outcomes in Black women compared with non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in black women end in induced abortion, compared to 11% for white women. [3]

Less than half of pregnancies in black women result in the birth of a live baby (48%). Induced abortion is 3.7 times more common in Black than in non-Hispanic white women, and Black women more commonly have later abortions (13%) compared with white women (9%). It is known that the risk of death from induced abortion increases by 38% for every week after eight weeks gestation. [4] It is possible that the higher rate of legal induced abortion may account for most of the racial disparity noted in pregnancy mortality. This data, especially in relation to

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[2] Professional Ethics Committee of AAPLOG. (2019). *Induced Abortion & the Increased Risk of Maternal Mortality.* [Commitee Opinion]. American Association of Obstetricians & Gynecologists.https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-Abortion-Increased-Risks-of-Maternal-Mortality.pdf

[3] Ibid.

[4] Professional Ethics Committee of AAPLOG. (2019). *Induced Abortion & the Increased Risk of Maternal Mortality.* [Commitee Opinion]. American Association of Obstetricians & Gynecologists.https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-Abortion-Increased-Risks-of-Maternal-Mortality.pdf

abortion's effects on maternal mortality, unequivocally support banning elective abortions in the 2nd and 3rd trimester ("late term abortions").

When looking at countries where aggressive and transparent data collection is performed, a starkly different reality is presented. According to a 2016 study conducted in Finland, then published in the British Journal of Obstetrics and Gynecology, after termination of pregnancy (abortions), mortality rates were highest for all but medical causes. For example, the mortality rate for external causes was 8.1/100 000 among pregnant women and after pregnancies ending with delivery, whereas after termination of pregnancy, the mortality was sixfold higher (49.5/100 000). Importantly, for all pregnancy outcomes, in all age groups under 40, mortality rates were highest after termination of pregnancy.[5]

A study by Koch, et al, of maternal mortality data from 32 states in Mexico revealed that laws that restrict abortion do not lead to an increase in maternal mortality - a claim that is made by many who oppose state abortion restrictions. Koch's study showed that states with less permissive abortion legislation exhibited lower maternal mortality ratios (MMR) overall (38.3 vs 49.6; $p<0.001$), MMR with any abortive outcome (2.7 vs 3.7; $p<0.001$) and induced abortion mortality ratio (0.9 vs 1.7; $p<0.001$) than more permissive states.[6]

Geographically diverse countries - such as El Salvador, Chile, Poland, and Nicaragua - which prohibit abortion after having previously allowed it, have not seen their maternal mortality

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[5] Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population−based register study of pregnancy−associated deaths in Finland 2001–2012. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(7), 1115-1121.

[6] Koch E, Chireau M, Pliego F,et al. Abortion legislation, maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal deaths: a natural experiment in 32 Mexican states.BMJ Open2015;5:e006013. doi:10.1136/bmjopen-2014-006013.

worsen. In fact, maternal mortality has improved. South Africa, on the other hand, has seen maternal mortality worsen after the legalization of abortion after its longstanding prohibition. [7]

The ramifications of abortions for women stretch beyond the short-term risks of the current pregnancy, and into later pregnancies through the rise of pre-term birth in women who have undergone abortive procedures. The Institute of Medicine has listed induced abortion as an *immutable* risk factor for preterm birth (PTB).[8]

This increased risk of preterm birth is especially impactful in the African American population which already has a 3-4x higher abortion rate and a 2x higher preterm birth rate than Caucasians.[9]

The abortion-PTB link has been proven by more than 160 studies over 50 years. This doesn't just impact the woman's future children, it also impacts her. Mothers who deliver preterm are at a higher risk of medical complications later in life, including cardiovascular disease and stroke.[10]

Non-Hispanic black race (compared with non-Hispanic white race) is a consistent risk factor for preterm birth and adverse pregnancy outcomes in the United States. The risk associated with race

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[7] Hogan MC, Foreman KJ, Naghavi M,et al. *Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5.* Lancet 2010; 375: 1609–23

[8] Butler, A. S., & Behrman, R. E. (Eds.). (2007). *Preterm birth: causes, consequences, and prevention*. National Academies Press.

[9] Schaaf JM, Liem SM, Mol BW, Abu-Hanna A, Ravelli AC. *Ethnic and racial disparities in the risk of preterm birth: a systematic review and meta-analysis*. Am J Perinatol. 2013 Jun; 30(6):433-50.

[10] Manuck TA. *Racial and ethnic differences in preterm birth: A complex, multifactorial problem.* Semin Perinatol. 2017;41(8):511-518. doi:10.1053/j.semperi.2017.08.010

is significant; in a large systematic review of 30 studies, black women were found to have a 2-fold increased risk (95% CI: 1.8–2.2; pooled odds ratio) compared with whites.[11]

Surgical abortions increase a woman's risk of preterm birth in future pregnancies by approximately 35% after one abortion and up to 90% after two abortions. Medication abortions that have to be completed surgically (up to 20% in some studies) increase a woman's risk of preterm birth by up to 300%.[12]

The National Academy of Science (NAS) report on abortion safety, which claimed no increased risk of preterm birth from induced abortion, chose only 5 studies to look at, despite the 160 statistically significant studies that show a link between induced abortion and preterm birth. Even by NAS's narrow inclusion criteria, 70 of these studies should have been included but weren't, and without explanation as to why.[13]

In addition to the physical ramifications of abortive procedures, there is also a direct relationship between abortions and mental health complications. As America battles its largest mental health pandemic to date, it is appalling that lawmakers would push legislation that further threatens the mental health of Americans.

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[11] Schaaf JM, Liem SM, Mol BW, Abu-Hanna A, Ravelli AC. *Ethnic and racial disparities in the risk of preterm birth: a systematic review and meta-analysis*. Am J Perinatol. 2013 Jun; 30(6):433-50.

[12] Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Risks of Preterm Birth.* [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. https://aaplog.org/wp-content/uploads/2019/12/FINAL-PRACTICE-BULLETIN-5-Abortion-Preterm-Birth.pdf

[13] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Board on Population Health and Public Health Practice; Committee on Reproductive Health Services: Assessing the Safety and Quality of Abortion Care in the U.S.. The Safety and Quality of Abortion Care in the United States. Washington (DC): National Academies Press (US); 2018 Mar 16. Available from: https://www.ncbi.nlm.nih.gov/books/NBK507236/ doi: 10.17226/24950.

From 1993 to 2018, there were 75 studies examining the abortion-mental health link, of which two-thirds showed an increased risk of mental health complications after abortion. The NAS report ignored the majority of these, choosing, instead, to review only 7 studies. 5 of these studies were derived from the same group of women - the Turnaway cohort. There are several well-known problems with the Turnaway cohort.

First, the Turnaway studies were led by abortion activist Dr. Daniel Grossman, who has well-known extensive financial ties to the abortion industry. The cohort itself had poor participation rates and a high attrition rate - only 37% of women responded and an additional 44% dropped out - leaving a cohort of only 17% of those surveyed and increasing the risk of self-selection bias towards women less wounded by their abortions. The cohort also left out important demographic factors known to increase the risk of adverse mental health outcomes, such as gestational age at the time of abortion - a late term abortion is a significant risk factor for psychiatric distress after an abortion, supporting the calls for bans on abortions after the first trimester.[14]

If the 14 risk factors for adverse mental health outcomes determined by the American Psychological Association are applied to women seeking abortions, then the majority of women who abort are at risk for adverse mental health outcomes.[15]

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[14] Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health.* [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf

[15] American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the Task Force on Mental Health and Abortion. Washington, DC: Author.* Retrieved from http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf

The most comprehensive review of available literature by Coleman showed that 49/75 of the studies (65%) showed a positive correlation between abortion and adverse mental health outcomes. Abortion significantly increases the risk for depression, anxiety, substance abuse and suicidal ideation and behavior - even when compared to women with unintended pregnancies who carried to term.[16] The Finland study on maternal mortality showed an alarming 7x higher suicide rate after abortion when compared to giving birth - the mortality rate for suicides was 3.3/100 000 in ongoing pregnancies and pregnancies ending in birth while it was 21.8/100 000 after termination of pregnancy and 10.2/100 000 among non-pregnant women.[17]

There is consensus amongst most social science scholars that a minimum of 20-30% of post-abortive women suffer from serious, prolonged negative psychological consequences - yielding at least 260,000 new cases of mental health problems each year.[18] Given the current mental health crisis in the US, it is especially irresponsible for certain lawmakers to exacerbate the mental peril of the COVID-19 pandemic by increasing access to procedures known to be harmful to patients regardless of race or social demographic.

Women seeking abortions deserve the same level of healthcare as any other woman. The cases of patient mistreatment, of physicians practicing outside of their area of expertise and of abandonment by abortion centers after the conclusion of the procedure is unacceptable,

[16] Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health.* [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf

[17] Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population−based register study of pregnancy−associated deaths in Finland 2001–2012. *BJOG: An International Journal of Obstetrics & Gynaecology*, *124*(7), 1115-1121.

[18] Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health.* [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf

unethical, and irresponsible. The ramifications of these procedures are not felt by the providers of abortions, or by their clinics, but instead by the women undergoing the procedures who are left alone and in the dark as to how, when or where to seek treatment when complications unavoidably arise.[19]

A large component of this issue lies in the abortion industry, and medical organizations claiming to be working to provide the highest level of care for women in the United States. A glaring example of the politicization, and turning away from acceptable care can be found in the largest medical membership organizations in the United States for obstetricians and gynecologists, of which I was once a member.

While the American College of Obstetricians and Gynecologists (ACOG) claims to represent all OB/GYN's in the US and to be the standard setting organization for the practice of obstetrics, they have a clear double standard when it comes to abortion and they have never supported a single abortion restriction or safety regulation.[20]

The risks of abortion increase significantly the farther along in pregnancy a woman is, and so accurate assessment of her gestational age is crucial. In their Committee Opinion #815, titled "Increasing Access to Abortion", ACOG states that ultrasounds are "medically unnecessary" prior to abortions. [21] Yet, their own Committee Opinion on establishing due dates in pregnancy

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[19] Brief of Amicus Curiae American Association of Pro-Life Obstetricians and Gynecologists in Support of Rebekah Gee, Secretary, Louisiana Dept. of Health and Hospitals, Case Nos. 18-1323 & 18-1460. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/126927/20191227154424488_AAPLOG%20Amicus%20Brief.pdf

[20] Ibid.

[21] Committee on Health Care for Underserved Women. (2020). *Increasing Access to Abortion.* [Committee Opinion]. American College of Obstetricians & Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion

states that only approximately 50% of women will be able to accurately recall their last menstrual period - and a pregnancy without an ultrasound examination that confirms or revises the estimated due date before 7 weeks of gestational age should be considered sub-optimally dated.[22]

ACOG also claims that admitting privileges or formal patient handoffs are medically unnecessary for women experiencing abortion complications. [23] And yet, their Committee Opinion #517 "Communication Strategies for Patient Handoffs" states "Patient handoffs are a necessary component of current medical care...Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety...One of the leading causes of medical errors is a breakdown in communication...One predictable and critical communication event is the patient handoff. A handoff may be described as the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians."[24]

In ACOG's Practice Bulletin 225 on Medication Abortion, they state that if a woman has an Rh negative blood type and obtaining Rhogam (a medication critical to prevent future pregnancy

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[22] Committee on Obstetric Practice. (2017). *Methods for Estimating Due Date.* [Committee Opinion]. American College of Obstetricians & Gynecologists. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf

[23] Brief of amici curiae American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, American College of Nurse-Midwives, American College of Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Society for Reproductive Medicine, National Association of Nurse Practitioners in Women's Health, North American Society for Pediatric and Adolescent Gynecology, and Society for Maternal-fetal Medicine in Support of Petitioners, Case No. 18-1323. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/100434/20190520175434029_18-1323%20ACOG%20et%20al.%20cert.%20amicus%20brief.pdf

[24] Committee on Patient Safety and Quality Improvement (2007). *Communication Strategies for Patient Handoffs*. [Committee Opinion]. American College of Obstetricians & Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/communication-strategies-for-patient-handoffs

complications) would “significantly delay a medication abortion”, it is acceptable to not give Rhogam after “shared decision making” with the patient - despite known risk to future pregnancies and their recommendations that Rh negative women experiencing first trimester miscarriage be given Rhogam.[25]

ACOG opposes mandatory waiting periods before abortions, and yet the data support that many women are either unsure of their decision or pressured into it.[26] A 2004 study that spoke with women who had undergone abortions in the US showed the importance of waiting periods, increased counseling and in person visits in order to screen for coercion[27]:

- 67% stated they received no counseling prior to their abortion
- Only 11% felt that the counseling they received prior to their abortion was adequate
- Only 17% were counseled on alternatives
- 64% of women responded that they felt pressured to have the abortion
- 54% of women were unsure about their abortion decision at the time
- 30% of women who responded had health complications after their abortions
- 36% of women had suicidal ideations after their abortions and 54% felt bad about their decision
- 60% of women stated that they felt "part of me died"
- Only 4% claimed to feel more in control of their life after their abortion

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[25] Committee on Practice Bulletins. (2014). *Medication Abortion Up to 70 Days of Gestation.* [Practice Bulletin]. American College of Obstetricians & Gynecologists. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf

[26] Committee on Health Care for Underserved Women. (2014). *Increasing Access to Abortion.* [Committee Opinion]. American College of Obstetricians & Gynecologists. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion

[27] Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Medical Science Monitor*, 10(10), SR5-SR16.

As physicians, the right of conscience operates as the cornerstone of responsible practice. The right of physicians to choose rather or not to perform procedures based on not only our consciences, but also based on our best medical judgment, is pertinent to professional medical practice. As a physician that practices on the grounds of the Hippocratic Oath, I swore to protect all patients - and to not intentionally end the life of or harm my patients. Abortion is not a part of essential women's healthcare and physicians should not be forced to perform it.

The most recent survey of OB/GYN's in private practice indicates that only 7% perform abortions.[28] Abortion can't possibly be essential women's health care if more than 90% of women's health care specialties don't perform it. Furthermore, contrary to popular rhetoric from abortion activists, there is absolutely no need for abortions beyond viability - even to save the life of the mother.

In this case, we would just deliver the baby and care for both baby and mom. The sole intent of an abortion is to produce a dead fetus, not a live birth. A preterm (or even previable) delivery of an intact fetus in order to save the life of the mother is not at all the same thing as intentionally ending the life of the fetal human being (often through the means of dismemberment).

Laws like the WHPA are not needed in order to allow physicians to save the life of the mother in the rare circumstances that this is needed. Establishing a right for all women to access abortions for any reason and at any time also necessarily requires that physicians and healthcare institutions provide abortions - which is in direct violation of federal conscience protections. We

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[28] Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. *Contraception*. 2018 Apr;97(4):297-302. doi: 10.1016/j.contraception.2017.11.004. Epub 2017 Nov 21. PMID: 29174883; PMCID: PMC5942890.

oppose any efforts that would force us to recommend or perform procedures that end the life of one of our patients and significantly harm the other.