AAME Statement on Abortion

The active termination of pregnancy has existed since 1550 BCE, with the first documented abortion occurring in Egypt.[1] The School of Hippocrates included the following prohibition against abortion in the oath named for him in approximately 400 BCE: "I will not give to a woman a pessary to cause abortion."[2] The attitude toward abortion throughout its 3500-year history has varied from general acceptance to criminalization of the act, including the death penalty in certain circumstances.[3] That range of perspective, except for the death penalty, remains today with the overall trend worldwide toward increasing cultural acceptance of abortion. AAME affirms the historical prohibition against abortion, as supported by the following:

A. Biological

1. When a sperm fertilizes an ovum, two haploid sets of chromosomes are combined, resulting in a unique compilation of chromosomes.
2. Except in the phenomenon of identical twinning, no other individual will possess this unique collection of chromosomes.
3. The genetic encoding contained within these chromosomes determines and regulates the ongoing development of the embryo.
4. After fertilization, this ongoing development and growth consist solely of cell division and specialization. Normally, no further alteration of the chromosomal composition occurs.
5. Therefore, at fertilization there is the creation of a unique collection of chromosomes capable of directing growth and development represents the event in which the life of a new individual begins.
6. Science defines the creation at fertilization of a new human being. [5,6,7]
7. The concept of a pre-embryo (fertilization to the formation of primitive streak about day 14) is an illegitimate attempt to lessen the moral status of the earliest forms of a human being.[8]
8. Any effort to stop the normal growth and development of this unique individual after fertilization is equivalent to taking the life of this human being.
9. The active effort to end a pregnancy is known as "elective abortion" to differentiate it from spontaneous abortion or miscarriage. Throughout the remainder of this document, the word abortion will refer to elective termination of a pregnancy.

B. Social

1. Statistics

a. In the US alone, an estimated 63 million abortions[9] have been performed since the nationwide legalization of abortion in 1973 following the Supreme Court's *Roe v. Wade* ruling. The total estimates of elective abortions worldwide is over 1.5 billion since 1980.[10]
b. In the US, abortion advocates emphasize that the number of reported abortions per 1,000 women 15 to 44 years old has declined in recent years. However, states are not required to report abortion data to the Centers for Disease Control and Prevention (CDC)[11] and accurate data are not available.

2. *Roe v. Wade*
    a. While science makes clear that a developing baby is a human being, the law has not always followed science. Abortion in the US hinges on the flawed legal rationale developed by the Supreme Court in the 1973 *Roe v. Wade* and *Doe v. Bolton* decisions, ruling abortion a Constitutional right, without legitimate Constitutional justification.[12]
    b. The Supreme Court ruling also tore governance and decision-making power away from the citizens and their duly elected representatives in the states, and opened the door to nationwide abortion on demand.
    c. In analyzing medical ethics, Supreme Court Justice Blackmun acknowledged the later confluence of the Hippocratic oath with Christian biblical principles. Yet, he chose to cast his lot with non-Hippocratic ancient Greeks who rationalized killing.
3. Abortion as a business
    a. To abortion providers such as Planned Parenthood, terminating the lives of developing babies is not only an ideology; it is also a lucrative business. As a "nonprofit" enterprise, Planned Parenthood in one year made well over a billion dollars with a profit approaching one-quarter of a billion dollars. Taxpayer money provided a third of funding to Planned Parenthood for many years.[13] Planned Parenthood performs roughly a million abortions every three years.[14]
4. Abortion clinic conditions and regulations
    a. Since *Roe v. Wade,* the regulation of abortion clinics has repeatedly been removed by the court system, such that now abortion clinics are not required to meet routine standards required of heath care facilities. Without regulation and standards, there is no ability to audit or prevent the "back-alley" abortion.
    b. Without proper oversight, the risk of harm to women increases dramatically (e.g. Gosnell)[15]
5. Pro-abortion advocacy
    a. The American College of Obstetricians and Gynecologists (ACOG) aggressively promotes abortions and access to abortions.[16] Other leading medical specialty organizations cannot be relied upon to provide objective scientific evidence supporting a pro-life position.
    b. A prominent pro-abortion argument is that abortion allows a woman to control the most intimate aspect of her life.[17] This argument ignores that the majority of unwanted pregnancies occurs as a result of poor sexual choices by both men and women. Women and their unborn children bear the disproportionate consequences of those choices.
6. Pro-life advocacy provides alternatives to the perceived need for abortion
    a. Thanks to the compassionate work of thousands of pregnancy centers around the country, women who face financial and personal challenges during pregnancy and

after giving birth are receiving financial, medical, and practical help plus emotional and spiritual support. Young fathers are learning, through pregnancy centers' education, counseling, and mentoring, to share in the responsibility and fulfillment of bringing a new life into the world.

b. Multiple national organizations help shepherd thousands of community-based pregnancy centers offering counseling, testing, education, and provisions to pregnant women.
c. Pro-life clinics often provide services such as childbirth classes, parenting classes, ongoing pregnancy support, as well as maternity and baby clothing at no cost to the client.
d. Many organizations continue supportive services after the birth of the child. There are organizations that will help with adoptions, if needed. For the protection of the child, baby safe haven laws exist in all states.

C. Medical (see Appendix)

1. Abortion can be induced through medications or performed through surgical methods.
2. The option of FDA-approved medication abortion began in 2000 using mifepristone with the prostaglandin misoprostol for termination of a pregnancy less than 49 days duration.[18] These chemical agents are hazardous and have resulted in significant morbidity and the loss of many lives.[19]
3. If after taking mifepristone (progesterone blocker), the woman changes her mind, then reversal of the effects of mifepristone with progesterone has been evaluated with small anecdotal reports and one large case series. Successful reversal rates between 64 and 68% have been achieved.[20]
4. Short-term complications of surgical abortion include infection, perforation, hemorrhage, incomplete abortion, anesthesia-related complications, and death of the mother.[21,22]
5. Long-term complications may surface several years after the abortion and include pre-term birth, infertility, breast cancer, and increased long term mortality.[23,24]
6. Mental health complications are not being systematically reported, and we recognize that there are many anecdotal reports of mental health harm, but overall these harms are difficult to assess.[23] Documentaries such as *Silent No More* have recorded the personal testimonies of women who were traumatized by having an abortion.[25]

D. Ethical

1. Two ethical questions usually form the basis for the arguments for or against abortion:[17]
    a. The moral status of the embryo/fetus.
    b. The woman's right to control her body to the exclusion of any interests from the embryonic/fetal human being, her child.
2. The status of the embryo/fetus
    a. Some pro-abortion advocates argue that the embryo/fetus, because of their absolute dependence upon the mother for survival, does not constitute a separate being worthy of the status of personhood.
        i. Some who hold this view will argue that the fetus does not become a separate being of worth until birth.
        ii. Others will go further to include the requirement that the baby must be wanted and valued even after birth. This view justifies infanticide for babies born alive during an abortion.

iii. Some will argue that the fetus becomes a person with dignity only when the threshold for viability outside the uterus is achieved. The proponents of this view will support early abortion but will oppose late-term abortion.

b. AAME holds that fertilization creates at least one new individual with inherent dignity worthy of all the protections, rights, and respect granted to any human being. Therefore, the embryo/fetus has the moral status of a human being from the time of conception.

3. The right of the woman to control her body
    a. Some pro-abortion advocates emphasize the autonomy of the woman over her pregnancy, and may characterize the pregnancy as an invasion of her body.
        i. This position invalidates the independent moral status of the embryo/fetus and relegates it to the will of the woman.
        ii. In this view, if the woman decides to terminate her pregnancy, she is within her rights, independent of the status of the embryo/fetus.
    b. AAME respects, honors, and cherishes the unique abilities of a woman to bear children. AAME respects the autonomy of women. AAME holds that the embryo/fetus has inherent value as a unique human being. The mother has responsibility for her child that is not lessened by her autonomy. She should not end the life of her unborn child, regardless of her non-life threatening medical circumstances.
    c. In the rare instance that the continuation of a pregnancy threatens a woman's life, decision-making should proceed on the basis that two lives are at stake, that of the mother and the baby. AAME recognizes these situations are rare, complex, and difficult. In extremely rare circumstances with a medical condition that will result in the death of both the mother and the fetus, therapeutic abortion may be indicated.

AAME Recommendations for the Community

1. AAME recommends that communities develop and support local organizations providing loving care and resources to assist women with unwanted pregnancies.
2. AAME recommends the address the couple's physical, spiritual, emotional, and psychological needs.
3. AAME recommends the community give those struggling with an unwanted pregnancy love, understanding, and compassion. In providing support to these persons, we must be careful not to be self-righteous, but to act with humility.
4. AAME holds that the community should advocate against laws and regulations promoting abortion at the local, state, and federal levels.
5. AAME condemns any violence perpetrated against abortion centers and abortionists. Vigils and demonstrations at abortion centers need to follow local regulations.

AAME Recommendations for Health Care Professionals

1. AAME recommends that HCPs counsel patients with unwanted pregnancy against abortion, while helping them access resources that are available. HCPs should be a voice of healing without condemning, shaming, or being judgmental.
2. AAME believes that HCPs caring for women with a history of abortion should maintain a loving and compassionate attitude, especially if she is suffering from a complication.

3. AAME believes that if the HCP refers for a medication or surgical abortion, the HCP is complicit in the act of abortion.
4. AAME recommends that HCP's consider offering their expertise and support to local crisis pregnancy centers on a complimentary basis.

Appendix to AAME Statement on Abortion

Medication Abortion:

1. Due to reports of severe bacterial infection, excessive bleeding, ruptured ectopic pregnancies, and death, the FDA revised the black box labeling for Mifepristone on November 15, 2004, to include those complications.[26]
2. After multiple reports of additional significant adverse effects associated with mifepristone use, the FDA issued a public health advisory in 2005 highlighting the risk of sepsis with Mifepristone and Misoprostol when used in a manner not consistent with approved labeling.[27]
3. In 2006 an additional public health advisory was issued by the FDA following reports of multiple deaths associated with the use of Mifepristone and Misoprostol.[28]
4. A report summarizing adverse events from Mifepristone and misoprostol use by approximately 1.52 million women up through 4/30/2011 found the following:[29]
    a. 2207 cases with adverse events
    b. 14 deaths
    c. 612 hospitalizations
    d. 58 ectopic pregnancies
    e. 339 patients requiring blood transfusion
    f. 256 infections with 48 classified as severe
5. Because of the accumulating evidence of serious adverse effects of Mifepristone and Misoprostol, including death, the FDA determined that a REMS (Risk Evaluation and Mitigation Strategy) was necessary for Mifepristone.[30]
6. As part of this REMS, physicians who prescribed Mifepristone had to meet the following qualifications:[31]
    a. Ability to assess the duration of pregnancy accurately
    b. Ability to diagnose ectopic pregnancies
    c. Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding or to have made plans to provide such care through others
    d. Can assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
    e. Have read and understood the prescribing information of Mifeprex (Mifepristone).
7. In 2016, the FDA extended the gestational age during which Mifepristone and Misoprostol could be used to up to ten weeks gestation.[32]
8. This extension included the continued use of the previous REMS. The REMS was updated to include the following:
    a. Mifepristone must be ordered, prescribed and dispensed by or under the supervision of a healthcare provider who prescribes and who meets specific qualifications

    b. Healthcare providers who wish to prescribe Mifepristone must complete a Prescriber Agreement Form prior to ordering and dispensing Mifepristone
    c. Mifepristone may only be dispensed in clinics, medical offices, and hospitals by or under the supervision of a certified healthcare provider
    d. The healthcare provider must obtain a signed Patient Agreement Form before dispensing Mifepristone
9. In April of 2019, the FDA modified the REMS for Mifepristone to a single, shared system (SSS) REMS. This update included an assessment plan that detailed various metrics to be collected from 4/11/2019 over the next year and every three years after that. These metrics included the number of prescribers, the number of women exposed to Mifepristone, any program deviations, and an analysis of whether the REMS was meeting its goals.[33]
10. The COVID-19 pandemic of 2020 prevented the FDA from reviewing the REMS data from the manufacturer of Mifepristone in April of 2020.
11. On July 13, 2020, the United States District Court of the District of Maryland ruled that the FDA REMS "In-Person Requirements impose a substantial obstacle to abortion patients seeking medication abortion care."[34] The Court then imposed a nationwide injunction on the FDA REMS requirements until 30 days after the Department of Health and Human Services declares that the COVID-19 pandemic has passed.
12. According to the Guttmacher Institute, by 2017, chemical abortions made up 39% of all abortions within the United States.[35]

Reversal of Medication Abortion:

1. Small case series using high dose progesterone before ingestion of Misoprostol have resulted in healthy live births in 4 of 6 women[36] and 2 out of 3 women[37]
2. A significant case series of 754 patients using progesterone to reverse the effects of Mifepristone found[20] successful reversal rates between 64-*68%* depending on the route of administration without an increase in congenital anomalies.
3. A randomized prospective study comparing observation alone with progesterone supplementation in women who took a single dose of Mifepristone was stopped prematurely due to severe bleeding in the group receiving only Mifepristone.[38]
    a. Four of the five women who received progesterone rescue had living fetuses at the 2-week follow-up.
    b. 40% of the women in the Mifepristone alone arm had a viable fetus at follow-up.
4. A 2013 study evaluating the risk of congenital malformations in 105 pregnancies exposed to Mifepristone found the overall rate of major malformations at 4.2%, slightly increased over the baseline rate.[39]

Complications of Abortion:

1. Short-term complications of surgical abortion
    a. Inherent bias within the medical literature compromises the data regarding complications of both medical and surgical abortion.
    b. The risk of surgical complications from abortion escalates as the pregnancy progresses.
    c. A recent study of complications following surgical abortion found:[40]
        i. A total complication rate of 1.3% for first-trimester abortion.
        ii. A total complication rate of 1.5% for second-trimester abortion.

iii. Complications included:
1. Incomplete abortion
2. Uterine perforation
3. Anesthesia-related complications

iv. However, 57% of the complications were classified as "other or undetermined," undermining the study.

d. A Swedish study observed an overall surgical complication rate of 5.2%.[41]

e. While some favorably compare the mortality from abortion as less than that following childbirth,[42] the veracity of this conclusion has been challenged because of the following methodological problems:[43]

i. Incomplete reporting
ii. Definitional incompatibilities
iii. Voluntary data collection
iv. Research bias
v. Reliance upon estimations
vi. Inaccurate and incomplete death certificate completion
vii. Failure to include indirect causes of death such as suicide

2. Long-term complications

a. Increased long-term mortality

i. A study using Danish population-based records revealed[44] long-term mortality rates were increased by 45%, 114%, and 191% for 1, 2, and 3 abortions, respectively, compared to women with no abortions.

ii. A review of abortion mortality in Denmark found[45] women whose first pregnancy ended with either a first or second-trimester abortion had significantly higher mortality 1-10 years later compared to women whose first pregnancy ended in the birth of a child.

b. Preterm birth

i. A Practice Bulletin of the American Association of Prolife Obstetricians and Gynecologists (AAPLOG) concluded the following regarding abortion and preterm birth:[46]

1. Women with a history of a single abortion are at 30% increased risk over baseline of preterm birth
2. Women with a history of two or more abortions have a 200% increased risk of preterm birth

c. Breast Cancer

i. A meta-analysis of published reports on abortion and breast cancer found[47] patients with any history of elective abortion had an odds ratio of 1.3 for developing breast cancer.

ii. A follow-up meta-analysis and systematic review of studies on the association between abortion and breast cancer documented:[48]

1. The odds ratio of developing breast cancer in women with a history of abortion was 2.51.
2. Five studies demonstrated increasing odds as the number of abortions increased.

d. Infertility

I. A recent review of the data concluded:[49]

1. There is sufficient evidence to suggest a link between abortion and infertility that warrants investigation.
2. Infertility from abortion may not be a rare phenomenon.
3. Possible mediating factors include but are not limited to:
    1) Cervical or endometrial damage
    2) PID
    3) Intrauterine adhesions

e. Mental Health Complications

I. AAPLOG has issued a Practice Bulletin detailing the controversial history of efforts to scientifically evaluate the association between abortion and subsequent mental health problems.[50] They make the following conclusions:

1. Women who have an abortion after the first trimester may be at higher risk of experiencing trauma symptoms than women who have an abortion during the first trimester.
2. All women who present for elective abortion should be screened for risk factors for adverse mental health outcomes.
3. Women experiencing adverse mental health outcomes may benefit from mental health interventions.
4. More research on the association between abortion and mental health complications is needed.

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