



Written testimony of Christina Francis, MD, for the Senate HELP Committee hearing on “The Assault on Women’s Freedoms: How Abortion Bans Have Created a Health Care Nightmare Across America”

June 4, 2024

Chairman Sanders, Ranking Member Dr. Cassidy, and Members of the Committee,

Thank you for the opportunity to submit testimony on behalf of myself, as a board-certified OB/GYN, and on behalf of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), a professional medical organization with more than 7,000 members across the country and internationally, for which I serve as CEO. I thank you for the chance to offer my expert analysis on the impact of laws protecting life on the healthcare of my patients.

Our country is divided over the issue of abortion, but I do think that there is common ground to be found. However, in order to work together to improve the health and lives of American women, we must ensure that women and physicians are receiving accurate information – beginning with not making women feel that the Supreme Court’s *Dobbs* decision has led to a nightmare for their healthcare. One thing we should all be able to agree upon is that women deserve excellent healthcare and to be empowered with accurate information to inform that healthcare. Prior to the *Dobbs* decision in 2022, we had nearly unfettered access to abortion for 49 years and yet we had one of the worst maternal mortality rates¹ in the developed world, along with the worst preterm birth rate.² My patients deserve better, and it is time for us to look for real solutions to the root causes of these problems.

As OB/GYN physicians, we care for two patients during pregnancy. Abortion guarantees the ending of the life of one of our patients – and can severely threaten 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. 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.”³

¹ Tikkannen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). Maternal mortality and maternity care in the United States compared to 10 other developed countries. Maternal Mortality Maternity Care US Compared 10 Other Countries | Commonwealth Fund. Retrieved July 16, 2022, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#:~:text=In%202018%2C%20there%20were%2017,%2C%20Norway%2C%20and%20New%20Zealand>

² March of Dimes. (n.d.). Born too soon global map. Global Map. Retrieved July 16, 2022, from <https://www.marchofdimes.org/mission/global-preterm.aspx>

³ Kirscher, C. W. (2020, July 17). When Does Human Life Begin? The Final Answer. American Life League. <https://www.all.org/learn/stemcells/when-does-human-life-begin-the-final-answer/>.

A 2018 survey showed that 95% of more than 5000 human biologists were in agreement that life begins at fertilization.⁴ This is not a matter of opinion or political persuasion – it is a matter of science. Notably, this held true regardless of the biologist’s position on abortion or political affiliation.

As a practicing OB/GYN hospitalist, I manage both low- and high-risk pregnancies. I have sat with my patients during the best and worst times of their lives – including when facing a potentially life-threatening complication of a very wanted pregnancy. The decision to intervene in these situations, especially preterm, is extremely difficult and not one that I take lightly. I have sat on the edge of my patient’s bed, crying with her, as we discussed why we couldn’t wait even one or two more weeks, when her baby might survive, to deliver her. After doing everything possible to maximize both her and her baby’s health, sometimes we have to intervene, even knowing it’s too early for her baby to survive. But in all these discussions, we don’t talk about doing an abortion – because our intent in intervening is not to end the life of her child. Even in those situations where we deliver before the baby can survive, we do so in a way that respects the dignity of the lives of both the mother and her child. This is how I’ve practiced for nearly two decades and I’ve always been able not only to provide excellent care to my patients but also to intervene at the first sign of a potentially life-threatening complication.

Abortive procedures aren’t detrimental only to the life of the preborn child; they are also dangerous to the mother both in the short and long term. Pregnancy is not a disease and induced abortion is not healthcare. Despite what proponents of abortion may claim, induced abortion carries no maternal health benefit and ends the life of a separate human being. As demonstrated by hundreds of studies over nearly five decades, abortive procedures carry several deleterious effects for women, including increasing the risk of preterm birth and mental health problems. These problems have a statistically greater impact on minority populations.

The effects of induced abortions impact women throughout their lifespans, and as board-certified physicians, we believe that our patients’ health will be improved if they receive actual healthcare – not the devastation and false promises of abortion. In fact, induced abortion exists to solve a social problem, not a medical one.

Since the *Dobbs* decision overturned *Roe* and *Casey*, there have been repeated claims that restricting abortion will lead to women dying and that by increasing access to abortion we can decrease maternal mortality rates. These statements, meant to instill fear in women and medical professionals, are baseless for several reasons.

⁴ Jacobs, Steven and Jacobs, Steven, Biologists’ Consensus on ‘When Life Begins’ (July 25, 2018). Available at SSRN: <https://ssrn.com/abstract=3211703> or <http://dx.doi.org/10.2139/ssrn.3211703>

Maternal Mortality

First, extremely poor data collection on maternal deaths and their causes, as well as inaccurate data on the number of abortions performed in the United States, have led to false claims that abortion is safer than childbirth.⁵

Abortion proponents claim that restricting abortion has a disparate negative impact on minority women. In taking a closer look, however, it is clear that this argument is not only disproven by science, but it also serves to further target minorities by creating even higher rates of induced abortion which will contribute to greater rates of maternal mortality – something that is already unacceptably high in the United States. It is noteworthy that there are significant differences in birth outcomes in black women when 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.⁶

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 women 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.⁷ It is possible that the higher rate of legal induced abortion for black women may account for a significant portion of the racial disparity noted in pregnancy mortality. This data, especially in relation to abortion's effects on maternal mortality, unequivocally support preventing induced abortions at least in the 2nd and 3rd trimester (later abortions).

When looking at countries where comprehensive and transparent data collection is performed, a much clearer picture of the impact of abortion is presented. According to a 2016 study conducted in Finland and published in the British Journal of Obstetrics and Gynecology, after termination of pregnancy (induced abortions), mortality rates were the highest (other than for deaths from chronic medical problems). 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.⁸

⁵ Professional Ethics Committee of AAPLOG. (2019). Induced Abortion & the Increased Risk of Maternal Mortality. [Committee Opinion]. American Association of Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-AbortionIncreased-Risks-of-Maternal-Mortality.pdf>

⁶ Ibid.

⁷ Professional Ethics Committee of AAPLOG. (2019). Induced Abortion & the Increased Risk of Maternal Mortality. [Committee Opinion]. American Association of Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-AbortionIncreased-Risks-of-Maternal-Mortality.pdf>

⁸ 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.

A study of maternal mortality data from 32 states in Mexico by Koch, et al., 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 laws exhibited lower maternal mortality ratios (MMR) overall (38.3 vs. 49.6), MMR with any abortive outcome (2.7 vs. 3.7), and induced abortion mortality ratio (0.9 vs. 1.7) than more permissive states.⁹

Geographically diverse countries – such as El Salvador, Chile, Poland, and Nicaragua – which prohibit abortion after previously allowing it, have not seen their maternal mortality 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.¹⁰

Treating potentially life-threatening conditions in pregnancy – clearing up misinformation

False claims abound that state abortion restrictions will prevent physicians from being able to treat ectopic pregnancies, miscarriage, and other life-threatening complications in a pregnancy (such as an intrauterine infection). This is blatantly absurd, as not a single state law restricting abortion prevents treating these conditions.

According to the Royal College of Obstetricians and Gynaecologists (RCOG) “When undertaking a termination of pregnancy, the intention is that the fetus should not survive and that the process of abortion should achieve this.”¹¹ Our intent when we treat an ectopic pregnancy or other life-threatening conditions in pregnancy is to save the life of the mother, not to directly end the life of the embryonic or fetal human being. Therefore, these are not abortions, a fact even Planned Parenthood acknowledges.¹² Life-threatening conditions in pregnancy most commonly occur after the point of viability (where the fetus can survive outside of the mother’s womb). In these situations, it is absolutely ludicrous to suggest that an induced abortion is needed. We simply deliver the mother and provide care for both her and her baby – something that is not only consistent with the oath we took as physicians to never intentionally harm our patients, but is also much more expedient than an abortion procedure at this stage of pregnancy. In the rare, but real, circumstances where this occurs prior to the point of viability (now 21-22 weeks in some centers), we can provide life-saving care to the mother in a way that also respects the dignity of her preborn child. Again, these interventions are not prevented by any law in this country.

⁹ 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 Open* 2015;5:e006013. doi:10.1136/bmjopen-2014-006013.

¹⁰ 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

¹¹ Royal College of Obstetricians and Gynaecologists, “Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales,” at 29 (2010), available at: https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport_18may2010.pdf

¹² <https://www.plannedparenthood.org/learn/pregnancy/ectopic-pregnancy>

A miscarriage, though medically coded as a *spontaneous* abortion, is a condition in which the embryonic or fetal human being has already passed away and therefore any treatment of a miscarriage would not be an induced abortion. For the 93%¹³ of practicing OB/GYNs who do not perform abortions but have always been able to offer life-saving treatment to women, we can still do so, regardless of state laws on abortion. Our medical expertise and years of training make it very possible for us to discern when we need to intervene to save a woman's life, and competent physicians, either on their own or in consultation with colleagues and subspecialists, who are monitoring their patients closely will be able to make this determination well before death is imminent. All OB/GYN residents are already trained in the procedures and treatments necessary to evacuate a woman's uterus when medically indicated, and laws restricting abortion will not impact this in any way. Specific training in induced abortion aimed at ending the life of our fetal patient is not needed.

Spurious claims of impact on physician numbers

Recently, an article from the Association of American Medical Colleges that looked at medical residency application numbers for the 2023-2024 cycle has been gaining a lot of attention. The article details how overall application numbers dropped, but that the drop was more dramatic in states with laws preventing abortion than in those with no abortion regulations.¹⁴ The authors imply that this drop is because of those states' abortion laws. However, correlation is not causation. There are many factors that likely contributed to this decrease. Leading these factors is that this has been an "intentional goal" of the AAMC ERAS (residency match) system as well as individual specialties for several years – to decrease the number of applicants/residency spot. The report acknowledges that all residency programs filled, and OB/GYN actually saw an overall increase (albeit small). If medical students are avoiding states with pro-life laws, it also is likely because of the wealth of misinformation about being able to provide women with life-saving care in those states.

Impact of induced abortion on women's health

As stated previously, pregnancy is not a disease and induced abortion is not healthcare. It is not even a neutral option. The ramifications of abortions for women stretch beyond the short-term risks of the current pregnancy and into later pregnancies through the rise of preterm birth in women who have undergone abortive procedures. The Institute of Medicine (now known as the National Academy of Medicine) has listed induced abortion as an *immutable* risk factor for preterm birth (PTB).¹⁵ This increased risk of preterm birth is especially impactful in the black

¹³ 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.

¹⁴ <https://www.aamcresearchinstitute.org/our-work/data-snapshot/post-dobbs-2024>

¹⁵ <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy>

population, which has a 3-4x higher abortion rate and a 2x higher preterm birth rate than Caucasians.¹⁶

The association between abortion and PTB has been shown in more than 160 studies over 50 years. This doesn't just impact the woman's future children; it also impacts the woman herself. Mothers who deliver preterm are at a higher risk of medical complications later in life, including cardiovascular disease and stroke.¹⁷

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 is significant; in a large systematic review of 30 studies, black women were found to have a 2-fold increased risk of PTB (95% CI: 1.8-2.2; pooled odds ratio) compared with non-Hispanic whites.¹⁸ Surgical abortions increase a woman's risk of PTB in future pregnancies by approximately 35% after one abortion and up to 90% after two abortions.¹⁹

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 epidemic to date, it is appalling that lawmakers would oppose legislation that would limit something shown to worsen mental health outcomes and suicide rates. States should be able to pass laws that will protect both the physical and mental health of their citizens.

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 National Academy of Science report²⁰ on abortion ignored the majority of these, choosing instead to review only 7 studies. Five of these studies were derived from the same group of women, known as the Turnaway cohort. There are several well-known problems with the Turnaway cohort.

The Turnaway studies were done through ANSIRH (Advancing New Standards in Reproductive Health), a pro-abortion research group at the University of California at San Francisco. The Turnaway 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

¹⁶ Butler, A. S., & Behrman, R. E. (Eds.). (2007). *Preterm birth: causes, consequences, and prevention*. National Academies Press.

¹⁷ 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.

¹⁸ 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

¹⁹ 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>

²⁰ National Academies of Sciences, Engineering, and Medicine. 2018. *The Safety and Quality of Abortion Care in the United States*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24950>

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. An abortion done after the first trimester is a significant risk factor for subsequent psychiatric distress.²¹ Also, their own study found that more than 96% of women who had been denied abortions were glad they didn't have an abortion five years later.

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.²²

The most comprehensive review of available literature revealed that 49 out of 75 of the studies (65%) showed a positive correlation between abortion and adverse mental health outcomes. Induced 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.²³ 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 – actually showing a *protective* effect from giving birth.²⁴

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 186,000 new cases of mental health problems each year.²⁵ Given the current mental health crisis in the U.S., it is incumbent upon us as a medical profession to do everything that we can to help improve the mental health of our patients. Decreasing the number of abortions in this country, and instead giving women the support they truly desire, would be a big step towards accomplishing this.

A recent peer-reviewed study showed that only 1/3 of abortions were considered “wanted,” nearly 1 in 4 women reported feeling forced or coerced into their abortion decision, and a staggering 60% of women reported that they would have chosen to carry their pregnancies and

²¹ 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>

²² 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>

²³ 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>

²⁴ 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.

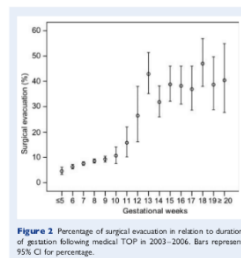
²⁵ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). Abortion and Mental Health. [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf>

Deliver had they had the emotional or financial support that they needed.²⁶ We should all be able to agree that women should not make a life-altering decision simply because they lack the support they and their children deserve.

The Nightmare of Unregulated Chemical Abortions

Despite some states deciding to prevent induced abortions, the FDA has provided the abortion industry a way to skirt these state laws by allowing chemical abortion drugs to be dispensed through the mail or through a pharmacy without an in-person visit with a physician. It should be noted that this started long before *Roe* was overturned,^{27,28} lest anyone try to state that women are being forced into this option because abortion might be illegal in their state. The dangerous use of these drugs not only jeopardizes the life of every preborn human being exposed to it but also represents one of the greatest threats to the health of women related to induced abortion. Rigorous registry-based studies show that medication abortions have a 4x higher risk of complications than do surgical abortions²⁹ – and this is under controlled circumstances where women are examined by a physician and the drugs are not given beyond 9 weeks' gestation. The FDA's own data shows that roughly 1 in 25 women who take mifepristone will end up in the emergency room. Removing appropriate medical oversight increases risk to women for a number of reasons.

The complications of the abortion drug mifepristone increase with increasing gestational age. At 10 weeks' gestation (current upper limit approved by FDA), 1 in 10 women will require a surgery to complete their abortion – just three weeks later, this increases to at least 1 in 3 women.³⁰



This is a significant issue for women that do not have immediate access to a hospital with 24/7 emergency surgical services available. Without an in person visit and ultrasound, gestational age cannot be confirmed (see below) and women cannot possibly be adequately counseled on their risks if their gestational ages are not known.

²⁶ Reardon DC, Longbons T. Effects of Pressure to Abort on Women's Emotional Responses and Mental Health. *Cureus*. 2023 Jan 31;15(1):e34456. doi: 10.7759/cureus.34456. PMID: 36874642; PMCID: PMC9981219.

²⁷ <https://www.acog.org/news/news-releases/2020/05/acog-suit-petitions-the-fda-to-remove-burdensome-barriers-to-reproductive-care-duringcovid-19>

²⁸ https://aidaccess.org/en/media/inline/2019/9/9/19_09_09_verified_complaint_with_exhibits-420116928.pdf

²⁹ Niinimäki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate complications after medical compared with surgical termination of pregnancy. *Obstet Gynecol*. 2009 Oct;114(4):795-804. doi: 10.1097/AOG.0b013e3181b5ccf9. PMID: 19888037.

³⁰ Mentula MJ, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study. *Hum Reprod*. 2011 Apr;26(4):927-32. doi: 10.1093/humrep/der016. Epub 2011 Feb 11. PMID: 21317416.

Further, an in person visit and ultrasound are required to adequately rule out an ectopic pregnancy, one of the main contraindications to chemical abortions³¹ and one of the leading causes of maternal death in the first trimester. Ectopic pregnancies occur in 1 in 50 pregnancies and are life-threatening. The symptoms of a rupturing ectopic pregnancy are very similar to symptoms from a chemical abortion – pain and bleeding. A delay in diagnosis by even a few hours can be catastrophic. And yet, the same abortion proponents who are falsely claiming that women won't be able to receive ectopic pregnancy treatment if abortion is restricted are the same people claiming that abortion drugs being dispensed online without proper screening for ectopic pregnancy is completely safe.

Finally, it is imperative that women seeking abortions be screened for coercion, intimate partner violence (IPV), and trafficking. For many trafficking victims, an interaction with a healthcare professional is one of their only chances of finding help.³² Not only does online provision of these drugs not allow for adequate screening for these abuses, but it potentially supplies abusers with a supply of drugs to force abortions on their victims. Women deserve better care and support than this irresponsible dispensing of potentially dangerous drugs provides.

The abortion industry has abandoned women

Women seeking abortions deserve the same level of healthcare as any other women. 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, 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 who are left alone and in the dark as to how, when, or where to seek treatment when complications unavoidably arise.³³

While many claim that abortion restrictions interfere with the patient/physician relationship, many abortion providers have no previously established relationship with the patients they see. These providers subsequently leave the aftercare of said patient to other physicians who do have that previous relationship or to physicians in the patient's local emergency department.

Unfortunately, this negligent model of care has been propped up by large medical organizations claiming to be leaders in women's healthcare. A glaring example of placing a political agenda ahead of sound medical care can be found in the largest medical membership organization in the United States for obstetricians and gynecologists, of which I was once a member.

³¹ https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

³² AAPLOG. "Committee Opinion 5: Joint Committee Opinion Pornography, Sex Trafficking and Abortion." 2019. https://aaplog.org/wpcontent/uploads/2019/07/revised-AAPLOG-Joint-CO-5-Pornography-Sex-Trafficking-and-Abortion_with-ACPeds-logo-2.pdf

³³ 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

While the American College of Obstetricians and Gynecologists (ACOG) claims to represent all OB/GYNs in the U.S. 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 not supported even common-sense regulations that would ensure women seeking abortions are cared for under the safest possible conditions and receive fully informed consent.³⁴

The risks of abortion increase significantly the further 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.³⁵ Yet, their own Committee Opinion on establishing due dates in pregnancy 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.³⁶ This is important because without an accurate dating of their pregnancies, women will not be able to provide informed consent which requires an understanding of their risks for hemorrhage, retained tissue and emergency surgery--all of which depend on gestational age of the pregnancy.

ACOG also claims that admitting privileges or formal patient handoffs are medically unnecessary for women experiencing abortion complications.³⁷ 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.³⁸

³⁴ Ibid.

³⁵ 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>

³⁶ 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>

³⁷ 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

³⁸ 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/committeeopinion/articles/2012/02/communication-strategies-for-patient-handoffs>

ACOG opposes mandatory reflection periods before abortions, and yet the data support that many women are either unsure of their decisions or pressured into them.³⁹ A 2004 study that spoke with women who had undergone abortions in the U.S. showed the importance of waiting periods, increased counseling and in person visits to screen for coercion:⁴⁰

- 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.

ACOG's position on abortion, which is radically out of step with the majority of their members, was made crystal clear in a statement in a 2023 Washington Post Letter to the Editor: "Abortion is safe. It improves and saves lives, and it must be available without restrictions, without limitations and without barriers..."⁴¹ (emphasis mine). This same call for induced abortion without any restrictions or regulations (including gestational age limits which the vast majority of Americans support) is echoed in the so-called "Women's Health Protection Act" which would be more aptly named the "Abortion Until Birth for Any Reason Act."

Providing true healthcare and support for women

As stated above, the majority of women who have abortions actually desired to carry their pregnancies to term and deliver their children. That any woman would feel that she had to choose to end the life of her child simply because she didn't have appropriate support in a country like the United States is a travesty and something we should all be united in solving. Induced abortion has long been touted as a panacea for many challenges that women face, and it has failed to be a solution to anything. Rather than focusing our attention on "increasing access" to abortion, we should be focusing on real solutions for women and improving the healthcare that pregnant women receive. Examples of unifying policies include expanding support for pregnancy centers that are often a first point of contact and could be supported to provide early prenatal care, expanding support for working mothers (including transportation and childcare), encouraging involvement of fathers, and prioritizing full-service health clinics in

³⁹ 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>

⁴⁰ 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.

⁴¹ <https://www.washingtonpost.com/opinions/2023/08/30/abortion-debate-honesty-matters/>

maternal care deserts that would be able to provide low-risk prenatal care and appropriate and timely referrals to higher level care when needed. I don't propose to know every possible solution, but I do know that when induced abortion is the automatic answer for any challenging pregnancy, we will never find the right solutions.

We have a lot of work to do in this country to improve maternity care for women – none of which requires intentionally ending the lives of vulnerable human beings or exposing women to the harms of induced abortion. We also owe it to women to be sure they receive accurate information – not fearmongering that tells them they won't be able to receive the life-saving care that they need. Stories of women being sent home to “get sicker” before they can receive care highlight the lack of proper explanation of state prolife protections. For those of us who have practiced our entire careers without performing procedures that intend the death of our fetal patients, we know that providing women with excellent healthcare in states where abortion is illegal is not only possible but can produce the best outcomes. We are leading the way in showing how to provide true healthcare for all of our patients – not a band-aid for social issues that need to be addressed outside of the medical profession. We are also working to restore the integrity of the physician-patient relationship by restoring the trust that patients should have that their physician is recommending what is best for their health and the health of their child based on the most current medical evidence and informed by the ethical principles that have guided the practice of medicine for millennia.⁴² This also requires physicians having accurate information about their state laws so that they do not hesitate to provide indicated life-saving care to women and, when possible, their children. Our patients are empowered when they are given accurate information, fully informed consent and real healthcare solutions rather than a political narrative.

Respectfully submitted,

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⁴² The Hippocratic Oath forbids doctors to perform abortion, stating “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy.” William C. Shiel, Jr., M.D., Medical Definition of the Hippocratic Oath (2018), available at: <https://www.medicinenet.com/script/main/art.asp?articlekey=20909>

