Public Statement Regarding Recent Group of Six Statements on Abortion and Conscience Protections

Given that many of our members are also current members of the Group of Six professional primary care organizations, we call on the Group of Six to respect our position and to represent *all physician members* in their public statements. We urge the Group of Six to not use the "sanctity of the patient-physician relationship" as an excuse to passively ignore or actively reject the sanctity of human life, from conception to natural death. Furthermore, we encourage our primary care colleagues to recognize the inherent right to life of all human persons, regardless of age, stage of development, physical or mental ability, physical location, state of dependency or the subjective designation of "being desired." We call for better and more equitable healthcare for all vulnerable populations, including improved access to maternal and fetal healthcare, and improvement on social determinants of health.

In recent months, over a dozen states have strengthened legislation to improve safety and informed consent for women receiving abortions, as well as place better protective restrictions on the practice of abortion itself. Given the risks associated with abortion, some states have adopted safety protocols for abortion facilities, requiring them to maintain the same healthcare standards required for other outpatient surgical centers. Some states also require abortion providers to maintain hospital admitting privileges in case of complications. Certain states decline the option of telemedicine abortion, which does not provide in-person medical oversight, including a dating ultrasound or the ability to intervene if complications arise. Other states have limited abortion after fetal pain is anticipated or a heartbeat is present. Informed consent has also been improved in some locations, requiring medical staff to show a woman her ultrasound if she desires; to participate in a short waiting period to allow her unpressured time to make a definitive decision; to notify her of medication that may help reverse a chemical abortion; and to disclose to her that an abortion ends the life of a "whole separate unique living human being." Unfortunately, several medical societies have mounted unprecedented legal opposition[1,2] to even these basic protections for women.

The "Group of Six" medical societies (http://www.groupof6.org), comprising the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family

Physicians, the American College of Physicians, the American Psychiatric Association and the American Osteopathic Association, have released joint public statements and letters for several years. Many of these are laudable efforts to address healthcare inequities through public policy, with specific focus on access to primary care. However, several recent Group of Six statements[2] have sought to oppose new state laws by invoking the "sanctity of the patient-physician relationship," and call for unrestricted access to abortion, which is described as "safe, legal and necessary medical care" and "evidence-based healthcare" and without which "endangers our patients' health by limiting, and sometimes altogether eliminating, access to medically accurate information and to the full range of health care."

Recent legislation is also described as mere "outside interference" and "political interference," ignoring the fact that the legislators advancing bills protecting life are, in fact, voted in by democratic process and with full expectation of their acting in a manner consistent with the voting majority's perspective. Moreover, they are responsible for protecting citizens within their states from harm and promoting genuine healthcare. With this in mind, we must address the inaccuracies of the Group of Six statements:

1. **Abortion destroys a human life.** Life, according to Stedman's Medical Dictionary, 27th edition, is defined as "the condition of being alive; the state of existence characterized by such functions as metabolism, growth, reproduction, adaptation and response to stimuli." Zygotes, embryos, and fetuses, along with all other children, have the capacity for all these functions. Given sufficient time and the proper environmental and nutritional support, they eventually exhibit all the characteristics of "personhood" that we recognize in older human beings. Neither a person's size, age, ability, state of dependence, state of 'being wanted,' nor the environment in which he or she happens to live confers any bearing on the value of his or her life. These factors do not negate the inherent and foundational right to life due to all human beings.

   The explicit purpose and function of government is to protect citizens, all citizens, from willful destruction of innocent human life, and especially the most vulnerable. Legislation should also protect vulnerable women from harm, by increasing safety measures, providing access to informed consent, including information about the human life in her womb and the risks of and alternatives to abortion, and finally providing adequate access to prenatal healthcare with social and economic support.

2. **Abortion is not "healthcare."** Scientifically-founded research to support and restore healthy physiological processes form the very definition of evidence-based healthcare. Fertility, procreation, and pregnancy are natural and healthy reproductive processes. Similarly, every human being goes through the same stages for healthy development, from zygote to embryo to fetus to neonate and so on. The related diseased or disordered conditions in reproductive healthcare include infertility, miscarriage, and intrauterine fetal demise. For this reason, we have the fields of reproductive endocrinology, maternal-fetal medicine and the burgeoning advancements of fetal surgery, aimed at correcting serious malformations prior to birth. The intentional termination of an embryo or fetus prior to birth does nothing to correct any underlying maternal or fetal disorder; it therefore does not qualify as healthcare.

3. **Abortion is not "necessary" for women's healthcare**.[3-4] While rates of maternal morbidity and mortality are high in the United States and increasing among all demographic strata, especially among African-American women and those from low-income and rural communities, restrictions on abortion are not the cause. It is true that some of the states that have more restrictive abortion laws also have higher maternal mortality; however, the causes of these deaths (including cardiovascular disease, complications of medical disorders such as diabetes or hypertension, hemorrhage, sepsis, and other coagulopathic disorders) do not derive from abortion restrictions, nor, for that matter, from "back-alley" abortions.[6] In fact, the maternal health issues make it even more important to assure safety regulations around maternal care. Moreover, some areas with the most liberal abortion laws have rates of mortality just as high (e.g., the District of Columbia)[6,7] and the significant contributors here are domestic violence, unstable housing, lack of transportation and access to prenatal care, and substance use. Abortion here is a merely chemical or surgical attempt – and clearly a failed one, in that abortion has been legally available for over 45 years – to solve much deeper healthcare and societal inequities. Abortion does not address or improve these problems, particularly in minority populations – it simply removes the association with pregnancy.

   Secondly, even in the exceptionally rare cases where medical conditions threaten the life of a pregnant woman, abortion itself is not "necessary medical care."[5] Even abortionists have recognized that there is no reason to perform an abortion over early induction of labor or, if indicated, a C-section delivery, which may be offered prior to term for proportionate reasons. Furthermore, the 'age of viability' wherein a fetus can survive outside the womb is equally evidenced-based[8] and must inform any discussion of reproductive healthcare. A child capable of survival outside the womb certainly has no need to be actively terminated prior to or during delivery. The real challenge is not to end pregnancies prematurely; it is, rather, to improve preconception, prenatal, intrapartum and postnatal care.

4. **Abortion does not support the "vulnerable."** The unborn child is arguably the most dependent – and therefore most vulnerable - member of the human family, and every abortion intentionally kills an unborn child. From this vantage point, the recently passed "heartbeat bills" are at the service of our most vulnerable patients. After all, cardiac activity, which can be noted between 5 and 6 weeks gestation, is a universally accepted sign of life. In addition, abortion disproportionately targets unborn children with disabilities, and in some populations, unborn female infants. Similarly, Supreme Court Justice Clarence Thomas raised serious concerns about abortion facilitating both eugenics and racial discrimination, given that a disproportionately large percentage of abortions occur in minority populations.[9] Rather than protecting the vulnerable, abortion kills the vulnerable.

   Abortion also denies the unborn child's vulnerability to pain; a vulnerability that is readily acknowledged during intrauterine surgery when the fetus is wanted. Fetuses receive intrauterine anesthesia to prevent harmful neurodevelopmental effects of pain.[10] Similarly, premature infants of the same gestational ages as fetal victims of dilation and evacuation

abortions, also receive anesthesia during procedures and surgeries, since their suffering is evident in the absence of analgesia.

Abortion does not support vulnerable women. First, extraordinarily few abortions are performed for reasons of rape, incest, fetal anomalies or danger to the mother's life.[11-13] According to Florida's 2018 data, only 4.5% were performed for these reasons, while the overwhelming majority of women cited social and economic pressures. About 20% of women reported partner or parental pressure, reflecting that this is often not a woman's free choice, but rather one of coercion and manipulation. Another study showed that 58% of women had an abortion to make others happy and 28% procured an abortion because they feared abandonment by the partner if they continued the pregnancy; few felt empowered or liberated by the experience, and 32% expressed no benefit from the experience.[14]

Paul and colleagues[15] describe several risk factors for negative post-abortion psychological adjustment in the National Abortion Federation textbook for abortion providers including commitment and attachment to the pregnancy. In fact, very few qualitative studies have been published capturing the range of personal experiences of women who abort, particularly among those who have suffered enough to seek out post-abortion counseling services. Most qualitative studies are small, with the vast majority involving fewer than 50 participants.[14] Moreover, available qualitative studies on abortion experiences suffer from a lack of diversity, typically sampling only single women in their teens and 20s, and very few studies examine long-term post-abortion experiences.[16, 17]

It is true that abortion disproportionately affects vulnerable populations including women of color and those from disadvantaged backgrounds. However, while pro-choice physicians often claim to speak on behalf of these disadvantaged patients, a recent Gallup poll revealed that patients from racial and ethnic minority backgrounds, and those with lower education and lower socio-economic status, are significantly more likely to identify as being pro-life.[18] One must consider that many of these vulnerable women are being pressured not only by partners and parents, but also by highly educated, affluent health professionals to pursue an abortion that they would not otherwise have chosen, out of a sense of abandonment due to receiving biased and inadequate information?

5. **Abortion is not "safe."** As described above, abortion is not safe for the child. For the woman, while it is often stated that abortion is safer than childbirth, data in this regard are incomplete and substantially biased.[19,20] Woman can present to the emergency department experiencing complications without admitting to an abortion and there is no way to identify this as the cause of death. Furthermore, many women who die while pregnant suffer complications, not from childbirth, but underlying medical disorders. Data reported by abortion clinics to state health departments and ultimately to the CDC significantly under-represent abortion morbidity and mortality for several reasons: 1) abortion reporting is not required by federal law and many states do not report abortion-related deaths to the CDC; 2) deaths due to medical and surgical

treatments are reported under the complication of the procedure (e.g., infection) rather than the treatment (e.g., induced abortion); 3) most women leave abortion clinics within hours of the procedure and go to hospital emergency rooms if there are complications that may result in death. Only 27 states require providers to report post-abortion complications.[21] However, when looking at retrospective mortality rates in Finland, which collects comprehensive population data, women were 3.5 times more likely to die within a year compared to those who carry to term, including 7 times more likely to commit suicide.[22,23]

There are substantial and long-term physical and emotional harms of this procedure as well.[14] All abortions have risks of complications and are dependent on the technology, skill of abortionist, and gestational age. Complications include hemorrhage, damage to pelvic organs, incomplete removal of the embryo or fetus, anesthesia complications, sepsis or DIC. Some patients undergoing chemical abortions will require admission and surgical management, as high as 10%.[24]

6. **Abortion is not solely a religious issue**. One statement by the Group of Six rejects conscience protections as stipulated in Section 1557 of HHS's proposed rule, including laws which have been long established to prevent discrimination and coercion of healthcare personnel and organizations from performing abortions.[25] Firstly, suggesting that healthcare personnel or organizations would refuse to care for women who have had abortions or are experiencing complications after an abortion is blatantly false. While declining to perform or participate in abortions, faith-based and other non-profit healthcare organizations do not discriminate against patients who are experiencing complications after an abortion, but aid all who need genuine medical care. This is not "refusing to care" for women with unwanted pregnancies.

   Secondly, framing objection to abortion exclusively as a "religious exemption" undermines those who reject abortion as a matter of conscience, without a religious basis. According to Gallup's recent poll, one in three Americans who identify as pro-life describe themselves as atheist or agnostic; they seldom or never attend religious services.[22] There are multiple organizations, such as "Secular Pro-Life"[26], "Pro-Life Humanists"[27] and "Feminists for Life"[28] that do not reflect a theistic worldview. They also agree that no healthcare facilities or personnel should be mandated to terminate life, nor is it discrimination to protect the unborn from harm.

7. **Abortion is not universally supported by any segment of society**. There is unparalleled divide on this issue throughout society and contrary to popular belief, it is not based on party lines or gender. According to Gallup, 25% of pro-life persons identify as Democratic, and 21% of pro-lifers describe themselves as Liberal. Men and women are equally likely to be pro-life as pro-choice, and the overall divide between pro-life and pro-choice is 48% to 48%.[29] Many Americans want to see abortion legally limited with 37% arguing that abortion should be illegal in most or all cases.[30] However, another recent poll showed that only 25% of those who identified as pro-choice thought abortion should be available entirely without restriction and over half of those polled supported both a healthcare provider and organization refusing to participate for moral

reasons.[31] Even within medical societies, this divide is clear, with only 14% of OBGYNs reporting that they participate in abortion.[32] While no such data is readily available for family medicine, internal medicine or pediatrics, the percentage of physicians providing abortion in practice is presumably even less. It is inappropriate that minority views on such a strongly debated topic would govern public policy, position statements and legal action by powerful medical societies.

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Michelle Cretella, MD
Executive Director
American College of Pediatricians

Donna J. Harrison M.D.
Executive Director
American Association of Pro-Life Obstetricians and Gynecologists

John Schirger, MD
President
Catholic Medical Association

David Stevens, MD, MA (Ethics)
Chief Executive Officer
Christian Medical Association

Ayman Iskander, MD
Treasurer
Coptic Medical Association

Diana Ruzicka, RN, MSN, CNS-BC
President
National Association of Catholic Nurses, U.S.A.

Dr. Marie T. Hilliard, MS (Maternal Child Health Nursing), MA (Religious Studies), JCL (Canon Lawyer), PhD, RN
Senior Fellow
The National Catholic Bioethics Center

American Association of Pro-Life Obstetricians & Gynecologists (AAPLOG) is a non-profit professional medical organization that consists of 3,000 obstetrician-gynecologist members and associates. AAPLOG held the title of "special interest group" within the American College/Congress of Obstetricians and Gynecologists (ACOG) from 1973 to 2013 until this designation was discontinued by ACOG. AAPLOG is concerned about the quality of care provided to pregnant women and the potential long-term adverse consequences of abortion on women's future health, and explores data from around the world regarding abortion-associated complications (such as depression, substance abuse, suicide, other pregnancy-associated mortality, subsequent preterm birth, and placenta previa) in order to provide the general public and others with a realistic appreciation and understanding of abortion-related health risks.

American College of Pediatricians (ACPeds) is a national not-for-profit organization of pediatricians and other healthcare professionals formed in 2002 dedicated to the health and well-being of children. The mission of ACPeds is to enable all children to reach their optimal physical and emotional health and well-being. To this end, ACPeds has written a number of position statements on matters unique to children and continues to produce sound policy based upon the best available research to assist parents and society in the care of children. Membership is open to qualifying healthcare professionals who share the ACPeds' Mission, Vision, and Values. ACPeds currently has members in forty-seven states, as well as in several countries outside of the United States.

The Catholic Medical Association ("CMA") is a national, physician-led community of healthcare professionals that informs, organizes, and inspires its members in steadfast fidelity to the teachings of the Catholic Church, to uphold the principles of the Catholic faith in the science and practice of medicine. CMA has a membership of approximately 2,200 health care professionals throughout the United States.

Christian Medical Association (CMA), founded in 1931, is a non-profit national membership organization primarily for physicians. With more than 19,000 members, CMA provides a public voice on bioethics and healthcare policy. CMA provides missionary doctors and medical education to the developing world, provides continuing medical education, and sponsors student chapters at most U.S. medical schools.

The Coptic Medical Association of North America (CMANA) is a non-for-profit organization aiming at uniting all Egyptian Christian health care providers from North America together and strengthens the ties with our home country, Egypt. This gives the organization three dimensions for operation. First and by far the most important scope seeks the poor through charity. The second targets ourselves by means of sharing knowledge, advice and guidance both spiritually and medically. The last dimension involves continuity with next generation of North American graduating doctors. In few years, when most of us retire and the influx of doctors from Egypt declines, the bond between the next generation doctors and Egypt will diminish substantially.

The National Association of Catholic Nurses-U.S.A. ("NACN-USA") is the national professional organization for Catholic nurses in the United States. A non-profit group of hundreds of nurses of different backgrounds, the NACN-USA focuses on promoting moral principles of patient advocacy, human dignity, and professional and spiritual development in the integration of faith and health within the Catholic context in nursing.

The National Catholic Bioethics Center (Center) is a non-profit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. The Center provides consultations to institutions and individuals seeking its opinion on the appropriate application of Catholic moral teachings to these ethical issues. Neither the Center's moral analyses nor any other project of the Center should be construed as an attempt to offer or render a legal or medical opinion or otherwise to engage in the practice of law or medicine, or other health care disciplines.

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