

Written testimony of Christina Francis, MD for the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce hearing on “Roe Reversal: The Impacts of Taking Away the Constitutional Right to Abortion”

July 16, 2022

Chairs DeGette and Pallone, Ranking Members Griffith and McMorris Rodgers, Members of the Subcommittee,

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

Our country is currently divided over the issue of abortion, but I do think that there is common ground to be found. One thing we should all agree upon is that women deserve excellent healthcare and to be empowered with accurate information to inform that healthcare. We have had nearly unfettered access to abortion in this country over the last 49 years and yet we continue to have one of the worst maternal mortality rates¹ in the developed world, along with the worst preterm birth rate.² I believe that my patients deserve better and it is time for us to look for real solutions to the root causes of these problems.

As OB/GYN physicians, we care for two patients during pregnancy. Abortion guarantees the ending of the life of one of our patients – and can severely threaten the life and health of the other. Science is clear that a new, distinct, and living human being comes into existence at the moment of fertilization. Dr. Ward Kischer, the author of one of my medical school textbooks, said this: “Every human embryologist in the world knows that the life of the new individual human being begins at fertilization...It is a scientific fact.”³ Abortive procedures are more than detrimental to the life of the pre-born child, though - they are also dangerous to the mother both in the short and long-term.

Pregnancy is not a disease and elective abortion is not healthcare. Despite what proponents of abortion may claim, elective abortion carries no maternal benefit and ends the life of a separate human being. As demonstrated by hundreds of studies over nearly five decades, abortive procedures carry several deleterious effects for women, including the risk of preterm birth and mental health problems. These problems have a statistically greater impact on minority populations.

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

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

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

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

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

Firstly, extremely poor data collection on maternal deaths and their causes as well as inaccurate data on the number of abortions performed in the United States have led to false claims that abortion is safer than childbirth.⁴

Abortion proponents claim that restricting abortion has a disparate negative impact on minority women. In taking a closer look, however, it is clear that this argument is not only disproven by science - it serves to further target minorities by creating even higher rates of elective abortion which will lead to greater rates of maternal mortality – something that is already unacceptably high in the United States. It is noteworthy that there are significant differences in birth outcomes in black women when compared with non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in black women end in induced abortion, compared to 11% for white women.⁵

Less than half of pregnancies in black women result in the birth of a live baby (48%). Induced abortion is 3.7 times more common in black than in non-Hispanic white women, and black women more commonly have later abortions (13%) compared with white women (9%). It is known that the risk of death from induced abortion increases by 38% for every week after eight weeks gestation.⁶ It is possible that the higher rate of legal induced abortion may account for a significant portion of the racial disparity noted in pregnancy mortality. This data, especially in relation to abortion's effects on maternal mortality, unequivocally support banning elective abortions at least in the 2nd and 3rd trimester ("late term abortions").

When looking at countries where comprehensive and transparent data collection is performed, a much clearer picture of the impact of abortion is presented. According to a 2016 study conducted in Finland, and published in the British Journal of Obstetrics and Gynecology, after termination of pregnancy (abortions), mortality rates were highest for all but medical causes. For example, the mortality rate for external causes was 8.1/100,000 among pregnant women and after pregnancies ending with delivery, whereas after termination of pregnancy, the mortality was sixfold higher (49.5/100,000). Importantly, for all pregnancy outcomes, in all age groups under 40, mortality rates were highest after termination of pregnancy.⁷

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

⁵ Ibid.

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

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

A study of maternal mortality data from 32 states in Mexico by Koch, et al, revealed that laws that restrict abortion do not lead to an increase in maternal mortality - a claim that is made by many who oppose state abortion restrictions. Koch's study showed that states with less permissive abortion legislation exhibited lower maternal mortality ratios (MMR) overall (38.3 vs 49.6; $p < 0.001$), MMR with any abortive outcome (2.7 vs 3.7; $p < 0.001$) and induced abortion mortality ratio (0.9 vs 1.7; $p < 0.001$) than more permissive states.⁸

Geographically diverse countries - such as El Salvador, Chile, Poland, and Nicaragua - which prohibit abortion after previously allowing it, have not seen their maternal mortality worsen. In fact, maternal mortality has improved. South Africa, on the other hand, has seen maternal mortality worsen after the legalization of abortion after its longstanding prohibition.⁹

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

According to the Royal College of Obstetricians and Gynaecologists (RCOG), "When undertaking a termination of pregnancy, the intention is that the fetus should not survive and that the process of abortion should achieve this."¹⁰ Our intent when we treat an ectopic pregnancy or other life-threatening conditions in pregnancy is to save the life of the mother, not to directly end the life of the preborn human being. Therefore, these are not abortions, a fact even Planned Parenthood acknowledges.¹¹

A miscarriage, though medically coded as a *spontaneous* abortion, is a condition in which the embryonic or fetal human being has already passed away and therefore any treatment of a miscarriage would not be an abortion. For the 93%¹² of practicing OB/GYN's who do not perform abortions, but have always been able to offer life-saving treatment to women, we will continue to be able to do so, regardless of state laws on abortion. Our medical expertise and years of training make it very possible for us to discern when we need to intervene to save a woman's life, and any competent physician, either on their own or in consultation with colleagues and subspecialists, who is monitoring their patients closely will be able to make this determination well before death is imminent. All OB/GYN residents are already trained in the procedures and treatments necessary to evacuate a woman's uterus when medically indicated and laws restricting abortion will not impact this in any way. Specific training in induced abortion aimed at ending the life of our fetal patient is not needed.

⁸ Koch E, Chireau M, Pliego F, et al. Abortion legislation, maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal deaths: a natural experiment in 32 Mexican states. *BMJ Open* 2015;5:e006013. doi:10.1136/bmjopen-2014-006013.

⁹ Hogan MC, Foreman KJ, Naghavi M, et al. *Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5*. *Lancet* 2010; 375: 1609–23

¹⁰ Royal College of Obstetricians and Gynaecologists, "Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales," at 29 (2010), available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf>

¹¹ <https://www.plannedparenthood.org/learn/pregnancy/ectopic-pregnancy>

¹² Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. *Contraception*. 2018 Apr;97(4):297-302. doi: 10.1016/j.contraception.2017.11.004. Epub 2017 Nov 21. PMID: 29174883; PMCID: PMC5942890.

The ramifications of abortions for women stretch beyond the short-term risks of the current pregnancy, and into later pregnancies through the rise of pre-term birth in women who have undergone abortive procedures. The Institute of Medicine (now known as the National Academy of Medicine) has listed induced abortion as an *immutable* risk factor for preterm birth (PTB).¹³ This increased risk of preterm birth is especially impactful in the black population, which has a 3-4x higher abortion rate and a 2x higher preterm birth rate than caucasians.¹⁴

The abortion-PTB link has been proven by more than 160 studies over 50 years. This doesn't just impact the woman's future children, it also impacts her. Mothers who deliver preterm are at a higher risk of medical complications later in life, including cardiovascular disease and stroke.¹⁵

Non-hispanic black race (compared with non-hispanic white race) is a consistent risk factor for preterm birth and adverse pregnancy outcomes in the United States. The risk associated with race is significant; in a large systematic review of 30 studies, black women were found to have a 2-fold increased risk (95% CI: 1.8–2.2; pooled odds ratio) compared with whites.¹⁶ Surgical abortions increase a woman's risk of preterm birth in future pregnancies by approximately 35% after one abortion and up to 90% after two abortions.¹⁷

In addition to the physical ramifications of abortive procedures, there is also a direct relationship between abortions and mental health complications. As America battles its largest mental health epidemic to date, it is appalling that lawmakers would oppose legislation that would restrict something that has been shown to worsen mental health outcomes and suicide rates. States should be able to pass laws that will protect not only the physical, but also the mental health of their citizens.

From 1993 to 2018, there were 75 studies examining the abortion-mental health link, of which two-thirds showed an increased risk of mental health complications after abortion. The National Academy of Science report¹⁸ on abortion ignored the majority of these, choosing, instead, to review only 7 studies. 5 of these studies were derived from the same group of women - the Turnaway cohort. There are several well-known problems with the Turnaway cohort.

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

¹³ <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy>.

¹⁴ Butler, A. S., & Behrman, R. E. (Eds.). (2007). *Preterm birth: causes, consequences, and prevention*. National Academies Press.

¹⁵ Schaaf JM, Liem SM, Mol BW, Abu-Hanna A, Ravelli AC. *Ethnic and racial disparities in the risk of preterm birth: a systematic review and meta-analysis*. *Am J Perinatol*. 2013 Jun; 30(6):433-50.

¹⁶ Manuck TA. *Racial and ethnic differences in preterm birth: A complex, multifactorial problem*. *Semin Perinatol*. 2017;41(8):511-518. doi:10.1053/j.semperi.2017.08.010

¹⁷ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Risks of Preterm Birth*. [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-PRACTICE-BULLETIN-5-Abortion-Preterm-Birth.pdf>

¹⁸ National Academies of Sciences, Engineering, and Medicine. 2018. *The Safety and Quality of Abortion Care in the United States*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24950>

significant risk factor for subsequent psychiatric distress.¹⁹ If the 14 risk factors for adverse mental health outcomes determined by the American Psychological Association are applied to women seeking abortions, then the majority of women who abort are at risk for adverse mental health outcomes.²⁰

The most comprehensive review of available literature revealed that 49 out of 75 of the studies (65%) showed a positive correlation between abortion and adverse mental health outcomes. Abortion significantly increases the risk for depression, anxiety, substance abuse and suicidal ideation and behavior - even when compared to women with unintended pregnancies who carried to term.²¹ The Finland study on maternal mortality showed an alarming 7x higher suicide rate after abortion when compared to giving birth. The mortality rate for suicides was 3.3/100,000 in ongoing pregnancies and pregnancies ending in birth while it was 21.8/100,000 after termination of pregnancy and 10.2/100,000 among non-pregnant women – actually showing a *protective* effect from giving birth.²²

There is consensus amongst most social science scholars that a minimum of 20-30% of post-abortive women suffer from serious, prolonged negative psychological consequences - yielding at least 186,000 new cases of mental health problems each year.²³ Given the current mental health crisis in the US, it is incumbent upon us as a medical profession to do everything that we can to help improve the mental health of our patients. Decreasing the number of abortions in this country and instead giving women the support they truly desire, would be a big step towards accomplishing this.

Finally, there has been a dangerous push over the last 2 years to dispense medication abortion pills through the mail or through a pharmacy without an in-person visit with a physician. It should be noted that this started long before *Roe* was overturned,^{24, 25} lest anyone try to state that women are being forced into this option because abortion might be illegal in their state. The use of this “chemical coathanger” not only jeopardizes the life of every preborn human being exposed to it but also represents one of the greatest threats to the health of women related to abortion. Rigorous registry-based studies show that medication abortions have a 4x higher risk of complications than do surgical abortions²⁶ – and this is under controlled circumstances where women are examined by a physician and the medications are not given beyond 9 weeks gestation. Removing this oversight increases risk to women for a number of reasons.

¹⁹ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf>

²⁰ American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the Task Force on Mental Health and Abortion*. Washington, DC: Author. Retrieved from <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>

²¹ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf>

²² Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012. *BJOG: An International Journal of Obstetrics & Gynaecology*, 124(7), 1115-1121.

²³ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf>

²⁴ <https://www.acog.org/news/news-releases/2020/05/acog-suit-petitions-the-fda-to-remove-burdensome-barriers-to-reproductive-care-during-covid-19>

²⁵ https://aidaccess.org/en/media/inline/2019/9/9/19_09_09_verified_complaint_with_exhibits-420116928.pdf

²⁶ Niinimäki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate complications after medical compared with surgical termination of pregnancy. *Obstet Gynecol*. 2009 Oct;114(4):795-804. doi: 10.1097/AOG.0b013e3181b5ccf9. PMID: 19888037.

First, the complications of medication abortion increase with increasing gestational age. At 10 weeks gestation (current upper limit approved by FDA), 1 in 10 women will require a surgery to complete their abortion – just three weeks later, this increases to 1 in 2-3 women.²⁷

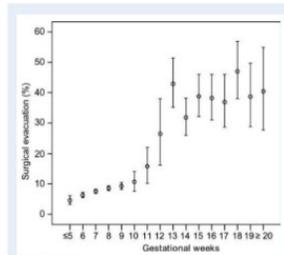


Figure 2 Percentage of surgical evacuation in relation to duration of gestation following medical TOP in 2003-2006. Bars represent 95% CI for percentage.

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

Second, an in person visit and ultrasound is required to adequately rule out an ectopic pregnancy, one of the main contraindications to medication abortion.²⁸ Ectopic pregnancies occur in 1 in 50 pregnancies and are life-threatening. The symptoms of a rupturing ectopic pregnancy are very similar to symptoms from a medication abortion – pain and bleeding. A delay in diagnosis by even a few hours can be catastrophic. And yet, the same abortion proponents who are falsely claiming that women won't be able to receive ectopic pregnancy treatment if abortion is restricted are the same people claiming that abortion pills being dispensed online without proper screening for ectopic pregnancy is completely safe.

Finally, it is imperative that women seeking abortions be screened for coercion (see below), intimate partner violence (IPV) and trafficking. For many trafficking victims, an interaction with a healthcare professional is one of their only chances of finding help.²⁹ Not only does online provision of these pills not allow for adequate screening for these abuses, but it potentially supplies abusers with a supply of pills for forced abortions in their victims. Women deserve better care and support than this irresponsible dispensing of potentially dangerous medication provides.

Women seeking abortions deserve the same level of healthcare as any other woman. The cases of patient mistreatment, of physicians practicing outside of their area of expertise and of abandonment by abortion centers after the conclusion of the procedure is unacceptable, unethical, and irresponsible. The ramifications of these procedures are not felt by the providers of abortions, or by their clinics, but instead by the women

²⁷ Mentula MJ, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study. *Hum Reprod.* 2011 Apr;26(4):927-32. doi: 10.1093/humrep/der016. Epub 2011 Feb 11. PMID: 21317416.

²⁸ https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf

²⁹ AAPLOG. "Committee Opinion 5: Joint Committee Opinion Pornography, Sex Trafficking and Abortion." 2019. https://aaplog.org/wp-content/uploads/2019/07/revised-AAPLOG-Joint-CO-5-Pornography-Sex-Trafficking-and-Abortion_with-ACPeds-logo-2.pdf

who are left alone and in the dark as to how, when or where to seek treatment when complications unavoidably arise.³⁰

While many claim that abortion restrictions interfere with the patient/physician relationship, many abortion providers have no previously established relationship with the patients they see, and subsequently leave the aftercare of said patient to other physicians who do have that previous relationship.

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

While the American College of Obstetricians and Gynecologists (ACOG) claims to represent all OB/GYN's in the US and to be the standard setting organization for the practice of obstetrics, they have a clear double standard when it comes to abortion and they have not supported even common-sense regulations that would ensure women seeking abortions are cared for under the safest possible conditions and receive fully informed consent.³¹

The risks of abortion increase significantly the farther along in pregnancy a woman is, and so accurate assessment of her gestational age is crucial. In their Committee Opinion #815, titled "Increasing Access to Abortion", ACOG states that ultrasounds are "medically unnecessary" prior to abortions.³² Yet, their own Committee Opinion on establishing due dates in pregnancy states that only approximately 50% of women will be able to accurately recall their last menstrual period - and a pregnancy without an ultrasound examination that confirms or revises the estimated due date before 7 weeks of gestational age should be considered sub-optimally dated.³³ This is important because without an accurate dating of their pregnancy, women will not be able to provide informed consent which requires an understanding of their risks for hemorrhage, retained tissue and emergency surgery, all of which depend on gestational age of the pregnancy.

ACOG also claims that admitting privileges or formal patient handoffs are medically unnecessary for women experiencing abortion complications.³⁴ And yet, their Committee Opinion #517 "Communication Strategies for Patient Handoffs" states "Patient handoffs are a necessary component of current medical care...Accurate communication of information about a patient from one member of the health care team to

³⁰ Brief of Amicus Curiae American Association of Pro-Life Obstetricians and Gynecologists in Support of Rebekah Gee, Secretary, Louisiana Dept. of Health and Hospitals, Case Nos. 18-1323 & 18-1460. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/126927/20191227154424488_AAPLOG%20Amicus%20Brief.pdf

³¹ Ibid.

³² Committee on Health Care for Underserved Women. (2020). *Increasing Access to Abortion*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion>

³³ Committee on Obstetric Practice. (2017). *Methods for Estimating Due Date*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf>

³⁴ Brief of amici curiae American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, American College of Nurse-Midwives, American College of Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Society for Reproductive Medicine, National Association of Nurse Practitioners in Women's Health, North American Society for Pediatric and Adolescent Gynecology, and Society for Maternal-fetal Medicine in Support of Petitioners, Case No. 18-1323. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/100434/20190520175434029_18-1323%20ACOG%20et%20al.%20cert.%20amicus%20brief.pdf

another is a critical element of patient care and safety...One of the leading causes of medical errors is a breakdown in communication...One predictable and critical communication event is the patient handoff. A handoff may be described as the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians.”³⁵

In ACOG’s Practice Bulletin 225 on medication abortion, they state that if a woman has an Rh-negative blood type and obtaining Rhogam (a medication critical to prevent future pregnancy complications) would “significantly delay a medication abortion”, it is acceptable to not give Rhogam after “shared decision making” with the patient - despite known risk to future pregnancies and their recommendations that Rh negative women experiencing first trimester miscarriage be given Rhogam.³⁶

ACOG opposes mandatory waiting periods before abortions, and yet the data support that many women are either unsure of their decision or pressured into it.³⁷ A 2004 study that spoke with women who had undergone abortions in the US showed the importance of waiting periods, increased counseling and in person visits in order to screen for coercion³⁸:

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

Healthcare for women and their children in a post-Roe America looks bright. States can enact common-sense protections for women seeking abortions to ensure that if abortion remains legal in that state, unsafe practices will not be tolerated. We now have a chance for individual states to hear from the physicians that practice there about how we can, instead, provide true healthcare for all of our patients – not a band-aid for social issues that need to be addressed outside of the medical profession. We also face the distinct possibility of restoring the integrity of the physician-patient relationship by restoring the trust that patients should have that their physician is recommending what is best for their health and the health of their child based on the most current medical evidence and informed by the ethical principles that have guided the

³⁵ Committee on Patient Safety and Quality Improvement (2007). *Communication Strategies for Patient Handoffs*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/communication-strategies-for-patient-handoffs>

³⁶ Committee on Practice Bulletins. (2014). *Medication Abortion Up to 70 Days of Gestation*. [Practice Bulletin]. American College of Obstetricians & Gynecologists. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf>

³⁷ Committee on Health Care for Underserved Women. (2014). *Increasing Access to Abortion*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion>

³⁸ Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Medical Science Monitor*, 10(10), SR5-SR16.

practice of medicine for millennia.³⁹ Our patients are empowered when they are given accurate information, fully informed consent and real healthcare solutions rather than a political narrative.

Respectfully submitted,

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³⁹ The Hippocratic Oath forbids doctors to perform abortion, stating “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy.” William C. Shiel, Jr., M.D., Medical Definition of the Hippocratic Oath (2018), available at: <https://www.medicinenet.com/script/main/art.asp?articlekey=20909>