A Second Opinion: Response to 100 Professors

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ABSTRACT: Induced abortion is a controversial topic among obstetricians. "100 Professors" extolled the benefits of elective abortion in a Clinical Opinion published in AJOG. However, scientific balance requires the consideration of a second opinion from practitioners who care for both patients, and who recognize the humanity of both. Alternative approaches to the management of a problem pregnancy, as well as short and long term risks to women as published in the peer reviewed medical literature are discussed. Maintaining a position of "pro-choice" requires that practitioners also be given a right to exercise Hippocratic principles in accordance with their conscience. **Key Words: Induced abortion, abortion, law, teaching hospital, abortion-risks, unwanted pregnancy, physician right of conscience.**

Elective abortion is a controversial topic among obstetricians. A recent paper in AJOG[1] from 100 professors of obstetrics praised the legalization and proliferation of induced abortion in the United States. However, their assertions do not reflect the consensus of obstetricians and gynecologists. "100 Professors" is not the same as 100% of professors. Scientific balance requires the consideration of an alternative point of view from obstetricians and related practitioners who consistently value and care for the lives of both of their patients: the mother and her baby. While there are many aspects of the 100 professors article with which we agree, there are several statements in the article that are problematic with regard to an evidence based approach to the management of a socially difficult pregnancy. The problematic statements include: 1) Reference to the "need" for an elective abortion rate of 1 out of every 4 pregnancies without recognition that elective abortion is not a treatment for any physical disease, and carries nearly a 100% mortality for our fetal patients; 2) The call for hospitals to embrace performance of elective abortions, while simultaneously ignoring safety standards in the provision

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[1] One Hundred Professors of Obstetrics and Gynecology. "A statement on abortion by 100 professors of obstetrics: 40 years later." *Am J Obstet Gynecol*. 2013 Sep; 209(3):193-9. doi: 10.1016/j.ajog.2013.03.007. Epub 2013 Mar 15. PMID: 23500455

of abortion services; 3) The misrepresentation of the impact of legalization of abortion on maternal mortality; 4) The advocacy for physician coercion and withholding of evidence based information about the risks of abortion and the humanity of her fetus from the woman during the informed consent process; and 5) the anti-choice position of the 100 Professors which denies the right of health care practitioners to practice Hippocratic medicine.

Problematic Statements by 100 Professors

Reference to the "need" for an elective abortion rate of 1 out of every 4 pregnancies without recognition that elective abortion is not a treatment for any physical disease, and carries nearly a 100% mortality for our fetal patients.

> The 100 professors were remarkably prescient in anticipating the need for 1 million legal abortions and today's abortion rate of one in four pregnancies.[2]

It is of great concern to see 100 current distinguished professors ignore our tradition of concern for both patients, and their Hippocratic vow in order to advocate for ending the life of one patient at the request of another. The historical teaching of obstetrics has been the opposite, as evidenced by quotes from our standard obstetrical textbook Williams Obstetrics:

> Since World War II, and especially in the last decade, knowledge of the fetus and his environment has increased remarkably. As an important consequence the fetus has acquired status as a patient to be cared for by the physician as he long has been accustomed to caring for the mother.[3]

> Obstetrics is an unusual specialty of medicine. Practitioners of this art and science must be concerned simultaneously with the lives and well-being of two persons; indeed the lives of the two who are interwoven.[4]

Before further discussing areas of disagreement, it is essential to define the term "abortion" as used by the 100 Professors, and as used in this paper. The term "abortion" is defined by the CDC as: "an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate a suspected or known ongoing intrauterine pregnancy and produce a nonviable fetus at any gestational age."[5]

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[2] *Id.*

[3] Hellman, L.M.; Pritchard, J.A." Williams Obstetrics." 14th ed. New York: Appleton-Century-Crofts, 1971.

[4] Williams Obstetrics 18th edition. Editors: Cunningham, MacDonald and Gant, 1989

[5] Center for Disease Control and Prevention Morbidity and Mortality Weekly Report MMWR. "Abortion Surveillance-United States 2010," *Surveillance Summaries*, Vol. 62 No.8, Nov. 29, 2013. Page 2 under "methods."

Deliberately producing the death of the embryo or fetus is what distinguishes an elective abortion from a birth or a miscarriage. This purpose was made explicitly clear in the USSC Partial Birth Abortion Ban hearings. While the death of a fetus during a D&E can be ensured, some plaintiffs argued that the ban on partial birth abortions would be an infringement of trade, since crushing the skull of the fetus during delivery was necessary to ensure production of the abortionist's product, which is a dead fetus. The majority opinion quotes testimony from abortionists:

> Yet one doctor would not allow delivery of a live fetus younger than 24 weeks because 'the objective of [his] procedure is to perform an abortion,' not a birth. [citations omitted]. The doctor thus answered in the affirmative when asked whether he would 'hold the fetus' head on the internal side of the [cervix] in order to collapse the skull' and kill the fetus before it is born. [citations omitted]. Another doctor testified he crushes a fetus' skull not only to reduce its size but also to ensure the fetus is dead before it is removed. For the staff to have to deal with a fetus that has 'some viability to it, some movement of limbs,' according to this doctor, '[is] always a difficult situation.' [citations omitted].[6]

The alternative to partial birth abortion, the D&E, was described in affidavits from the National Abortion Federation and Planned Parenthood, as quoted in the majority opinion by Justice Kennedy:

> The woman is placed under general anesthesia or conscious sedation. The doctor, often guided by ultrasound, inserts grasping forceps through the woman's cervix and into the uterus to grab the fetus. The doctor grips a fetal part with the forceps and pulls it back through the cervix and vagina, continuing to pull even after meeting resistance from the cervix. The friction causes the fetus to tear apart. For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman. The process of evacuating the fetus piece by piece continues until it has been completely removed. A doctor may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes. Once the fetus has been evacuated, the placenta and any remaining fetal material are suctioned or scraped out of the uterus. The doctor examines the different parts to ensure the entire fetal body has been removed. [citations omitted].
>
> Some doctors, especially later in the second trimester, may kill the fetus a day or two before performing the surgical evacuation. They inject digoxin or potassium chloride into the fetus, the umbilical cord, or the amniotic fluid. Fetal demise may cause contractions and make greater dilation possible. Once dead, moreover, the fetus' body will soften, and its removal will be easier. Other doctors refrain from injecting chemical agents, believing it adds risk with little or no medical benefit. [citations omitted].[7]

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[6] Gonzales v Carhart, 550 U.S. 124, 139-140 (2007).

[7] *Id.* at 135-136.

> D&E and intact D&E are not the only second-trimester abortion methods. Doctors also may abort a fetus through medical induction. The doctor medicates the woman to induce labor, and contractions occur to deliver the fetus. Induction, which unlike D&E should occur in a hospital, can last as little as 6 hours but can take longer than 48. It accounts for about five percent of second-trimester abortions before 20 weeks of gestation and 15 percent of those after 20 weeks.[8]

D&E remains the most common method of elective abortion when suction abortion is no longer adequate to kill and remove the fetus. For clarity of further discussion, we will use the term "abortion" or "elective abortion" consistent with the CDC definition, to mean the intentional killing and removal of the embryo or fetus at the request of the mother.

In contrast, separating the mother and fetus before fetal viability in life-threatening circumstances is distinct from elective abortion, since the purpose of the parturition is to hopefully produce both a living mother and a living fetus, but at least a living mother. There is no intent to produce a dead fetus. An international committee convened to investigate the relationship between elective abortion and maternal health care concluded:

> As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman. We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child. We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.[9]

Most elective abortions, even late term abortions are not done to protect the life of the mother. A recent study from the Bixby Center for Global Reproductive Health at UCSF states:

> Results: Women's reasons for seeking an abortion fell into 11 broad themes. The predominant themes identified as reasons for seeking abortion included financial reasons (40%), timing (36%), partner related reasons (31%), and the need to focus on other children (29%). Most women reported multiple reasons for seeking an abortion crossing over several themes (64%).[10]

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[8] *Id*. at 139-40.

[9] Committee on Excellence in Maternal Health Care. Available at http://www.dublindeclaration.com/ last visited 4/30/2014.

[10] Biggs MA, Gould H, Greene-Foster D. "Understanding why women seek abortions in the US." *BMC Women's Health* 2013, 13:29.

The findings of the Biggs study, that most abortions are done for socio-economic reasons, confirms other similar studies.[11, 12] Using the CDC definition of "elective abortion" (lines 37-40) as being the termination of a pregnancy with the intention to "produce a nonviable fetus at any gestational age," there is semantic support for stating that there is no medical "need" for an elective abortion. This is because the intention of a pregnancy termination for a medical complication of pregnancy (e.g. a pregnancy in a woman with pulmonary hypertension) is not primarily to kill the fetus, but simply to terminate the pregnancy, the death of the fetus being an unintended consequence.

In fact, elective abortion treats no medical illness, since pregnancy is not a disease. Elective abortion is an attempt to resolve social problems by subjecting women to a surgery, with all the inherent risks of surgery. Elective abortion also terminates the life of the human embryo or fetus in an effort to resolve a social, not medical, problem. Physicians who care for both their maternal and fetal patients seek to help women solve social problems with social solutions, rather than killing their embryos or fetuses. A list of suggestions from the authors is available as Appendix B.

The call for hospitals to embrace performance of elective abortions, while simultaneously ignoring safety standards in the provision of abortion services.

The 100 Professors state: "Today 90% of abortions, including the 10% that are in the second trimester, are done away from hospitals."[13] The choice of office-based abortion allows the abortionist to avoid the scrutiny inherent in hospital-based procedures: peer-review, morbidity and mortality review and records review, as well as state and federal safety standards. Abortions performed in the office often have minimal accountability as evidenced by the recent tragic deaths in the office of Dr. Gosnell. Office-based procedures legally circumvent safety regulations standard in surgical centers and hospitals performing similar levels of outpatient surgery.

The 100 Professors refer to this discrepancy in safety standards at free standing abortion clinics:

> At the same time, many states have passed legislation to shut down the freestanding clinics that are now responsible for most abortions by enacting cumbersome and expensive building regulations that are disguised as patient safety requirements.[14]

[11] Finer LB[1], Frohwirth LF, Dauphinee LA, Singh S, Moore AM. "Reasons U.S. women have abortions: quantitative and qualitative perspectives." *Perspect Sex Reprod Health.* 2005 Sep; 37(3):110-8.

[12] Jones RK1, Frohwirth L, Moore AM. "More than poverty: disruptive events among women having abortions in the USA." *J Fam Plann Reprod Health Care.* 2013 Jan; 39(1):36-43. doi: 10.1136/jfprhc-2012-100311. Epub 2012 Aug 20.

[13] One Hundred Professors of Obstetrics and Gynecology. "A statement on abortion by 100 professors of obstetrics: 40 years later." *Am J Obstet Gynecol*. 2013 Sep; 209(3):193-9. doi: 10.1016/j.ajog.2013.03.007. Epub 2013 Mar 15. PMID: 23500455.

[14] *Id*.

> There are now 25 states that, under the guise of patient safety, restrict abortions to hospitals that have their own restrictions or to specialized facilities.[15]

> Today, some hospitals confine pregnancy termination, even routine first and uncomplicated second-trimester spontaneous and induced abortions to operating rooms and have credentialing rules that prohibit the use of conscious sedation for these patients.[16]

In essence, the 100 professors contend that hospitals should allow abortionists to do abortions in the hospital, but believe they should exempt abortion providers from having to comply with all the safety requirements and regulations that are applied to other comparable surgeries. Yet, it is only in the case of abortion that these 100 professors oppose the health and safety regulations which surgical centers and hospitals are required to meet. Then, ironically, the 100 Professors recognize the need for the very safety requirements which they had previously argued were unnecessary:

> Although most first-trimester and many second-trimester abortions can be done safely and efficiently in a clinic setting, some second-trimester abortions, particularly those that are complicated by medical conditions, should be done in a hospital with rapid access to the operating room, interventional radiology, blood bank and other emergency interventions.[17]

What about the first-trimester and second trimester abortions which cannot be done safely and efficiently, and whose complications cannot be anticipated prior to the surgery? It is for the safety of women involved that all surgeries, including elective abortions, be held to standard safety requirements and regulations.

The misrepresentation of the impact of legalization of abortion on maternal mortality.

The 100 professors state: "The Centers for Disease Control and Prevention and others subsequently documented a steep decline in hospital admissions and morbidity and mortality rates from illegal abortion promptly after Roe v Wade made abortion legal in all states."[18]

However, this is a factual error. The table below shows CDC data on the maternal mortality rate in the United States from 1915 to 2003. There was a significant decline in maternal mortality beginning in the 1940's and continuing steadily until 2000. Abortion was not legalized in the United States until 1973. Abortion legalization did not increase the already present decline in maternal mortality. It is remarkable that the 100 professors are apparently unaware of CDC data on maternal mortality.[19]

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[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] Department of Health and Human Services, Center for Disease Control and Prevention. "Maternal Mortality and Related Concepts." *Vital and Health Statistics* Series 3 No. 33, Feb. 2007. Figure 1. Available at http://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf .

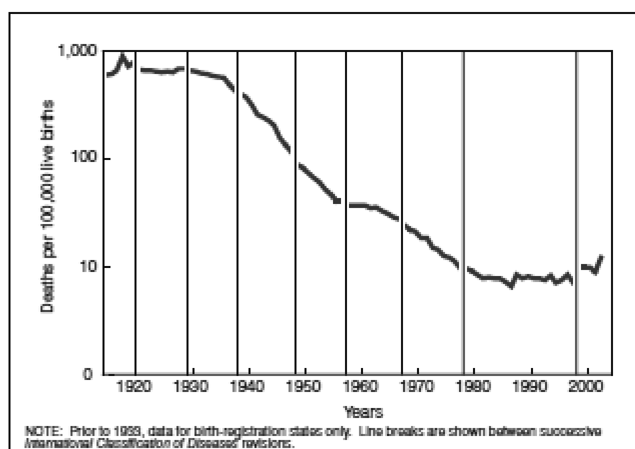

Figure 1. Maternal mortality rates, United States, 1915–2003

The advocacy for physician coercion and withholding of evidence based information from women about the risks of abortion, and the humanity of her fetus during the informed consent process.

The 100 professors quote their predecessors who recommended coercing women to abort during the informed consent process: "There are patients…who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies."[20] For a physician to actively encourage a woman to choose elective abortion is to abuse the power inherent in the doctor-patient relationship, especially in the face of a wanted pregnancy. This archaic approach to adverse prenatal diagnosis was not based in science, but in the desire of the physician to "get it over with." In situations of wanted pregnancies with an adverse prenatal diagnosis, the evidence based medicine approach is to offer perinatal hospice support, which has been shown to result in satisfactory outcomes for women and their families.[21, 22, 23, 24]

Evidence from peer reviewed studies of legal induced abortion reveal that abortion has the same immediate risks as any other surgery: hemorrhage, failed procedure and

[20] One Hundred Professors of Obstetrics and Gynecology. "A statement on abortion by 100 professors of obstetrics: 40 years later." *Am J Obstet Gynecol*. 2013 Sep; 209(3):193-9. doi: 10.1016/j.ajog.2013.03.007. Epub 2013 Mar 15. PMID: 23500455.

[21] Calhoun BC, Napolitano P, Terry M, Bussey C, Hoeldtke NJ. "Perinatal hospice: comprehensive care for the family of the fetus with a lethal condition." *J Repro Med* 2003; 48:343-348.

[22] D'Almeida M, Hume RF, Jr., Lathrop A, Njoku A, Calhoun BC. "Perinatal Hospice: Family-Centered Care of the Fetus with a Lethal Condition." *J of Physicians and Surgeons* 2006; 11(3):52-55.

[23] Calhoun BC, Hoeldtke NJ, Hinson RM, Judge K. "Perinatal hospice: should all centers have this service?" *Neonatal Network* 1997; 16:101-102.

[24] Hoeldtke NJ, Calhoun BC. "Perinatal hospice." *Am J Obstet Gynecol* 2001; 185:525-29.

need for reoperation. A large peer reviewed registry based study gives the numerical value to these risks in the first trimester,[25]

1. hemorrhage (15.6% of women undergoing medical abortion vs 2.1% of surgical abortion p<0.001),
2. incomplete abortion (medical 6.7% vs surgical 1.6% p<0.001),
3. need for surgical re-evacuation (medical 5.95 vs surgical 1.8% p<0.001),

and these risks increase in the second trimester.[26]

These complications increase dramatically as gestational age increases, as evidenced by CDC data as well as other studies.[27, 28] In fact, according to CDC data, the legal induced abortion mortality rate for abortions performed after 22 weeks exceeds the estimated risk of death from live birth.[29, 30]

Statistically significant peer reviewed studies[31] over 4 decades have revealed the association between abortion and subsequent preterm birth, including: Iams (2010 AJOG)[32], Hardy (2013 J Obstet Gynaecol Can)[33],Shaw (2009 BJOG)[34], Swingle (2009 J Repro Med)[35] Brown (2008 J EpidemComHealth)[36] The Epipage[37] study, and the Eu-

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[25] Maarit Niinimäki, MD, Anneli Pouta, MD, PhD, Aini Bloigu, Mika Gissler, BSc, PhD, Elina Hemminki, MD, PhD, Satu Suhonen, MD, PhD, and Oskari Heikinheimo, MD, PhD, "Immediate Complications After Medical Compared With Surgical Termination of Pregnancy." *Obstet Gynecol* 2009; 114:795–804.

[26] Mentula, Maarit, Niinimaki M, Suhonen S, Hemminki E, Gissler M and Heinkinheimo O. "Immediate adverse events after second trimester medical termination of pregnancy: results in a nationwide registry study." *Human Reproduction* (0)(0) p 1-6 2011.

[27] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. "Risk Factors for Legal Induced Abortion–Related Mortality in the United States." *Obstet Gynecol* 2004; 103:729-37.

[28] Mentula, Maarit, Niinimaki M, Suhonen S. Hemminki E, Gissler M and Heinkinheimo O. "Immmediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study." *Human Reproduction* (0)(0) p 1-6 2011.

[29] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. "Risk Factors for Legal Induced Abortion–Related Mortality in the United States." *Obstet Gynecol* 2004; 103:729-37.

[30] Chang J, Elam-Evans L, Berg C, Herndon J, Flowers L, Seed K, Syverson C, "Pregnancy-Related Mortality Surveillance-United States-1991-1999." 52(SS02); 1-8 Division of Reproductive Health, Center for Disease Control, Atlanta, Georgia, Feb 21, 2003.

[31] List of studies giving evidence of the association between induced abortion and subsequent Preterm Birth available at: http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-preterm-birth/bibliography/; last visited 5/12/2014.

[32] Iams JD, Berghells V. "Care for women with prior preterm birth." *Am J Obstet & Gynecol*. Aug. 2010; 203(3):89-100.

[33] Hardy G, Benjamin A, Abenhaim H. "Effect of Induced Abortions on Early Preterm Births and Adverse Perinatal Outcomes." *J Obstet Gynaecol Can* 2013; 35(2):138–143.

[34] Shah P. et al. "Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis." *BJOG* 2009; 116(11):1425-1442.

[35] Swingle HM, Colaizy TT, Zimmerman MB, Moriss FH. "Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis." *J Reproductive Med* 2009;54:95-108.

[36] Brown, et al. "Previous Abortion and the risk of low Birth weight and preterm birth." *J Epidem Com Health* 2008; 62:16-22.

[37] Moreau C, et al. "Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study." *BJOG* 2005; 112:430-437.

roPop[38] study. Even the Institute of Medicine lists elective abortion as an "immutable" risk factor for preterm birth.[39] The most recent summary by McCaffrey[40] summarized the impact of abortion on prematurity. The association between abortion and preterm birth is settled science.

Accumulating studies from around the world continue to show an increased risk of mental health problems for women who abort as compared with women who carry a pregnancy and give birth, including a 2011 quantitative comprehensive meta-analysis which reports an 81% overall increased risk for mental health problems, including depression, anxiety, alcohol abuse, and suicide behaviors associated with abortion.[41, 42] The National Abortion Federation lists 13 predisposing factors for negative reactions after abortion.[43] Considering the reasons that most women seek abortion as published by Biggs,[44] one can note that a substantial number of women fall into the NAF risk catagories for adverse mental health outcomes.

Accumulating studies from around the world[45] also provide increasing evidence that the loss of a pregnancy at less than 32 weeks gestation for any reason, including elective abortion, prior to the completion of a term pregnancy, is associated with an increased risk of premenopausal breast cancer, including a study[46] designed to look at pregnancy losses from etiologies other than elective abortion. The recent 2012 study in the French National BRCA cohort confirms this finding for BRCA carriers as well.[47]

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[38] Ancel P, et al. "History of induced abortion as a risk factor for preterm birth in European countries: results of the EUROPOP survey." *Hum Reprod* 2004; 19:734-40.

[39] Institute of Medicine, National Academy of Science, *Preterm Birth: Causes, Consequences, and Prevention* 625 (Washington, DC: National Academy Press, 2009).

[40] McCaffrey M. "Abortion's Impact on Prematurity: Closing the Knowledge Gap." *Family North Carolina* (Spring) 2013; 8(2): 22-27); available at: http://www.ncfpc.org/FNC/1305-FNC-Spring13-Abortion'sImpactOnPrematurity2.pdf last visited 4 30 2014.

[41] Coleman PK. "Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009." *Brit J Psychiatry* (2011) 199, 180–186. doi: 10.1192/bjp.bp.110.077230.

[42] Bibliography of studies available at http://aaplog.octoberblue.com/wp-content/uploads/2010/02/Full-Bibliography-Mental-Health.pdf.

[43] National Abortion Federation. *A clinicians guide to medical and surgical abortion*. Chptr 3 pg 29 Table 3-2 (See Appendix C for listing of risk factors from Table 3-2).

[44] Biggs MA, Gould H, Greene-Foster D. "Understanding why women seek abortions in the US." *BMC Women's Health* 2013, 13:29.

[45] Lanfranchi, AE & Fagan, P. "Breast Cancer and Induced Abortion." *Issues in Law & Med* (2014), 29:3-133.

[46] Innes KE, Byers TE, "First pregnancy characteristic and subsequent breast cancer risk among young women." *Int. J. Cancer* (2004) 112:306-311.

[47] Lecarpentier J, Nogues C, Mouret-Fourme E, Gautherier-Villars M, Lasset C, et al. "Variation in breast cancer risk associated with factors related to pregnancies according to truncating mutation location, in the French National BRCA1/2 carrier cohort (GENEPSO") *Breast Cancer Research* 2012, 14:R99 doi:10.1186/bcr3218. ISSN 1465-5411.

And mortality from all causes is higher in women who abort vs women who give birth.[48, 49] It is somewhat surprising that the 100 professors cite The Allan Guttmacher Institute, with its historic past financial relationship to Planned Parenthood, the nation's largest abortion provider, and neglect the entire body of medical literature performed by researchers not financially profiting from elective abortion.

It is further surprising that the 100 Professors make no mention of the omission of factual information from women during the abortion consent process. In the majority opinion in *Gonzales v. Carhart*, Justice Kennedy cites abortion expert witnesses who stated that they do not describe the procedure during the informed consent process.[50] And we can understand why. It must cause great internal conflict for an obstetrician to tell one mother at nineteen weeks gestation with a dilated cervix due to cervical insufficiency that "We can try to save your baby with an emergency cerclage," but the same day tell another patient with an uncomplicated but unwanted pregnancy at 19 weeks that "We can remove the products of conception," or "We can empty the uterus," or "We can do an abortion." If we speak of saving the baby with the cerclage, the honest way to state the alternative is "We will kill the baby by an abortion if it's what you desire." Euphemisms such as "removing the products of conception," "terminating the pregnancy", etc., don't change the fact that the purpose of an elective abortion is to produce a dead fetus. These euphemisms deny the mother important factual information that she needs to understand the "choice" of abortion. No matter how safely an abortion can be done for the mother, even if the physical risk could someday be reduced to zero, it's never safe for the fetus, who is almost always killed.

Glossing over the evidence-based risks and negative effects of pregnancy termination on women, and denying the scientific humanity and biological reality of the unborn child denies women a truly informed choice.

The anti-choice position of the 100 Professors which denies the right of health care practitioners to practice Hippocratic medicine.

We do not believe that the 100 Professors are being truly pro-choice, when they deny the rights of medical practitioners who refusal to violate their Hippocratic Oath. Such professors would allow for physicians not to refer for other elective procedures such as female genital mutilation, another surgery done for social reasons. We all agree that such surgery destroys normal tissue without giving any medical benefit. So also, elective abortion destroys not just normal tissue, but destroys a human life. Surely since a human life is destroyed in an elective abortion, then it is reasonable for a physician to

[48] Gissler M, Lauppila R, Merilainen J, Toukomaa H, Hemminki E. "Pregnancy-associated deaths in Finland 1987-1994: definition problems and benefits of record linkage." *Acta Obstet Gynecol Scand*. 1997 Aug; 76(7):651-7.

[49] Coleman PK, Reardon DC, Calhoun BC. "Reproductive History Patterns and Long-Term Mortality Rates: A Danish Population Based Record Linkage Study." *European J Public Health* (2013), 23(4): 569-574.

[50] Gonzales v. Carhart, 550 U.S. 124 (2007).

refuse to cooperate in destroying the life of one of her or his patients. And in an age of "choice", hospitals, nurses, and physicians should also have a choice not to participate, in any way, in an act which is clearly the destruction of an innocent human life - the killing of an unborn child. Medical practitioners shouldn't be forced to participate in, refer for, or pay for someone's elective abortion.

Areas of Agreement with the 100 Professors

The 100 professors conclude with these pledges. With some caveats, we can agree with most of these goals.

" (a) [T]each future practitioners about all methods of contraception and about uterine evacuation throughout pregnancy, which ranges from miscarriage management to emergent evacuations and the treatment of complications in accordance with our professional mandate from the Accreditation Council for Graduate Medical Education."[51]

We agree with this goal, which has traditionally been called Obstetrics and Gynecology Residency programs. However, there is no need to kill living fetuses and embryos in order to accomplish that goal. Anyone who has completed an approved residency program in Obstetrics and Gynecology is well aware that such programs offer ample opportunity to empty the uteri of women with embryonic or fetal loss at all gestational ages.

We further commit to remind future practitioners of their roots in the Hippocratic oath to first do no harm to heal sometimes but care always, and we commit to defend the conscience rights of providers who abide by their Hippocratic Oath and refuse to electively terminate the life of their unborn patients.

(b) [P]rovide evidence-based information to all patients who seek family planning or pregnancy termination.[52]

We can also agree with this goal. We would welcome such an evidence based approach which includes acknowledgement of the 4 decades of studies demonstrating an association between induced abortion and preterm birth in subsequent pregnancies, the studies on abortion and adverse psychological outcomes for women who abort vs women who give birth, and the studies on pregnancy loss prior to completion of a term pregnancy and the association with subsequent breast cancer. We would welcome screening for the risk factors for adverse mental health outcomes as listed by the National Abortion Federation[53] prior to abortion, as part of the informed consent process.

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[51] One Hundred Professors of Obstetrics and Gynecology. "A statement on abortion by 100 professors of obstetrics: 40 years later." *Am J Obstet Gynecol*. 2013 Sep; 209(3):193-9. doi: 10.1016/j.ajog.2013.03.007. Epub 2013 Mar 15. PMID: 23500455.

[52] *Id*.

[53] National Abortion Federation. *A clinicians guide to medical and surgical abortion.* Chptr 3, pg 29, Table 3-2 (See Appendix C for listing of risk factors from Table 3-2.)

Also, we welcome the evidence based discussion of the risk to the subset of women who abort their first pregnancy, especially in their teen years, then delay childbearing and the resulting increased risk of breast cancer. This discussion is especially pertinent to women with BRCA mutations.

We further propose that the requirement to give evidence-based information be extended to include accurate description of the gestational age specific characteristics of the embryo or fetus, and an accurate description of the abortion procedure used to end the life of that embryo or fetus.

(c) [P]rovide evidence based information to legislators who propose laws requiring inaccurate information or unindicated procedures for women seeking to terminate a pregnancy.[54]

We can also heartily support this goal, understanding that such evidence based information includes the studies on abortion and preterm birth, abortion and adverse mental health outcomes, and abortion and breast cancer for the subset of women who abort a first pregnancy before 32 weeks and subsequently delay childbearing, as well as evidence based information on the gestational age specific description of the fetus and an accurate description of the abortion procedure designed to end the life of that fetus. We will join with the 100 professors in passing such evidence based legislation.

(d) [I]nsist that the hospitals where we care for women and teach students and residents admit patients who require hospital-based pregnancy terminations.[55]

Any woman who requires a separation of the mother and fetus to save the mother's life is already admitted in all hospitals capable of the procedure, including Catholic Hospitals. However, the 100 professors here used the term "pregnancy termination" instead of abortion. The use of "pregnancy termination" instead of "abortion" underscores the fact that elective abortions are, by definition, not medically required.

Pregnancy is not a disease, and elective abortion does not treat any medical problem. Elective abortion subjects women to all the risks of surgery in order to solve a social, not a medical problem, and carries almost a 100% mortality for the subset of unborn patients involved in the procedure (the fetus), and a maternal mortality rate that exceeds childbirth for women who abort after 22 weeks, according to CDC statistics[56].

[54] One Hundred Professors of Obstetrics and Gynecology. "A statement on abortion by 100 professors of obstetrics: 40 years later." *Am J Obstet Gynecol*. 2013 Sep; 209(3):193-9. doi: 10.1016/j.ajog.2013.03.007. Epub 2013 Mar 15. PMID: 23500455.

[55] *Id*.

[56] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. "Risk Factors for Legal Induced Abortion-Related Mortality in the United States." *Obstet Gynecol* (2004); 103:729-37.

Epilogue

We realize that once physicians have advocated for or performed elective abortions, it is very difficult to change that position. However, it is not impossible to reconsider past clinical actions and to change practice for the improvement of both maternal and fetal health. Some of us have performed abortions in the past and realized over time that the procedure was destroying both of our patients. It is rare, however, for a physician who has come to understand the humanity of both of our fetal and maternal patients to resort again to elective abortion as the solution to a problem pregnancy. We write in the hope that many obstetrician colleagues, as well as residents and medical students who are not yet committed to either position will realize that the "100 Professors" do not represent 100% of all professors and that there are more positive solutions to a problem pregnancy than the destruction of a human life.

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Appendix B. Suggestions to help with a socially problematic pregnancy from the authors

1. If a woman is troubled because she cannot afford obstetric care, you can offer to provide her care without charge. Many of us have done this, and it's not a great burden.

2. If a woman is in an abusive relationship and has no safe place to stay, you can connect her with a safe house or shelter, or arrange for a safe place for her to stay. Some of us have done this, and can tell you that you will be edified by good people, who may stay in touch for years, and are grateful for your help in giving life to their child.

3. If a woman is worried that she won't be able to financially care for her child, you can put her in touch with one of the many pregnancy aid centers which can provide clothing, food, diapers, and a crib, and then you can support these centers financially. Many of us have done this—it helps.

4. If a woman feels that the pregnancy and caring for the child will crush her dreams of an education, you can encourage her that it doesn't need to, and in fact, the need to care for a child can be a strong motivation for doing well in school. Many of us have done this, and it has helped women who need encouragement to care for their child.

5. If a woman feels she can't raise a child with disabilities, you can put her in touch with one of the agencies (e.g. Bethany Christian Services, Michigan Adoption Resource Exchange, and others) which have waiting lists of families willing to provide love and comfort for children with disabilities, even the most severe and lethal problems, such as anencephaly or Trisomy 18, for as long as the child lives. Many of us have done this, and it helps both the mom of the disabled child, and the families who welcome that child into their lives.

6. You can also help entire families in temporarily stressful situations by opening your home to foster children. You'll provide a safe and loving environment for the child while the parents work out their problems. When the child eventually goes home, you can start a 529 educational fund for the child. Some of us have done this many times, and it's encouraging to the parents that someone believes enough in them and their child to think a higher education is possible. It makes them see their child differently. It gives the parents more hope for this child and perhaps for their other children, present and future.

Appendix C

COMPLETE LIST OF RISK FACTORS IDENTIFIED IN THE NAF's "A Clinician's Guide to Medical and Surgical Abortion"

Predisposing Factors for Negative Reactions

(Excerpted from Chapter 3, p29 - Table 3-2.)

1. Low self-efficacy: expecting depression, severe grief or guilt, and regret after the abortion
2. Low self-esteem prior to the abortion
3. An existing mental illness or disorder prior to the abortion
4. Significant ambivalence about the decision
5. Lack of emotional support and receiving criticism from significant people in their lives
6. Perceived coercion to have the abortion
7. Belief that a fetus is the same as a 4-year-old human and that abortion is murder
8. Fetal abnormality or other medical indications for the abortion
9. Usual coping style is repressing thoughts or denial
10. Unresolved past losses and perceptions of abortion as a loss
11. Experiencing social stigma and antiabortion demonstrators on the day of the abortion
12. Past childhood sexual abuse.
13. Commitment to the pregnancy