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IN THE DISTRICT COURT OF THE NINTH JUDICIAL DISTRICT

IN AND FOR TETON COUNTY, WYOMING

DANIELLE JOHNSON; KATHLEEN DOW; GIOVANNINA ANTHONY, M.D.; RENE R. HINKLE, M.D., CHELSEA'S FUND; and CIRCLE OF HOPE HEALTHCARE d/b/a Wellspring Health Access; Plaintiffs, v. STATE OF WYOMING; MARK GORDON, Governor of Wyoming; BRIDGET HILL, Attorney General for the State of Wyoming; MATTHEW CARR, Sheriff Teton County, Wyoming; and MICHELE WEBER, Chief of Police, Town of Jackson, Wyoming, Defendants.	)	Case No. 18853

AMENDED EXHIBIT 3

COMES NOW the Wyoming Legislators, Wyoming Secretary of State and Right to Life of Wyoming and attach hereto the Amended Exhibit 3 because certain

pages of the attachments were not included with the original exhibit which was attached to the proposed *Amicus Memorandum*.

This Exhibit 3 is important because it medically differentiates between abortion and healthcare. As the noted doctors state, elective abortion is not healthcare.

RESPECTFULLY SUBMITTED this 22nd day of March, 2023.

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CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of March 2023, a true and correct copy of the foregoing document was email filed with the Teton County District Court. It was also served upon the following person(s) in the following manner as indicated:

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Junuenth Daniels, *Paralegal*
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AAPLOG

March 21, 2023

Re: Wyoming HEA 88

Your Honor,

We are writing you as board-certified OB/GYNs and also the heads of two professional medical organizations. The American Association of Prolife OB/GYN's (AAPLOG) represents over 6000 medical professionals across the country including in Wyoming. The Alliance for Hippocratic Medicine (AHM) represents over 30,000 medical professionals across the country. Both organizations represent medical professionals who do not use killing human beings as a therapeutic option.

We have reviewed Wyoming HEA 88, which clearly defines that what is prohibited is the intentional killing of a human being in the womb. Opponents inaccurately state that somehow elective abortion, which is clearly defined in Wyoming HEA 88 as intentional killing of human beings in the womb, is needed for women. Opponents obscure the clear definition of abortion in HEA 88, confusing that term with other actions which are clearly not abortions, such as separating a mother and her fetus to save the mother's life, and treatment of ectopic pregnancy and treatment of miscarriage. Each of these three other situations are clearly and explicitly excluded from Wyoming HEA 88.

Attached are two documents prepared by Maternal Fetal Medicine (high risk obstetrics) physicians from AAPLOG. The Wright document clearly explains what is not an abortion, as consistent with HEA 88. The Practice Guideline 10 clearly explains that abortion is the intentional killing of a human being for no medical reason. Both of these documents are scientifically accurate and both of these documents uphold and confirm the definition of abortion in Wyoming HEA88. We have also attached AAPLOG's Committee Opinion (written by our research committee) that details the scientific evidence that would support any state restricting elective abortion with bills such as HEA 88.

Opponents of HEA 88 are counting on confusion of terms. They can produce no circumstance in which the elective killing of in utero human beings as defined in HEA 88 would in any way benefit the life of a mother. They are counting on confusion and fear that women will not be able to receive medically indicated life-saving care. However, Wyoming HEA88 is exquisitely clear, and does not in any way preclude excellent medical care for women.

Sincerely,

Christina Francis, MD
Chief Executive Officer
AAPLOG

Donna Harrison, MD
Director of Research
AAPLOG

Chair of the Board
Alliance for Hippocratic Medicine

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Exhibit 3

What is NOT an Abortion?

Jeffrey Wright, MD, FACOG
Maternal Fetal Medicine

Since the overturning of *Roe v. Wade*, there has been a flurry of new state laws restricting abortion and a reemergence of older state laws that restricted abortion. The media is filled with assertions that these laws will prevent physicians from providing medical care that is necessary to treat serious medical illnesses. Much of the confusion stems from the fact that the medical term abortion refers to any pregnancy that ends prior to 20 weeks. Such a pregnancy ending might be spontaneous or it might be induced. The medical procedure to intentionally end the pregnancy might involve medication, a surgical procedure, or both.

On the other hand, in our common language, the natural loss of a pregnancy is most commonly termed "miscarriage." In our common language, we typically use the word "abortion" to mean a procedure that was chosen in order to end a pregnancy that otherwise could have progressed to the delivery of a baby. As a Maternal Fetal Medicine physician, I occasionally recommend that a pregnancy be terminated in order to protect the mother's physical health. I tend to use terms such as "ending the pregnancy," "terminating the pregnancy," or "separating the fetus from the mother."

When a pregnancy is located outside the uterine cavity, when a fetus has already died, or when a fetus never formed, physicians typically have not thought of the treatment for these conditions being an abortion.

Miscarriage or fetal death can sometimes occur as a complication or side effect of medical or surgical treatments such as appendectomy, removal of ovarian cysts, cervical cone biopsy, chemotherapy, radiotherapy, hysterectomy for malignancy, etc. These unintended consequences are not thought of as an abortion.

Fetal death can sometimes occur as a complication of an intrauterine surgical procedure to treat a single fetus or to treat an abnormality such as twin to twin transfusion syndrome. Again, those occurrences are not viewed as abortions.

When a condition arises in pregnancy such as severe hemorrhage, uterine infection, or severely elevated blood pressure, some physicians might consider the procedures to end those pregnancies to be an abortion. However, they do not consider those procedures to be elective. They do not consider that type of pregnancy termination to be avoidable. Rather, they consider those procedures to be medically necessary procedures to save the life of one of the two patients that they are treating.

In those cases, the loss of the fetal life is a byproduct of the medical treatment necessary to save the life of the mother. This type abortion is ethically, medically, and morally distinct from an elective abortion that is done for social or economic reasons involving an otherwise healthy mother and fetus.

It is important to understand that medical diagnosis, and furthermore prognosis, is imprecise. Estimations of level of risk to a mother's life or her bodily function vary between physicians. Patients and physicians have a range of views regarding how much risk is acceptable. Two physicians may see the same patient and arrive at different diagnoses and then recommend substantially different treatments. On the other hand, the enforcement of a legal statute requires certainty beyond a reasonable doubt.

For example, Texas H.B. No. 1280 allows abortion for life -threatening physical conditions aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced. What conditions might meet that standard?

The reader should understand that I am not purporting to offer legal advice. I am offering the perspective of a prolife physician who has practiced Maternal Fetal Medicine for over three decades. I am considering what this law says and then suggesting which conditions might meet that standard.

The conditions listed below, in my opinion, meet the above-outlined legal criteria for justifying abortion. Conversely, this list does not represent a standard of care that requires that an abortion be performed. Any medical procedure requires consent of the maternal patient, and the physician's willingness to participate. Individual patients vary greatly in the level of risk they are willing to accept in order to have a child. Any physician has the right to decline to perform an abortion based on their own conscience.

The reader should understand that I am not purporting to define whether an act to end pregnancy is ethical or moral, only whether it is performed within the bounds of the regulation cited above as I understand the language.

No list of medical indications for any procedure can possibly include every potential diagnosis. Various medical organizations commonly publish such lists and generally indicate that limitation. Decisions regarding patient care require the physician's judgment regarding the entirety of the clinical circumstances. I recognize that any pregnancy involves some level of risk to the mother. In suggesting this list, I seek to identify a threshold that places the mother's risk of death or substantial impairment of major bodily function that seems to meet what the statute states.

- The presence of active hemorrhage into the peritoneal cavity, pelvic cavity, pelvic organs, or through the cervical canal associated with a maternal hemoglobin of less than 9.0 g/dL or hematocrit less than 27.0.
- Intrauterine infection as defined by 2 or more signs including: maternal fever greater than 100.4°, uterine tenderness, persistent maternal heart rate greater than 100, persistent fetal heart rate greater than 160, or foul smelling discharge through the cervical os.

- Premature rupture of the membranes prior to 24 weeks gestational age by LMP or 22 weeks post conception.
- Severe hyperemesis gravidarum as evidenced by 3 or more hospital stays for dehydration and hypokalemia (less than 3 mEq/L) unresolved by multiple medication therapy.
- Cardiovascular collapse associated with obstetric (ie amniotic fluid embolus) or non-obstetric conditions.
- Preeclampsia with severe features (includes HELLP syndrome or mirror syndrome) occurring prior to 24 weeks gestational age by LMP or 22 weeks post conception.
- Acute Fatty Liver of Pregnancy
- Partial molar pregnancy
- Hemolytic Uremic Syndrome or Thrombotic Thrombocytopenic Purpura
- Chronic or acute kidney disease with serum creatinine level of 1.4 or greater.
- Prior or planned solid organ transplant
- Current maternal malignancy
- Poorly controlled autoimmune disease (ie catastrophic antiphospholipid syndrome, scleroderma renal crisis, severe lupus nephritis)
- Substantial cardiovascular disease as defined by WHO Class III and IV.

This may seem to some to be a very long list. But, most of these diseases are very rare. The ones that are somewhat common rarely occur at a previable gestational age with a living fetus.

There is no doubt that the inaccurate and sometimes hysterical comments in the media have many physicians and others in healthcare fearing that they will violate a criminal statute. Most physicians spend their entire careers with some level of worry about malpractice litigation and/or what might happen if they violate any one of the numerous federal statutes that strictly govern the practice of medicine. In general, physicians and other healthcare workers are very much law-abiding citizens. It is not difficult to scare them. To make matters worse, they are not accustomed to reading the actual text of laws, and the majority are far too overworked to have time to look up and examine the laws themselves. I do not claim to have read every state statute regulating abortion. But, the ones I have read consistently allow medical treatments needed to treat physical illnesses. The laws use terminology that indicate that it is the physician's judgment that determines whether or not those treatments are legitimately needed. In my view, the laws empower the individual physician to use their medical knowledge and training to determine whether medication or a surgical procedure is needed to end the pregnancy in order to treat a serious medical illness. There is nothing unusual about a physician being required to use their judgment. A physician is responsible to use their best judgment in the evaluation and treatment of every single patient they ever see. These laws do not threaten physicians providing legitimate medical care.

AAPLOG

COMMITTEE OPINION

Number 10, August 2022; updated September 2022

State Restrictions on Abortion: Evidence-Based Guidance for Policymakers

The Supreme Court decision on Dobbs v. Jackson *returns abortion regulation to each state, similar to the way the practice of medicine is regulated at the state level. State policymakers must be aware of the most up-to-date evidence on abortion and the effects of abortion restrictions in order to implement what is best for their constituents. There is no scientific evidence that restricting elective abortions leads to increasing maternal mortality; in fact, several good-quality studies show a decrease in maternal mortality after abortion restrictions have been implemented. State restrictions which enforce standard medical care, such as making a diagnosis before implementing an intervention, requiring fully informed consent with appropriate waiting periods between decision and intervention, and requiring screening for contraindications, including mental health risk factors, are common-sense interventions. Restrictions on elective abortions—those procedures done with the primary intent to produce dead offspring—will have no effect on medically-indicated separation procedures necessary to save the life of a woman.*

Background

The court that wrote *Roe v. Wade* into jurisprudence recognized that governments have legitimate interests in protecting a fetus, such as the interest in population and economic growth. However, the *Roe* court did not delineate what this fetal interest is or how it is to be applied. The Court only commented that state interests increase with gestational age, and they created a "trimester" system (then unknown in obstetrics) to crudely delineate when the states were allowed to pass any regulations on abortion.[1]

For the past 50 years, *Roe* largely quashed difference of interpretation of that interest — all states were functionally required to relinquish any interest in protecting fetuses until the third trimester, when they could

AAPLOG Committee Opinion. This document was developed by four authors on the Research Committee. Committee Opinions summarize best practices that form an important part of pro-life practice.

theoretically restrict abortion, protecting fetal life. As the limits of fetal viability were extended into the second trimester by survivals of fetuses born at 24 weeks, a second Supreme Court decision, *Planned Parenthood v. Casey*, eliminated the *Roe* trimester limitations, instead substituting a viability standard that allowed states to restrict abortion on the basis of fetal interests after viability.[2] Since then, states have passed laws displaying varying interpretations of the state's interest in protecting fetal life and some judges have treated some fetuses as juridical persons.[3]

Roe's court acknowledged that there is difference in opinion about when human life begins, but did not engage with any evidence for these opinions or allow any opinion other than its own. The *Dobbs* court has appropriately reestablished states' legal ability to determine how to protect their compelling and legitimate interests in fetal life, in accord with the values held by the people.

Additionally, there are a variety of perspectives on how to define women's health and how this intersects with the interest in protecting the fetus. Although abortion advocates often discuss the harms to women due to abortion restrictions, there are very few comparisons of abortion policy in the United States given the forced uniformity of *Roe*. However, available data from natural experiments worldwide suggest that abortion restrictions are not automatically associated with undesired or adverse outcomes.

Clinical Questions and Answers

Q Do abortion restrictions prevent physicians from ending pregnancy for the sake of saving maternal lives?

Appropriate abortion restrictions do not prohibit physicians from ending pregnancy in the case that the life of the mother is threatened. A recent survey of obstetricians in private practice indicates that only 7% perform abortions, suggesting that abortion is not essential to women's health if over 90% of women's health physicians do not offer it.[4-6] If a life-threatening maternal medical condition requires separation from the fetus, delivery can be initiated without the primary intent to cause a fetus to die. Preterm and even previable delivery of an intact (and usually living) infant to save the life of the mother is fundamentally different from intentionally ending the life of the fetal human being prior to delivery, often by means of dismemberment.[7]

In fact, separation procedures or deliveries designed to avoid overt feticide can be as fast as abortions that make feticide a goal. Deliveries can be accomplished surgically or medically. In the case of a need for emergency separation to save the life of the mother, a C-section can take place in approximately 30 minutes or less, comparable to the speed of a surgical abortion. An induction with gestational age-appropriate doses of misoprostol or Pitocin usually take approximately 24 hours, which is

comparable or slightly slower than medication abortion.[8]

Q Is the availability of abortion by dilation and evacuation (D&E) important for women's health?

After 14 weeks, dilation and evacuation (D&E) is a common way to quickly terminate pregnancy, as D&C becomes less feasible due to fetal maturity and calcified bones. D&E requires that the cervix be dilated, which may be done with osmotic inserts placed hours before the procedure and/or sterile metal rods of increasing size. Once the cervix is open to a sufficient size to allow passage of fetal parts, the body of a fetus is removed in pieces. By this gestational age, this means removing a fully formed head and face, four extremities, fingers and toes, and most internal organs in their mature configuration.[9] The fetus dies either of exsanguination due to tearing of the umbilical cord or other arteries, or directly from crush injuries to the spinal cord, brain, or heart. The placenta is also removed. Depending on the cervical dilation, larger pieces of the fetal body may emerge—even the entire fetus. Cervical dilation is the step of this procedure which likely causes the well-documented increased risk of subsequent preterm birth after these procedures.[10,11]

Often, the most difficult part of a D&E is extraction of the fetal head with its calcified but fragile skull. Grasping the skull may lead to extrusion of brain contents out of the woman's body. This may cause fetal death if not already achieved by other injury and may cause cervical laceration from bone fragments.

At the end of the procedure, the fetal parts are reassembled to ensure their presence outside of the uterus, and ultrasound is often used for confirmation of an empty uterus, as remaining parts could lead to infection or hemorrhage. This procedure was described by former Justice Ruth Bader Ginsburg as "tear [the fetus] apart."[12]

D&E is *not* a required option to protect maternal safety; rather, it represents an unnecessary ending of the life of a fetal patient. At times, D&E is used after the age of viability, which is described as 22-24 weeks gestational age (20-22 weeks conceptional age).[13] This fact puts the purpose of D&E in stark light: if there is another way to end pregnancy in settings to protect maternal health, then demand for D&E cannot stand solely on grounds that it is needed to protect maternal lives. Instead, D&E becomes a redundant option distinguished by the end result of an assembly of body parts on a table, rather than a neonate. Women's health does not require dead fetuses; it only requires the ability to separate from a fetus when medical safety demands it.

Abortion providers do not deny that the purpose of D&E, and abortion in general, is to produce a dead fetus. The Royal College of Obstetrics and Gynaecology points out

that abortion providers should be intentional about achieving feticide to avoid live birth.[14] In the partial-birth abortion ban hearing before the Supreme Court, abortion providers claimed that their product was to produce a dead fetus, and that banning procedures which would ensure that the fetus was dead was an infringement on their trade—a telling admission about a procedure which "kills the fetus and is distinct from delivery."[15]

Q Is the availability of abortion by dilation and extraction (D&X), or intact D&E, important for women's health?

Partial-birth abortion (also called D&X or intact D&E) was used to end pregnancy after 22 weeks gestational age before a federal ban on the procedure in 2003.

In this procedure, done up to term, the cervix is dilated so that the operator can reach the fetal legs with instruments (often reaching past the fetal head, face, and other extremities). The legs, followed by the entire body of the fetus, are pulled into the vagina, trapping the head at the cervix. With the head entrapped, the base of the skull is punctured and the brain stem is disrupted, similar to pithing for vivisection of lab animals. The skull is then emptied of its contents with suction to allow easier passage of the head through the vagina. The federal ban on this procedure was upheld by the Supreme Court.[15]

This procedure was developed to spare women the risk of internal laceration due to skull and other bony fragments, but this risk can also be avoided by pursuing induction and vaginal delivery of a fetus without feticide. Intact D&E thus provides no unique or vital role in protecting women's health, over and above delivery for maternal safety.

Q What does a dismemberment abortion ban prohibit, and why ban dismemberment abortion?

Most dismemberment abortion bans prohibit D&E, although most also have an exception that allows D&E on a living fetus when needed to save the maternal patient's life or to prevent serious irreversible physical harm, which will be alleviated by separating the mother and the fetus.

Dismemberment abortion bans may be pursued by policymakers whose constituents seek to prohibit living human organisms from experiencing painful stimuli until their death by feticide. This is an unnecessary addition to the steps required to end pregnancy for the sake of the mother.

There is increasingly definitive evidence that fetuses at the gestational ages when D&E is common possess neurological structures that transmit painful stimuli to the brain.[16] This same evidence has prompted the use of fetal analgesia and paralytics for fetal surgery at gestational ages in the second and third trimesters.[17]

During exposure to painful stimuli (presumably including dismemberment), fetuses display an increase in heart rate, increase in serum stress hormones, and withdrawal from the stimulus. AAPLOG supports bans on dismemberment abortions on living fetuses out of concern that performing feticide in a way that causes a pain or stress response is not only unnecessary but unethical.

Q Is feticide by other means, without dismemberment, important for women's health?

Potassium chloride injection, digoxin injection, and saline induction are ways of ending fetal life prior to delivery and are performed throughout pregnancy. Saline induction is usually performed after D&C becomes more difficult (after 14-20 weeks) and is not used as often as it was in the 1970s. Potassium chloride and digoxin may be used as early as the first trimester.

Injecting potassium chloride into the heart or amniotic sac of a fetus or embryo causes death by cardiac arrest, similar to its use to induce cardioplegia in adult cardiac surgery when the patient is on cardiac bypass.[18] Without bypass, potassium chloride is effectively a lethal poison. After death from this injection, the fetus or embryo's body is either using medication, removed by curettage or other mechanical means, or (as in selective reduction) may remain alongside living siblings until delivery of the surviving fetus(es).

Injecting digoxin into the heart or amniotic sac of a fetus or embryo is also cardiotoxic. In patient-facing literature from abortion providers, this medication is described as useful to "decrease the risk of live birth" and "the risk of the doctor or nurse violating the federal [partial birth] abortion ban," causes an increase in cardiac contractility and cardiac failure in most cases.[19] It is not used to cause delivery or to separate mother from child; in fact, delivery is listed as an unwanted adverse effect.[19]

In saline inductions, a needle is used to introduce a supraphysiologic concentration saline into the amniotic fluid, which causes surface injury to the placenta, the skin, mucous membranes, the respiratory tract, and the gastrointestinal tract. The fetus suffocates as his or her oxygen supply is cut off by the constriction of the fetal blood vessels in the placenta or from electrolyte derangement.[20] Fetal death due to saline abortion takes place over 24 to 30 hours. Saline induction is less common due to the number of fetuses who survive attempted feticide and become advocates against abortion and for healing relationships with their families.[21] Some of these survivors relate that a second feticidal attempt was made prior to delivery to avoid live birth, which again demonstrates the separation from delivery and the feticidal intention of non-dismemberment abortions.

Q Is it mandatory to resuscitate a periviable infant born after a delivery is done, rather than a D&E?

A periviable infant (variously interpreted in the United States as one between 20 and 24 weeks gestational age) is a critically ill patient due to developmental immaturity. As is the case for any other class of critically ill patient, these neonates can be offered goal-oriented intensive care including resuscitation and invasive interventions or can be offered comfort-oriented end of life care such as warming, morphine for air hunger, and feeding if applicable.

A previable infant born alive (variously interpreted as a fetus delivered before 20 to 24 weeks, with those before 20 weeks being termed *abortus* or miscarriage in medical literature) is a patient at the end of his or her natural life. As with all end-of-life patients, priority should be placed on comfort and anticipatory grief for family members and other second victims, such as healthcare workers.

As a corollary to this, healthcare providers should not create situations in which the fetal patient is made critically ill unless the maternal patient is likewise facing critical illness and has a serious or acute indication to end the pregnancy. In no other situation would a healthcare provider iatrogenically cause critical illness when another solution is possible; just so, previable or extremely preterm delivery without medical indication is not part of responsible obstetric care. As noted by other professional organizations including the American College of Obstetricians and Gynecologists, a well-timed delivery should be a means of avoiding, not causing, complications.[22] More complete descriptions of the interaction of ethically ending pregnancy[23] and perinatal palliative care[24] are published under separate cover.

Q Do abortion restrictions actually decrease abortion rates?

Abortion restrictions can decrease abortion rates, but statistics are often used to misrepresent this effect. One example of this statistical misrepresentation is found in the assessment of the Mexico City Policy, later known as the Protecting Life in Global Health Assistance Policy (PLGHA). PLGHA is a policy through which the United States restricts USAID funding to organizations that promote abortion in the developing world, while still permitting maternal care. PLGHA has been instated and revoked several times with the changing U.S. political landscape.

Authors associated with the Guttmacher Institute have asserted that countries impacted by this policy saw an *increase* in abortions while the policy was implemented.[25] This is alarming for PLGHA supporters, who aim to promote authentic maternal healthcare and decrease the rate of abortion. However, this conclusion emerges from a misuse of a statistical model called the difference-in-differences

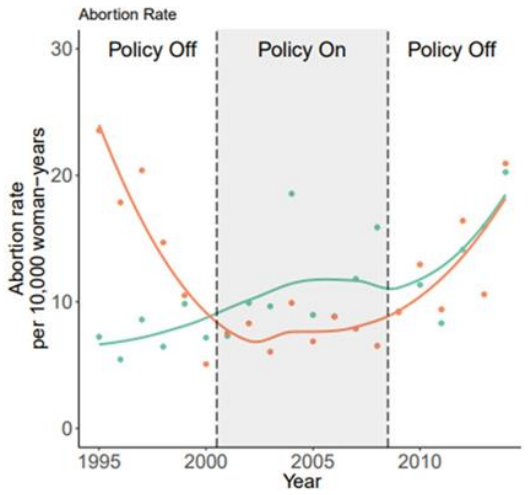

Figure 1. Rates of abortion in countries receiving significant (green) vs less (orange) USAID. Reproduced from The Lancet, Brooks et al., with permission.

assessment, which obscures the impact of policies on abortion rates.

The difference-in-differences model is an econometric model designed to assess the impact of an intervention over time using a comparison group in which the intervention was not implemented. The method compares the difference between the intervention and comparison groups before the intervention is implemented, to the difference between them afterwards. The impact of the intervention is judged by how much the difference between the two groups changes, not on the actual change within the intervention group, which accounts for background trends due to other causes. With this model, investigators compared relative changes in abortion rates, not actual numbers. The authors compared abortion rates in countries most reliant on USAID funding to those less reliant on USAID funding. Their data are presented so that it appears there was a paradoxical increase in abortions with the PLGHA in the countries reliant on USAID funding, when in fact those countries' rates stopped rising and began to fall while the policy was in place.

A closer examination of the data demonstrates this (Figure 1).[25] The abortion rates between countries with the most influence from USAID funding (green) and the least influence from USAID funding (orange) did not move in parallel prior to the PLGHA. Without PLGHA, abortion rates were rising in the countries receiving more USAID funding but were falling in countries receiving less. This violates the "equal trends" assumption of the difference-in-differences model and therefore makes it an inappropriate analysis of the impact of PLGHA. With the implementation of PLGHA, countries reliant on USAID funding eventually saw a decline in abortion rates before the policy was revoked, when abortion rates increased sharply again. This picture is against a somewhat confusing background of countries less dependent on USAID funding, which saw increases and decreases in abortion rates less connected with PLGHA.

Overall, there is not a universal answer available as to whether abortion restrictions uniformly decrease abortion rates; many variables are at play, such as socioeconomic and cultural factors, as well as access to maternal and child healthcare. Further study would be necessary to respond to the answer in each case with straightforward data.

Q *Does expanding abortion access increase abortion rates?*

A common assertion is that legalizing abortion keeps the number of abortions stable while decreasing the proportion of unsafe abortions, but this contradicts U.S. estimates between 1972 and 1973. In 1972, NARAL estimated there were 200,000 illegal abortions,[26] and census data documents approximately 4,176,000 females aged 15 to 44,[27] for a total rate of 3.1 abortions per 1000 women. The Guttmacher Institute, which provides statistics on abortion rates from 1973, reports an abortion rate of 16.3/1000 in 1973, more than five times the pre-*Roe* rate.[28]

Q *Do abortion restrictions result in higher maternal mortality rates?*

Abortion advocates often assert that maternal mortality rates inevitably increase when women cannot readily access abortion, but very poor data exist to support this claim.[29] In fact, some data suggest that *abortion* is associated with higher mortality rates, and restrictions may result in improved maternal outcomes.

In Finland, where health data is centralized and progressive policies are in place, abortion is associated with 49.5 maternal deaths per 100,000 women; in comparison, all external causes of death after delivery represented only 8.1/100,000. For all pregnancy outcomes in all age groups under 40, mortality rates were highest after termination of pregnancy.[30] This may relate to several things, including that patients seeking abortion may have a higher baseline risk of maternal mortality. Even if this statistic is very biased, it shows that abortion is unable to resolve any underlying mortality risk.

It is noteworthy, too, that abortion is associated with high risk of maternal death even though Finland only permits abortions before 12 weeks, the least dangerous time of abortion. In contrast, most U.S. states permit abortion through the second trimester, even though the risk of death due to induced abortion increases by 38% for every week after eight weeks gestation.[31] Maternal health outcomes in Finland are superior to U.S. outcomes, and statistics such as these support restriction of abortion to improve rates of maternal mortality.

Mexican states with more restrictive abortion laws had lower overall maternal mortality ratios (38.3 vs 49.6; $p < 0.001$) compared to Mexican states with more permissive abortion laws. Moreover, abortion itself may also be safer in states with more restrictive laws, given that these states have lower maternal mortality ratios after induced abortion (0.9 vs 1.7; $p < 0.001$).[32]

In Chile, an enormous drop in the rate of maternal mortality over a fifty-year period was largely related to health and safety infrastructure. During this period, Chile made abortion illegal, but continued to see the same improvement in maternal mortality rates—making abortion illegal neither improved nor perturbed the improvement in maternal mortality.[33]

South Africa, a counterexample has seen maternal mortality rates *improve* with legalization of abortion after a longstanding prohibition.[34] As in Chile, abortion restrictions are one variable in a network of contributors to maternal mortality, but they do not automatically increase the rate of maternal deaths.

Q Do abortion restrictions result in sub-standard care for women?

Women seeking abortions deserve the same level of healthcare as any other woman. In many cases, abortion restrictions improve the level of care for women by making abortion more like other interactions between physicians and their patients. Restrictions such as ultrasound requirements, hospital privileges and waiting periods can protect women who deserve care like patients in other areas of surgical and pregnancy care.

Ultrasound requirements require abortion providers to verify gestational age and pregnancy location. Put simply, these restrictions ensure that providers make an accurate diagnosis before beginning an intervention. The risks of abortion increase significantly the further along in pregnancy a woman is, so accurate assessment of her gestational age is crucial to providing her a correct sense of the risks she accepts by consenting to abortion.[31] The American College of Obstetricians and Gynecologists (ACOG) describes that only half of women accurately recall their last menstrual period, the simplest way to date pregnancy. For this large proportion of women, dating should be based on ultrasound estimates. Women without an ultrasound to confirm or revise their due date before 22 weeks are suboptimally dated.[35]

According to this guidance, women who do not receive an ultrasound prior to abortion are suboptimally dated, which diminishes the accuracy of providers' counseling about procedure risks. However, in the case of abortion, ACOG claims that ultrasounds are "medically unnecessary" prior to abortions.[36] ACOG does not comment on how informed consent could be adversely impacted or even impossible without accurate knowledge of intrauterine location and gestational age. In contrast, AAPLOG recommends ultrasounds as medically appropriate.[37]

Hospital privilege requirements help abortion providers accurately assess complications and outcomes of their procedures and prevent women from being medically abandoned after their procedure. Currently, the ramifications of abortions are not usually felt by the abortion providers or clinics, but by urgent care facilities, emergency departments, and other women's health providers who provide treatment for abortion complications.[38] These providers typically do not have contact with the abortion providers or access to patient histories, which represent a significant gap in communication about care.

ACOG acknowledges that "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" and that "[o]ne of the leading causes of medical errors is a breakdown in communication."[39] In fact, ACOG describes a "handoff" as "the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another."[39] ACOG does not encourage any form of handoff between abortion providers and emergency personnel and no standards for such handoff exist. One alternative to handoffs would be to have abortion providers on call for surgical complications, like many surgical providers in the American healthcare system, but ACOG guidelines do not support this practice.

In summary, ACOG's general communication standards are excellent for women's health, but need to be consistently applied to providers who perform abortion. In the absence of this practice, states may have a vested interest in regulating patient handoffs or admitting privileges to avoid medical error, patient abandonment, or inaccurate perception of complications among those performing abortions.

Q *What supports restrictions on the provision of abortions by non-physician practitioners?*

Non-physician healthcare providers became more common in abortion provision after the National Academy of Sciences (NAS) report which encouraged their involvement.[40] It is possible that the majority of OB/GYNs do not wish to provide abortions.[4-6] In general, OB/GYNs more often intervene in pregnancies for medical reasons, while most abortions are done for social reasons.[41] Advanced Practice Registered Nurses (APRNs) and Certified Nurse Midwives (CNMs) are now able to provide abortions.[42]

Ancillary healthcare workers do not have the same level of training as physicians. Provision of surgical procedures by health care providers who are not trained in recognizing or treating the complications that inevitably follow greatly increase the risk to women who undergo these procedures. Women seeking abortion deserve the same level of care as any pregnant woman, and they do not get that without the care of a physician who has undergone years of hands-on education in surgical technique and hemorrhage management.

Physicians who are certified and licensed to operate on the female reproductive system complete undergraduate training, followed by an additional four-year accredited medical school program. OB/GYNs, the surgeons who predominantly operate on women's reproductive organs, then further complete an additional four-year postgraduate residency program that specifically trains them in performing surgical procedures and the recognizing and managing of treatment complications. This training includes exposure to many procedures, different anatomical variations, different clinical outcomes, and various complications. Residents' medical knowledge is tested through a yearly exam, and after residency, OB/GYNs must pass written and

oral board certification examinations. For the years they are in practice, OB/GYNs complete continuing education. Due to concerns for patient safety and liability, most hospitals do not allow physicians who are not board certified to operate on any of their patients.

Further evidence of the need for years of training is that the American Board of Medical Specialties has recognized the inherent complexity in performing abortions in the second and third trimesters by approving an additional two-year subspecialty training for abortions performed beyond the first trimester.[43]

The healthcare training of ancillary healthcare workers (non-physicians) is not equivalent in depth to the training received by physicians. For example, the requirements for midwifery training as outlined by the American College of Nurse Midwives (ACNM) include only a bachelor's degree with or without being a registered nurse (usually with plans for accelerated nursing studies prior to midwifery education) or RN without a bachelor's degree (usually only when bridging to a BSN prior to midwifery studies).[44]

CNM training is focused on normal delivery of term infants, under the supervision of a physician. Their training does not focus on performance of normal or abnormal surgeries on the female reproductive system, nor does it include training in the management of surgical complications of D&Cs including perforation of the uterus or nearby organs.

An APRN may have even less training.[45,46] An APRN may hold a bachelor's degree in nursing but may also enter APRN training with a three-year associate degree. APRN training programs typically require between one and three years of additional training, some of which may be conducted online. Their training also does not focus on the performance of normal or abnormal surgeries on the female reproductive system, nor does it include training in the management of surgical complications of D&Cs including perforation of the uterus or nearby organs. Neither a CNM nor an APRN would be eligible for surgical privileges at a hospital, because hospitals know the risks to patients that come from unskilled personnel providing surgery beyond their training.

Q Is it safe to permit non-physicians to perform surgical abortions?

Pregnancy results in dramatic anatomical, physiological and biochemical changes to every maternal organ.[47] Years of surgical experience with complication management provides more safety for women than provision by nonsurgically trained personnel such as midlevel providers. At least 1 in every 50 surgical abortions require additional surgery to manage complications.[48] Of abortions provided by non-physicians or even physicians without surgical training, this means 1 in every 50 patients needs a physician to manage the complications of this provider's actions.

Moreover, multiple causes of severe injury and death after abortion are best managed by persons with an in-depth medical and surgical education; these include hemorrhage (5.6%), genitourinary tract laceration (3.3%), retained products of conception (1.6%), uterine perforation (0.2-0.5%), uterine rupture (0.04-0.28%), infection (local or systemic), venous thromboembolic disease, rare complications of anesthesia, and rare cardiac or cerebrovascular events (heart attack or stroke). Incomplete tissue removal or damage to adjacent gynecologic, genitourinary, gastrointestinal or vascular organs may require additional emergency uterine surgery, hysterectomy, bowel resection, bladder repair, or other surgeries.[48-53] Abortions performed by non-physician providers may be at greater risk for complications, although there is definitive evidence of this.

Even if policymakers desire to allow non-physicians or physicians without surgical training to perform some abortions, evidence should be borne in mind that not all abortions are equivalent. The frequency of complications increases with gestational age due to the greater degree of anatomic and physiologic changes later in pregnancy.[31] Women are more likely to suffer hemorrhage, uterine perforation, and all complications with greater uterine size.[54-58] The overall rate of death for late term abortions in one study was almost tenfold the rate of death of all abortions (6.7 vs 0.7 per 100,000).[58]

Compared to first trimester abortions, the relative risk of maternal death from abortion at 13-15 weeks was 14.7 times higher (1.7/100,000), at 16-20 weeks was 29.5 times higher (3.4/100,000), and after 21 weeks was 76.6 times higher (8.9/100,000).[30]

These data may prompt restrictions on the provision of abortion by non-physicians to certain gestational ages, or completely prohibit these providers from performing abortions given their lack of in-depth training for dealing with complications of pelvic and obstetric procedures.

Q *Is there any consensus by various medical organizations on surgical training requirements for abortion procedures?*

The 2016 consensus statement from 32 medical and surgical societies focused on requirements for patient safety during surgical procedures.[59] All of these ten core principles assume that the person performing the surgery or procedure is of the minimal level training of a physician. Six of ten core principles are specifically violated by allowing APRNs or CNMs to perform office-based surgery.

Starting a surgical or medical procedure without having the skill set and ability to handle the known complications of that procedure is unethical. However, currently, many abortion providers do not maintain hospital privileges and their patients with complications are commonly sent to the local emergency room to be cared for by other physicians who often do not have the medical record of the patient. In rural areas, emergency providers may not have consulting physicians on call to

handle uterine perforations or other complications from surgical or medication abortion.

Q Would allowing non-physician providers the ability to perform abortions increase access for women who live far away from abortion providers?

One argument frequently made for allowing non-physician providers to offer abortions (especially medication abortion) is to increase access for women who desire elective abortions, but who live a long distance from an abortion provider.

Most studies of medication abortion were done in locations where emergency care is readily available for complications.[60] Cochrane reviewers take care to emphasize that results may not be generalizable to other settings such as rural locations.

Medication or surgical abortion performed by a non-physician provider without adequate backup and without knowledge, training or equipment to manage life-threatening complications should be unthinkable. Hemorrhage can occur rapidly due to anomalous anatomy, incorrect gestational age, undiagnosed ectopic pregnancy, or poor surgical technique. A woman remote from assistance may easily die from massive blood loss.

Some CNMs and APRNs perform procedures such as colposcopies, endometrial biopsies, and LEEPs, but these are not comparable to abortion. These procedures are done on non-pregnant patients who have a lower risk of bleeding and do not require the level of sedation needed for an abortion. The possible complications from these procedures are minimal compared to the complications which can occur after medication or surgical abortion.

Patient safety is not well-served by permitting non-physician provision of abortions. If a woman desires an abortion, it is far safer for her to travel to an area where there are adequately trained personnel and emergency services. Elective abortion is not an emergency medical procedure although its complication rates are gestational-age-specific; thus, making elective abortion available in many areas at the expense of the safety of this availability is misplaced compassion.

Q Do abortion restrictions result in coercion of women?

Just as some restrictions aid diagnosis by confirming intrauterine pregnancy and gestational age, others can aid informed consent. A 2004 study that surveyed women who had undergone abortions in the U.S. showed the importance of waiting periods, increased counseling and in-person visits in order to screen for coercion and ensure informed consent.[61] Selected findings include:

- 67% of women stated they received no counseling prior to their abortion.

- Only 11% of women felt that the counseling they received prior to their abortion was adequate.
- Only 17% of women 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 of their abortion.
- 30% of women who responded had health complications after their abortions.
- 36% of women had suicidal ideations after their abortions and 54% felt badly about their decision.
- 60% of women stated that they felt "part of me died."
- Only 4% of women claimed to feel more in control of their life after their abortion.

This cohort of patients' experiences is vulnerable to recall bias and selection bias, but it nevertheless provides evidence that some women remember their abortion as an experience of uncertainty, incomplete counseling, and regret. This suggests that a particular type of restriction, such as waiting periods or specific requirements for informed consent, may improve consent and sureness about decision-making.

A more recent survey of women who experienced medication abortion revealed that women feel the need for help after abortion:

- 82% did not know where to go for help after abortion
- 24% searched for help after their abortion experiences[62]

An advantage of restrictions might be to provide handoff, resources for post-abortion care, or follow-up. Potential advantages of waiting periods include the ability to provide standard medical care, such as Rho(D) immunoglobulin administration when indicated, which decreases the rate of alloimmunization in future pregnancies.[63]

Q Could abortion restrictions decrease preterm birth rates?

This question has never been directly studied. However, the Institute of Medicine lists surgical abortion as an immutable risk factor for preterm birth (PTB),[64] as over 165 studies converge on increased risk and dose effect from multiple abortions.[10,11]

Preterm birth adds $26.2 billion to U.S. healthcare expenditures yearly[65] and has unmeasured long-lasting costs related to the higher rates of cardiovascular disease and stroke among mothers who deliver preterm infants.[65] This increased risk of preterm birth is especially impactful in Black women, who already have a three-to-four-fold higher abortion rate and double the preterm birth rate compared to

non-Black patients.[66,67] As a result, states may see a compelling and legitimate interest in reducing preterm birth by restricting surgical abortions.

Q Could abortion restrictions decrease the burden of mental illness?

In addition to the physical ramifications of abortion, there is also a relationship between abortions and mental health complications. America is battling its largest mental health epidemic to date, and many women seeking abortion possess one or more of the 14 risk factors for adverse mental health outcomes determined by the American Psychological Association.[68] From 1993 to 2018 there were 75 studies examining the relationship between abortion and mental illness, of which two-thirds showed an increased risk of mental health complications after abortion.[69]

Abortion advocates usually focus on multiple studies that emerge from a single cohort of women (the Turnaway cohort), but these studies all carry biases that stem from the way the data was collected. The cohort had a response rate of 37%, low for a highly cited study with multiple secondary analyses.[69] After recruitment, 44% of women dropped out leaving a cohort of only 17% of eligible participants. This small slice of the population is vulnerable to selection bias since women more wounded by abortions may be less likely to participate. The original Turnaway study did not collect variables known to increase the risk of adverse mental health outcomes such as gestational age. Given these weaknesses it is unwise to rely only on Turnaway data; instead, an honest assessment of the effects of abortion should use the entirety of the scientific literature on this topic.

The most comprehensive review of available literature done in the U.S showed that 49 of 75 (65%) studies showed a positive correlation between abortion and adverse mental health outcomes.[69] In the literature reviewed as a whole, abortion increased the risk for depression, anxiety, substance abuse, suicidal ideation and suicidal behavior, even when compared to women with unintended pregnancies who carried to term.

Outside of the U.S., the most complete data set on this topic is the previously cited Finnish study on maternal mortality, which showed a seven-fold higher suicide rate after abortion when compared to giving birth. The mortality rate for suicides was 3.3/100,000 in ongoing pregnancies, 21.8/100,000 after termination of pregnancy, and 10.2/100,000 among non-pregnant women.[30] Certainly there are many factors that differ between the group of women seeking abortions, the group of women who continue toward delivery, and women who are not pregnant. At the very least, these data suggest that abortion cannot nullify the effects of these differences — it is not a cure for any pre-existing

determinants or conditions, nor is it a reliable preventative measure.

In summary, a minimum of 20-30% of women suffer from serious, prolonged negative psychological consequences after an abortion, which amounts to 260,000 new cases of mental health problems in the U.S. each year.[69] Given the current mental health crisis in the U.S., lawmakers may seek abortion restrictions to alleviate this burden on Americans.

Q *Could reporting requirements increase the accuracy of data?*

Published abortion outcomes data including rates of complications are inaccurate; the total number of legal abortions performed in the U.S. is not even known.[70] Data are voluntarily reported to the CDC by state health departments, and this leads to significant information gaps. California, for example, does not report any data on abortions.[71] The Guttmacher Institute independently supplies data, but it consistently reports higher numbers of abortions than the CDC. In 2014, for instance, the CDC reported 652,639 abortions while Guttmacher reported 926,000.[72,73] Twenty-seven states require abortion providers to report complications of abortions, but no enforcement penalties are in place. Twelve states require that coroners, emergency rooms or other health care providers to report abortion-related complications or deaths for investigation.[74] Mandated reporting and methods of enforcing these mandates could lead to more accurate data and a more informed policy approach.

Q *Do state-level abortion bans contradict "reproductive justice?"*

According to certain definitions of a just society, claims have been made that abortion restrictions violate "the human right [to] maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[75]

This framework focuses on the real burdens of pregnancy and childbirth, which are indeed separate from the subsequent burdens of parenting and are not relieved by surrendering or adopting a newborn.[76] However, this framework fails to take into account the fetal patient, which is also being cared for by prenatal care providers. Abortion is not the same as a decision avoid conceiving a child, it is actively ending the life of a preborn child.

State legislators need not endorse abortion as the only or best means of avoiding the legitimate burdens of pregnancy and childbirth. There are other options. Policymakers on both sides should strongly consider funding initiatives that alleviate poverty, aid families in need, improve prenatal care services, and prevent unplanned pregnancies.

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. The large majority of OB/GYNs do not perform abortions, suggesting it is not essential to women's healthcare.

2. Abortion restrictions do not prohibit physicians from separating mother and fetus through induction of labor or cesarean section in the case of life-threatening maternal conditions. Delivery can be initiated without the primary intent of causing the fetus to die.

3. Preterm or pre-viable delivery of an intact (usually living) fetus due to a life-threatening maternal condition is fundamentally different from intentionally ending the life of the fetal human being prior to delivery. The risk of death from induced abortion increases by 38% for every week after eight weeks gestation.

4. Surgical abortion is associated with increased rates of preterm birth; more abortions lead to higher increases in preterm birth rates.

5. There is an association between abortion and mental health problems, especially with certain underlying risk factors.

6. Abortion is associated with increased suicide rates in a Finnish sample.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

1. About 20-30% of women who undergo an abortion will subsequently suffer from serious, prolonged negative psychological consequences, which amounts to 260,000 new cases of mental health problems in the U.S. each year.

2. Some abortion restrictions reduce the rate of abortions, although many variables affect these situations.

3. Some women remember their abortion as an experience of uncertainty, incomplete counseling, and regret.

The following recommendations are based primarily on consensus and expert opinion (Level C):

1. Regulating handoff of post-abortion patients or requiring admitting privileges may support patient care by avoiding medical error, preventing patient abandonment, and improving measurement of abortion complications.

2. Waiting periods may improve consent and sureness about decision-making.

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AAPLOG
PRACTICE GUIDELINE

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Concluding Pregnancy Ethically

Uniform definitions surrounding the end of pregnancy are important for women's health providers, policymakers, and advocates. In particular, care of missed miscarriage, ectopic pregnancy, septic abortion, and previable life-threatening maternal conditions are often cited as conditions that require abortion. This guideline aims to describe a general approach to defining abortion, since not all medical or surgical decisions that surround the end of pregnancy are abortions. Here, abortion is defined as feticide (any drug, device or procedure used to ensure the death of the human being in utero before, during or in the process of separation of the mother and her embryo or fetus) or unnecessary delivery (any previable delivery without proportional danger of maternal death or any post-viable delivery with intentional death of fetus/neonate). Other ways to manage pregnancy are described that avoid abortion. Circumstances that are specifically NOT defined as abortion include separation of the mother and her embryo or fetus to prevent the mother's death or immediate, permanent, irreversible bodily harm which cannot be mitigated in any other way, including ectopic pregnancy and critical maternal illness.

Background

All pregnancies end. While pregnancy most often ends in delivery of live offspring, it ends in delivery of nonviable products of conception in a substantial minority of cases. Rarely, pregnancies end at the time of maternal death, with either live birth or stillbirth of the fetus.

Although pregnancies end with different outcomes, the actions leading to those outcomes can be either ethical or unethical. The outcome itself may be joyous, tragic, or a mixture of the two, but these emotions are separate from the morality of the actions leading to the outcome.

We recommend that all interventions considered to conclude a pregnancy be first evaluated within the guidelines of Table 1, "Unethical Actions to End a Pregnancy." These pregnancy-specific guidelines were written within the framework of the principle of double effect, as taught in the Catholic moral tradition. The principle of

AAPLOG Practice Guideline. This document was developed by [number] authors on the Research Committee. Practice Guidelines are evidence-based documents informing pro-life providers with high-quality, peer-reviewed literature.

double effect utilizes four criteria[1] for evaluating the moral status of a proposed action that will cause both good and bad effects:

a. The rationally chosen object of the act must be good, or at least morally neutral.

b. The agent must directly intend only the good effect and not the bad effect.

c. The good effect cannot be achieved by means of the bad effect.

d. The good effect must be proportionate to the bad effect, with no better alternative possible.

Different political and professional groups equivocate on terms such as "abortion," "induction," "delivery," and "termination of pregnancy." These terms refer to outcomes, and do not always clearly indicate what is essential (that is to say, what ethical principles are involved) in these endings.

While discussing issues which carry enormous ethical and medical weight, AAPLOG believes it to be important to carefully define terms and explain their essential differences (Figure 1), especially since those differences have not been well taught in typical medical education. This document proposes to outline the most common ways that pregnancy ends in order to establish a clear framework for evaluating the ethics of the actions around the conclusion of pregnancy. We seek to guide ways in which medical providers can respond to pregnancy complications both "medically and morally in light of the inviolable dignity and right to life of both the mother and the unborn child[2]." The topics are arranged according to pregnancy outcome, since the term "outcome" is well known to healthcare providers and their patients.

I. Spontaneous separation

A. Spontaneous separation <u>after</u> the gestational age of neonatal viability

Spontaneous separation of fetus from mother after neonatal viability is the most familiar group of outcomes, and has historically been termed "parturition" or "live birth." This category includes both term (37+ weeks) and preterm deliveries (prior to 37 weeks), but all occur after 23-24 weeks with a potentially viable[3] fetus. In their

[1] Medical Intervention in Cases of Maternal-Fetal Vital Conflicts, A Statement of Consensus. A Colloquium Organized by Ascension Health. The National Catholic Bioethics Center. 2014.

[2] Medical Intervention in Cases of Maternal-Fetal Vital Conflicts, A Statement of Consensus. A Colloquium Organized by Ascension Health. The National Catholic Bioethics Center. 2014.

[3] Although the word "viable" is the subject of much equivocation itself, one common use is to denote the gestational age after which a neonate could receive resuscitation approaching a 50% chance of survival, depending upon clinical circumstances. In the United States at the time of publication, this is generally regarded as 23 to 24 weeks with good dating or with an estimated fetal weight of 500 grams or greater. Within the 22- to 24-week range, opinions concerning viability and resultant practice varies widely, and it is beyond the scope of the present document to comment on these variations. It is important to determine the age of viability based upon one's

essences, term and preterm deliveries after spontaneous separation resemble each other in two key ways:

(1) There is no human intervention causing the pregnancy to end.

(2) The fetal patient is biologically capable of surviving the event in the absence of other disorders.

Thus, there is little moral discussion created by this class of pregnancy outcomes.

B. Spontaneous separation <u>before</u> the gestational age of neonatal viability

This category includes first- and second-trimester spontaneous deliveries, including spontaneous abortions and some preterm births between 20 weeks (the cutoff for the medical term "spontaneous abortion") and 23 weeks. Like spontaneous vaginal deliveries after viability[4], these outcomes typically do not arouse much ethical discussion because they don't involve medical causation.

II. Artificial Separation

Like the above categories, this category is also heterogeneous. Here, the uniting factor is that all the means to end pregnancy are artificial. "Artificial" is taken here in a classical sense, derived from the root *ars-*[5]. Hence "artificial" means brought about by human action. While "artificial" occasionally has negative connotations in colloquial use, the authors here use it to denote even indisputably good actions, such as medical induction of labor for pre-eclampsia with severe features at diagnosis after 34 weeks.

A. Artificial separation <u>after</u> the gestational age of neonatal viability

Although there are many complex medical (and sometimes ethical) decisions involved in artificial separation of mother and fetus after viability, they are beyond the scope of this monograph. In short, the risks of prematurity, fetal wellbeing and maternal morbidity must be carefully weighed to determine optimal timing of delivery, and the patient should be thoroughly counseled so that shared decision-making can be achieved.

B. Artificial separation <u>before</u> the gestational age of neonatal viability

Artificial separation prior to 23-24 weeks ought only to be undertaken in the most severe of circumstances, with the understanding of all parties involved that the fetus/neonate will likely not survive more

institutional and regional capabilities for neonatal resuscitation and ongoing care.

[4] Insightful readers may object to the use of the age of viability as an essential difference, since this is a moving target and depends not only on human development but on medical science. While the authors acknowledge this fact, they maintain that because life and death are key aspects of a physiological process involving inherent risk to multiple joined living organisms, the cutoff for viability (whenever it is) delineates this classification.

[5] *Ars-,* Latin: craft; encompassing the modern concept of technology; related to artifact and ardent

than minutes to hours after birth. In these tragic, but medically indicated, circumstances, multidisciplinary discussions are key, involving the patient, her family and/or support system, her nursing team, the neonatology team, her obstetrician and/or her Maternal Fetal Medicine physician. Pastoral care and perinatal hospice services should be offered whenever available, prior to delivery, if time permits.

As per Table 1, medically indicated artificial separation before viability is only ethically undertaken when both of the following criteria are met:

(1) There is proportional danger of maternal death or severe threat to long-term organ function.

and

(2) The maternal patient has provided her informed consent.

Examples of medically indicated previable separation are manifold. AAPLOG has already expressed the ethical reasons justifying previable induction of labor, such as with intrauterine infection, massive placental abruption, and progressive hypertensive disorders of pregnancy[6]. In countries with modern medical infrastructure, medical science is usually advanced enough to support the maternal patient through the 24 hours or less typically required for such inductions. If need be, blood product replacement, sedation, and intensive care can be employed to protect the maternal life in order to achieve successful induction of an intact fetal corpus without resorting to fetal dismemberment.

These discussions, consultations and decisions should be clearly documented in the patient chart, outlining the risks to both the maternal and fetal patient, the affirming maternal consent, and the plan for delivery management, genetic testing if indicated, and planned medical and psychosocial postpartum care.

III. Artificial Separation Methods

Once a decision for artificial separation has been made, there are various medical and surgical interventions that have been utilized by physicians to effect separation. We will briefly review several pharmacological and procedural interventions, with attention to ethical principles for each.

A. Medical Action

1. Medical action on the mother's body

This category is broad, and includes medically indicated inductions of labor (before and after viability), elective inductions of labor, and some medical

[6] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 3: "Previable Induction of Labor for Chorioamnionitis." *Issues Law Med*. 2018;33(2):247–256. www.aaplog.org Free full text: https://aaplog.org/wp-content/uploads/2019/02/PB-3-Previable-IOL-preliminary-without-tables.pdf

abortions. For the purposes of this document, "medically indicated" here means that there is some condition of the mother or the fetus which requires separation of the two in order to protect the life of one or the other (or both).

"Elective" in this document refers to inductions done in the absence of some condition of the mother or the fetus which requires separation of the two in order to protect the life of one or the other (or both).

a. Induction of labor

Labor can be stimulated with medications and other methods in order to initiate labor and effect delivery. Induction can be either medically indicated due to concerns for maternal/fetal health or elective.

While some elective inductions have been shown to offer medical benefit, the medical profession generally tries to avoid ending pregnancy without a compelling health-related cause prior to 39 weeks gestation. To date, the medical literature offers no support for the claim that abortion improves mental health or offers protection to mental health. In fact, there is evidence to the contrary. Thus, we consider inductions for the purpose of mental health treatment as elective. Instead of abortion, we recommend mental health therapy as would be indicated outside of pregnancy.

Similarly, "palliative induction" is offered to some patients carrying fetuses with life-limiting conditions such as anencephaly or renal agenesis. An induction in these cases may be considered between the time of diagnosis and the late preterm period. Improved maternal psychological health is typically the stated indication for "palliative induction", though in some circumstances, earlier induction is offered in order to plan an easier delivery when the fetus is smaller. Since the fetus has a life-limiting condition, this type of induction is thought to confer less risk to the fetus/neonate than preterm induction would place on a fetus with an expectedly normal extra-uterine lifespan. However, this view of "palliative induction" is mistaken, because in so doing, physicians actually accelerate the death of the fetus. They assume the same role that the fetus's disease process does, and they limit life even further. Although AAPLOG recognizes that certain details of anomalous gestations (e.g. head size in certain brain anomalies) can prompt legitimate concern requiring preterm induction, AAPLOG rejects the idea of "palliative inductions" simply to hasten the end of the pregnancy. Instead, AAPLOG proposes perinatal palliative care, which allows parents to be parents for the natural length of their fetus/neonate's lifespan, and allows them to grieve[7]. We also recommend maternal mental health resources as indicated per the individual clinical scenario.

[7] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 2: "Fetal Pain." *Issues Law Med*. 2018;33(2):237–246. www.aaplog.org Free full text: https://aaplog.org/wp-content/uploads/2019/02/PB-2-Fetal-Pain.pdf

Inductions have also been initiated when there are no fetal anomalies or maternal/fetal health conditions present, but the patient and physician have mutually agreed upon elective termination of pregnancy.

In settings where physicians lack training or volume in D&E procedures, inductions are often performed on L&D units in order to terminate undesired pregnancies. By definition, these elective procedures are not medically necessary. They are, as defined by AAPLOG, abortions.

B. Medication or chemical abortion

Much earlier in pregnancy, there are several drugs that can be given to effect separation of mother and fetus, inducing an abortion. Drugs used include but are not limited to:

● Mifepristone (RU-486, Mifeprex): a progesterone receptor antagonist, and prevents the maternal decidual tissue from receiving signals from maternal progesterone elaboration. This leads to a failure to supply the growing trophoblast, the major working organ of the embryo. The embryo dies of lack of nutrition and oxygen. By the AAPLOG definition, this medication acts as an abortifacient.

There are, however, other indications for use of this medication (e.g. spontaneous miscarriage, hyperglycemia in Cushing syndrome) which do not carry the same problematic ethical concerns.

• Misoprostol (Cytotec): a synthetic prostaglandin E1 analogue that induces uterine contractions. It can be used alone to induce abortion or in combination with mifepristone. Misoprostol also has other indications at varying dosage regimens (e.g. incomplete miscarriage, cervical ripening, labor induction, postpartum hemorrhage, gastric ulcer prophylaxis); these indications do not have associated ethical concerns.

It is important to note that both of the aforementioned medications can be used for ethically good or ethically bad indications. The medications themselves are ethically neutral, but the circumstances surrounding their use may be problematic. AAPLOG encourages continued access to ethically appropriate utilization of these medications, under physician and pharmacist supervision.

● Ulipristal (Ella): causes a dose-dependent decrease in endometrial thickness, even in doses pharmacologically similar to that used

clinically for emergency contraception[8][9][10][11]. Such changes in the endometrium lead to biological plausibility for iatrogenic embryo loss, although these changes take weeks for the human eye to appreciate[12].

● Levonorgestrel (Plan B One Step, Next Choice, My Way): while levonorgestrel 1.5 mg once or 0.75 mg in two doses 12 hours apart has been hailed as the perfect emergency contraceptive that won't disturb an already-implanted pregnancy, there are concerns[13][14][15] that it may also act after fertilization and/or after implantation. Of note, levonorgestrel at other doses and in other vehicles may be used as a traditional contraceptive. As with ulipristal use, there is concern for biologically plausible embryo loss.

All four drugs above act on maternal decidua and may alter implantation of an already active and separate human organism. Although the literature is yet unclear whether ulipristal and levonorgestrel can induce abortion at the doses utilized for emergency contraception, there is enough biological plausibility that it is reasonable for medical providers and faith-based

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[8] Glasier AF, Cameron ST, Fine PM, Logan SJ, Casale W, Van Horn J, et al. "Ulipristal Acetate versus Levonorgestrel for Emergency Contraception: A Randomised Non-inferiority Trial and Meta-analysis." *Lancet* 2010 Feb 13;375(9714):555-62. DOI: 10.1016/S0140-6736(10)60101-8. Epub 2010 Jan 29. Text available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60101-8/fulltext

[9] Hillemanns P, Hepp H. Letter to the Editor: K. Gemzell-Danielsson, "Emergency Contraception — Mechanisms of Action." *Contraception* 2013 Oct;88(4):581. DOI: 10.1016/j.contraception.2013.03.009. Epub 2013 Mar 22. Text available at: https://www.contraceptionjournal.org/article/S0010-7824(13)00095-4/fulltext

[10] Mozzanega B, Cosmi E, Battista Nardelli G. "Ulipristal Acetate in Emergency Contraception: Mechanism of Action." *Trends Pharmacol Sci* 2013 Apr;34(4):195-6. DOI: 10.1016/j.tips.2013.02.003. Epub 2013 Mar 13. Available at: https://www.cell.com/trends/pharmacological-sciences/fulltext/S0165-6147(13)00037-0?_returnURL=https%3A%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0165614713000370%3Fshowall%3Dtrue

[11] Rosato E, Farris M, Bastianelli C. "Mechanism of Action of Ulipristal Acetate for Emergency Contraception: A Systematic Review." *Front Pharmacol* 2016;6:315. Published 2016 Jan 12. DOI:10.3389/fphar.2015.00315. Free full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4709420/

[12] Williams AR, Bergeron C, Barlow DH, Ferenczy A. "Endometrial Morphology After Treatment of Uterine Fibroids with the Selective Progesterone Receptor Modulator, Ulipristal Acetate." *Int J Gynecol Pathol*. 2012;31(6):556–569. DOI:10.1097/PGP.0b013e318251035b. Available at: https://journals.lww.com/intjgynpathology/Abstract/2012/11000/Endometrial_Morphology_After_Treatment_of_Uterine.11.aspx

[13] Raviele K. "Levonorgestrel in Cases of Rape: How Does it Work?" *The Linacre Quarterly* 81 (2) 2014, 117–129. DOI: 10.1179/2050854914Y.0000000017. Free full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4028726/

[14] Kahlenborn C, Peck R, Severs WB. "Mechanism of Action of Levonorgestrel Emergency Contraception." *The Linacre Quarterly* 82 (1) 2015, 18–33. DOI: 10.1179/2050854914Y.0000000026. Free full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4313438/

[15] Schneider AP, Kubat C, Zainer CM. "Appreciation for Analysis of How Levonorgestrel Works and Reservations With the Use of Meloxicam as Emergency Contraception." *The Linacre Quarterly* 83 (1) 2016, 52–68. DOI: 10.1080/00243639.2016.1145894 Free full text: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5102175/

institutions with conscientious objection to opt out of providing either or both.

2. Medical action on an embryo/fetus's body

Medications can also be administered that act on the fetal body or placenta. These include but are not limited to methotrexate, which is discussed in a separate bulletin. Methotrexate acts on the trophoblast, the major working organ of the embryo[16].

B. Surgical Action

1. Surgical action on the mother's body

The most familiar (and most common) surgery performed in pregnancy is the cesarean delivery, whereby pregnancy is concluded by removing the fetus from the mother. There are many indications for cesarean delivery. They may be performed any time after viability, and can (in cases of emergency) be performed extremely quickly; fetal delivery is often possible within one minute of procedure start. Cesarean deliveries can also be performed in cases of already-deceased fetuses, though are often avoided in the case of stillbirth in order to minimize maternal surgical risks. While there is debate about whether cesarean deliveries are the optimal way to deliver women in certain circumstances, there is little debate about whether cesarean deliveries are morally acceptable in themselves.

In the first trimester, another surgical procedure performed on pregnant women is intervention for ectopic pregnancy, typically by salpingectomy[17][18]. This open or laparoscopic procedure is necessary and ethical in order to prevent maternal intra-abdominal hemorrhage and death. Although there may be embryonic cardiac activity at the time of surgery, this procedure meets the AAPLOG criteria set forth in Table 1, and are recommended and appropriate interventions for ectopic pregnancy.

Another set of procedures performed on pregnant women are transvaginal resections of products of conception, such as dilation and curettage (D&C) or dilation and extraction (D&E). While these procedures are surgical procedures that affect the mother's body, the effect on the fetal body is much more dramatic and thus they are placed in their own section.

B. Surgical action on the fetus's body

There are ways of ending a pregnancy by ending the life of one of the joined organisms. Examples include resection of

[16] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 9: "Ectopic Pregnancy." *Issues Law Med*. In press. www.aaplog.org

[17] There is good and reasonable debate amongst life-affirming physicians about the ethics of treating ectopic pregnancy with methotrexate and/or salpingostomy. Thus, we affirm the rights of medical providers and faith-based institutions with conscientious objection to methotrexate or salpingostomy to opt out of providing either or both. We agree that the ultimate purpose of these interventions is a life-saving one for the mother.

[18] Op. cit. Endnote 13, AAPLOG Practice Bulletin 9, "Ectopic Pregnancy."

the fetus in D&C, dismemberment and disarticulation of a living fetus in D&E, and selective reduction of one or more fetuses in multiple gestations.

Removal of a fetus from its implantation site in the first trimester during a procedure such as dilation and curettage scrapes the fetus and the extraembryonic organs it has built (e.g. the chorion and amnion) away from its site of obtaining nourishment and may break up the fetal body itself.

Dilation and extraction similarly divides the body parts of an older fetus and fetal death ensues. Death most often occurs from exsanguination when the umbilical cord is disconnected or when junctional hemorrhage occurs from disconnected extremities. Fetal death can also come about by neurological trauma when the calvarium is crushed or disconnected from the rest of the body. Physicians who perform D&Es know that fetal movement is occasionally palpable during these procedures, as there is already enough neuromuscular development for the fetus to relay some sensory input[19] and act in consequence. D&E does not allow for postnatal autopsy, and cuts short many cultural rituals of grieving, causing potential long-term effects on future pregnancy counseling and maternal mental health.

Some physicians opt to perform feticide and end the life of the fetus prior to performing D&E by injecting intra-cardiac potassium chloride or digoxin or by transecting the umbilical cord, believing this is a more "humane" and less painful way of performing the procedure. Regardless, it ends the life of a human being and does not honor the life of the fetal patient.

Finally, selective reduction, often performed by radiofrequency ablation of the umbilical cord or by intra-cardiac potassium chloride injection, also effects death of a previously-living fetus in the womb of a patient with multiple gestation. Ablation of the umbilical cord causes terminal fetal bradycardia and acidosis because the fetus loses its ability to conduct gas exchange.

The indications for selective reduction are often to preserve at least one live birth by lowering the risks associated with multiple gestation, such as extremely preterm birth, growth restriction, and even progressive conditions such as twin-twin transfusion syndrome or twin anemia-polycythemia sequence. Regardless, the act remains the same. In its essence, it is an action that ends the life of one human being in order to attempt to protect the life of another.

It is important to note two details regarding this section:

(1) None of the foregoing text applies to resection of a deceased fetus (i.e missed miscarriage or stillbirth). Pregnancy has already fundamentally concluded, but there is a delay in completion of the process of miscarriage or delivery.

[19] Op. cit. Endnote 3, AAPLOG Practice Bulletin 2, "Fetal Pain."

(2) None of the authors of the present document doubt the sincere concern that many physicians have in performing the above-described procedures on living fetuses, given that good effects may result (preserving the life of the mother or of other fetuses). However, the authors believe it important to separate the means from the consequences.

In conclusion, AAPLOG urges its colleagues in Obstetrics and Gynecology to cultivate a life-affirming practice of the specialty, in which both the maternal and fetal patients are treated with human dignity and respect.

Clinical Questions and Answers

- *When is it acceptable to move towards delivery for a medical comorbidity that threatens the mother's life during pregnancy?*

It is acceptable to deliver a patient before the gestational age at which the fetus could survive outside the womb only if the mother's life or health is in danger, which is proportional to the danger the fetus/neonate will face at birth. To be clear, this means the mother is facing death or immediate irreversible bodily harm which cannot be mitigated in any other way, including ectopic pregnancy and critical maternal illness, and this situation is rare.

It is deeply felt by the authors that this point is not clearly grasped by many women's health advocates and that many physicians do not seek alternative paths that could support maternal health during a pregnancy, rather than ending the pregnancy out of fear or blind adherence to what we are taught. There is relatively little literature on support of women with serious chronic health conditions through pregnancy, and the authors call on obstetricians and maternal-fetal medicine physicians to publish cases and protocols they utilize to find ways to preserve the mother's safety during a pregnancy. Before viability, a pro-life physician should exhaust all avenues of safeguarding the mother's health while she is joined to the fetus before recommending delivery.

After viability, the physician should still consider the mother's and fetus's proportion of risk, but there is not almost-certain risk of neonatal death and so induction can be initiated with greater ethical freedom. Induction criteria have been established for medical indications by other professional bodies including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine.

- *Is abortion (including medical abortion, D&C, or D&E) ever medically necessary?*

Elective induced abortions (performed purely for family planning) are medically unnecessary, because of their elective nature (Figure 1). However, maternal-fetal separation may be offered ethically in circumstances of maternal life or health endangerment, if that threat is proportional to the peril faced by the fetus or neonate at birth.

AAPLOG expresses significant concern with the inappropriate overuse of "maternal health" when the true reason for the termination of pregnancy is psychosocial

stress, fear of consequences of pregnancy, discomforts of pregnancy, lifestyle changes required by pregnancy, or pure autonomy. This is not medical necessity; rather, it is assertion of one human organism's power over another because of social problems that should be addressed in other ways.

AAPLOG recognizes that there are certain serious maternal medical conditions which worsen in pregnancy, and other conditions that arise *de novo* and require treatment to preserve the life of the maternal patient.

Before viability, grave maternal medical conditions may significantly endanger the life of the mother and fetus alike, with high risk of maternal mortality. Although not exhaustive, Table 2 provides a list of clinical scenarios that embody the type of severe risk that *may* place maternal life at proportional risk to fetal life – these are not automatic indications for maternal-fetal separation, but are circumstances in which proportional risk could be considered. Some of these clinical scenarios warrant rapid treatment with maternal-fetal separation in order to preserve the life of the mother, while others allow more time for consideration and consultation.

In the rare circumstances where maternal and fetal risk are proportionate, AAPLOG supports several ways of iatrogenically ending pregnancy. These ways largely include induction and cesarean section, which do not dismember the fetus. When maternal-fetal separation occurs in the setting of expected neonatal death, comfort care can and should be employed for the neonate born alive.

After viability and into the third trimester, life-threatening maternal conditions can usually be managed with delivery, either by induction of labor, or by cesarean section. If 24-48 hours is an acceptable time period in which to expect delivery, an induction can be carried out since there are regimens that effect delivery this quickly. If a more rapid delivery is required, a cesarean section is a good option. Many physicians are repelled by the idea of performing a cesarean section (possibly with a classical uterine incision) in order to avoid dismembering the fetus. However, it is AAPLOG's belief that classical cesarean delivery should not cause more repulsion than dismemberment or disarticulation of a living human fetus.

- *When is it acceptable to induce labor for a life-limiting fetal anomaly?*

AAPLOG recommends using the terminology "life-limiting fetal anomaly" rather than "incompatible with life". Given that a fetus with cardiac activity is presently alive, the term "incompatible with life" is a misnomer.

There do exist conditions, such as trisomy 6, which are fatal in the early first trimester. Other conditions are compatible with intrauterine life but not a normal lifespan outside the uterus. Such conditions include trisomy 13, trisomy 18, renal agenesis and anencephaly, but are not limited to these[20]. When a fetus is given a diagnosis for which little to no extra-uterine life is anticipated,

[20] In fact, other conditions typically thought of as extrauterine disabilities and supported in our culture also meet this definition. Such conditions include cystic fibrosis, some muscular dystrophies, and sickle cell disease.

the diagnosis is better described as "life-limiting."

With the term "life-limiting" in hand, it is easier to see that an induction for fetal anomaly actually further limits life. The healthcare provider in this case is acting in concert with the disease rather than combating it or helping patients to cope with it. As is true in the case of pediatric or adult life-limiting diagnoses, it is never appropriate to shorten the life of one person for the mental, emotional or social benefit or another. The physician can and should act in accord with her profession by promoting normal grieving and enabling the maternal patient (and her family if applicable) to savor and celebrate the extent of fetal and neonatal life lived, however limited[21].

Another way to see the mistake behind such "palliative inductions" is to note the absence of a proportion between the danger to the mother's life and the danger to the fetus's life. There is no equivalence between the danger to the mother and the danger to the fetus, so it is imperative that pregnancy be continued until such an equivalence develops. For example, if at 34 weeks a hydrocephalic fetus with holoprosencephaly has a head circumference of 40 weeks, the danger posed to the mother of a traumatic vaginal delivery or the risks inherent to a difficult cesarean section begin to approach the *a priori* risks to the fetus of respiratory distress due to prematurity.

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. There exist medical conditions that imminently endanger a pregnant woman's life such that it is proportional to fetal risk, which necessitate maternal-fetal separation.

2. Cesarean delivery is a rapid alternative to induction of labor, in the setting of insufficient time or level of care for a 24-hour process to effect delivery.

3. Mifepristone works to cause the demise of an already formed and living embryo if one is present.

4. Palliative inductions have not been demonstrated to benefit parents of fetuses with life-limiting conditions.

5. Centuries-old ethical principles outline when pregnancy can be artificially ended (even when neonatal death is expected): when maternal risk equals or exceeds expected neonatal risk, delivery by a method which does not effect fetal demise (e.g. induction of labor or cesarean section) is morally acceptable or good.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

[21] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 1: "Perinatal Hospice." www.aaplog.org Free full text: https://aaplog.org/wp-content/uploads/2019/02/PB-1-Perinatal-Hospice.pdf

1. Levonorgestrel as an emergency contraceptive may affect embryos which have already formed.

2. Perinatal palliative care offers some benefits to parents without excessive maternal risk.

The following recommendations are based primarily on consensus and expert opinion (Level C):

1. The need to end a pregnancy for a chronic medical condition is rare.

2. There is biological plausibility for an embryo-toxic, post-fertilization mechanism of action of ulipristal.

3. "Life-limiting" is preferred terminology compared to "not compatible with life" or "nonviable" when referring to conditions which can be tolerated *in utero* but shorten life outside the womb.

4. The expected maternal emotional effect of delivering a living child as a result of these recommendations (compared to a dead conceptus in situations otherwise managed by termination of pregnancy) require intense emotional support, and need further study.

Conclusion

Utilitarian solutions should not be engaged without moral and ethical reflection. There are actually very few ethically problematic ways of separating a mother and a fetus. These include: dismemberment or disarticulation of a living fetus or embryo; actions that utilize a drug, device or procedure to cause fetal/embryonal death prior to or during delivery; actions causative of fetal/embryonal death; previable delivery without proportional risk of maternal death or immediate, permanent, irreversible bodily harm which cannot be mitigated in any other way; or post-viable delivery with intentional death of the fetus or neonate. Any other delivery is ethically acceptable and encouraged by AAPLOG when medically appropriate.

References

1. See footnotes

Table 1. Unethical actions to end pregnancy

Ethical Principle	Action
Non-maleficence (fetal)	Dismemberment or disarticulation of a living fetus or embryo.
Non-maleficence (fetal)	Actions utilizing a drug, device or procedure to cause fetal or embryonal death prior to or during delivery.
Non-maleficence (fetal)	Actions causative of fetal or embryonal death
Beneficence (maternal), Autonomy (maternal)	Previable delivery without proportional risk of maternal death or immediate, permanent, irreversible bodily harm, which cannot be mitigated in any other way, **or** that which is performed without informed maternal consent.
Non-maleficence (fetal)	Post-viable delivery with intentional death of the fetus or neonate

Table 2. Conditions in pregnancy that <u>may</u> endanger maternal life or major bodily function

Condition	Details
Cardiovascular collapse	May be associated with obstetric (amniotic fluid embolism) or non-obstetric conditions
Exogenic cesarean scar pregnancy	A pregnancy implanted within the defect or "niche" of an incompletely healed cesarean scar (also called Type 2 CSP or "in-the-niche" CSP)
Ectopic pregnancy	A pregnancy that is not located within the uterine cavity
Active hemorrhage	Active bleeding into the peritoneal cavity, pelvic cavity, pelvic organs, or through the cervical canal associated with a maternal hemodynamic instability not resolved with usual treatments (transfusion, etc.)
Intrauterine infection	As per the current standard clinical definition
Preeclampsia with severe features before 22 weeks	As per the current standard clinical definition. Includes eclampsia and HELLP syndrome
Substantial cardiovascular disease	As defined by WHO Class III and IV with current hemodynamic compromise
Other conditions	Acute fatty liver of pregnancy, acute or chronic kidney disease, current maternal malignancy, hemolytic uremic syndrome, partial molar pregnancy, prior or planned solid organ transplant, thrombotic thrombocytopenic purpura, poorly controlled autoimmune disease

Figure 1.

Abortion

- **Feticide**: any drug, device or procedure used to ensure the death of the human being in utero before, during or in the process of separation of the mother and her embryo or fetus
- **Unnecessary Delivery**: an action that causes fetal delivery and results in embryonal, fetal or neonatal death without proportional danger of maternal morbidity or mortality

Not Abortion

- Separation of the mother and her embryo or fetus to prevent the mother's death or immediate, irreversible bodily harm with proportionate risk to the fetus, which cannot be mitigated in any other way
- Treatment of ectopic pregnancy
- Treatment for miscarriage
- Treatment of molar pregnancy

AAPLOG Practice Guideline. This document was developed by [number] authors on the Research Committee. Practice Guidelines are evidence-based documents informing pro-life providers with high-quality, peer-reviewed literature.