Fact Sheet: Medical Indications for Separating a Mother and Her Unborn Child

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Recent Statements

Many media sources have recently lamented the possibility that women may die or suffer severe harm if they are denied "medically indicated" abortions in states that have implemented elective abortion restrictions. NPR recently highlighted an unsubstantiated example from Poland, and a death in Ireland is resurfacing, as examples of women who died of sepsis because infected pregnancies were not terminated. Additional handwringing is occurring over whether doctors in Texas can treat an ectopic pregnancy, manage a miscarriage, or perform other medically indicated procedures.

The Reality

Although it is frequently stated that 5,000-10,000 women were killed yearly from "back alley" abortions before legalized abortion, early abortionist and co-founder of NARAL Dr. Bernard Nathanson admitted that these numbers "were totally false." He acknowledged, "…[I]t was a useful figure, widely accepted, so why go out of our way to correct it with honest statistics?"[1] In fact, numerous sources document that the number of deaths from illegal abortions was far lower, in the range of a less than one hundred a year.[2]

In our modern era, life-threatening situations are rare; however, when women are affected by them, induced abortion that aims to kill the unborn child is not the answer. Instead, there are humane medical interventions that aim for both mother and her unborn child to live when possible and do not inflict direct violence on the unborn child. In addition, laws that protect life already distinguish in their definitions between the acts of induced abortion which are restricted, and life-saving medical care of women, which is not. Maternal fetal medical specialists provide excellent care which usually allows high-risk mothers and their babies to make it safely through pregnancy and delivery.

Guidance from the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) acknowledges that-"centuries-old ethical guidelines," namely the principle of "double effect" which considers motives, consequences, and implications, "establish a clear

difference between treating an ectopic pregnancy" as well as other life-threatening cases "and elective terminations of intrauterine pregnancies."[3]

The Medical Facts

Life-threatening situations requiring a separation of a mother and her unborn child occur far less commonly than one may assume.[4] Furthermore, an induced abortion should not be confused with a medical indication for separating a mother from her unborn child. The two differ greatly, on both the goals and procedures.

In an induced abortion, "the intention is that the fetus should not survive, and the process of abortion should achieve this."[5] On the other hand, separation of the mother and fetus is "medically indicated" when there is some condition of the mother or the fetus which requires separation of the two in order to protect the life of one or the other (or both).[6]

AAPLOG advises, "There are actually very few ethically problematic ways of separating a mother and a fetus. These are: any dismemberment of a living fetus, any action causative of fetal death prior to any delivery,… any previable delivery without proportional danger of maternal death, and any post-viable delivery with intentional death of fetus/neonate. Any other delivery is ethically acceptable and encouraged by AAPLOG when medically appropriate."[7]

Interventions in the second half of pregnancy are more correctly termed **"premature parturition."** In these cases, the purpose of delivery is not to kill the fetus, as in elective abortion, but to save the life of the mother *and* the life of the fetus, or to save the life of at least one of them. This can be done in such a way, induction or C-section, that the baby is given an opportunity, even if slim, to live, while addressing the mother's health risks. With modern surgical techniques, a C-section delivery is usually very safe, even in an extremely sick woman. (One out of three pregnancies in our country are delivered this way.) By comparison, a dilation and evacuation (D&E) dismemberment abortion (the technique used to perform 95% of late abortions[8]) may necessitate several days of cervical preparation to allow the surgeon to enter the uterus.[9]

If a woman were truly sick enough to need emergent delivery, the delay necessary to perform an induced abortion would only worsen her condition. Additionally, a truly sick woman should be delivered in a hospital with available emergency equipment rather than in an abortion facility, which may have less available resuscitative equipment and less stringent facility standards.

In the event of a fetal abnormality, an autopsy can be performed to assist with counseling for future pregnancies. If the baby is too young or sick to survive, perinatal hospice will ensure he is comfortable while his family says good-bye.[10] A D&E dismemberment abortion, of course, does not allow for any of that.

While few OB/GYNs other than high-volume abortionists have the clinical skills to perform a later D&E, due to its complexity and high incidence of complications, all OB/GYNs can perform inductions or C-sections, thus allowing the woman's own physician to care for her in her distress and allowing for appropriate medical care for women when delivery is necessary.

Ectopic pregnancy:

When an embryo implants outside of the uterus, most commonly in the fallopian tube, it has the potential to become a life-threatening crisis for the mother. Ectopic pregnancy occurs in 1-2% of U.S. pregnancies,[11] but accounts for between 4-10% of pregnancy-related deaths.[12] As the pregnancy grows it will stretch the tube and may eventually cause it to rupture. This can cause catastrophic internal bleeding and has resulted in many maternal deaths.[13] Once diagnosed, physicians will offer treatment due to the substantial risks to the mother. Treatment options include: methotrexate injection, surgical removal of the pregnancy tissue (salpingostomy), surgical removal of the tube (salpingectomy) or, occasionally, close monitoring without treatment if there are signs the ectopic pregnancy may be miscarrying.[14] Current technology does not allow reimplantation of the embryo into the uterus to allow the baby to continue to develop[15], so it is not possible for the baby to survive. The baby will inevitably miscarry, and possibly threaten the mother's life if the pregnancy is allowed to continue.

Treatment of ectopic pregnancy is not controversial among most physicians, and even the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) affirms, "apart from very rare cases, ectopic pregnancy is a dangerous condition that requires that the pregnancy end, either by spontaneous demise of the embryo or by artificial removal of the pregnancy".[16] In fact, many states, including Texas, specifically exclude treatments for ectopic pregnancy from the state definition of induced abortion.

Previable preterm premature rupture of membranes (PPPROM):

On rare occasions, the amniotic membrane ruptures very early in pregnancy (previability) before the fetus can survive separated from his or her mother. Sometimes this is associated with active labor, but at other times labor is absent, and the clinician is confronted with the difficult decision of how to manage the patient. The prognosis for the fetus is very poor. The risk of stillbirth is 36%[17] and about 46% of liveborn babies will die within the first month.[18] Labor often ensues before the baby has reached the gestational age in which he can survive, and even if he reaches the point of viability, the lack of amniotic fluid may cause the lungs to fail to mature, leaving him unable to breathe when delivered.

Additionally, the risk of infection (chorioamnionitis) for the mother is very high. Even if she does not show obvious evidence of infection, it is likely that an infection is present, and may have been the event that caused the membranes to rupture. Microscopic examination documents evidence of infection in 94% of placentas in the setting of PPPROM between 21-24 weeks.[19] The risk to the mother of developing a more serious infection, if the pregnancy

continues, is high (up to 71%)[20], and may progress to sepsis (overwhelming blood infection) or even maternal death.

When chorioamnionitis occurs in this situation, the continued presence of the fetus and pregnancy tissue in the uterus prevents intravenous antibiotics from adequately treating the infection, so it is necessary to empty the uterus to resolve the life-threatening medical event. However, this does not require an induced abortion with the intention of killing the fetus. The American Association of Pro-Life Obstetricians and Gynecologists recommends, "the woman's obstetrician can select a pregnancy separation procedure which accomplishes the medically indicated purpose of separating the mother and the fetus without the secondary effect of producing a dead fetus.[21]

Other indications:

Separating a mother from her fetus at a time when the baby is uncertain to survive may sometimes be indicated for severe hypertension, placental abruption, rapidly worsening cardiac disease, and a few other rare conditions.

Miscarriage management:

Abortion advocates in the media sometimes predict that physicians in states with restrictive abortion laws will be unable to treat women suffering spontaneous abortions (miscarriages) because the treatments are similar to provision of early induced abortions. This should immediately be recognized for the fearmongering it is. Once diagnosed, an early pregnancy loss can be treated in several ways: expectant management (watchful waiting) may be employed if the miscarriage appears to be occurring naturally, a dilation and suction procedure removes the tissue in a minor surgery, or medications to cause uterine contractions may be given to hasten the process. Misoprostol is often used because it is readily available, but those with access to mifepristone (the restricted component of the medical abortion regimen) sometimes add that to misoprostol for miscarriage management. It should be noted that mifepristone is dispensed under a Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy (REMS), so only registered abortion providers have access to mifepristone for prescribing chemical abortion. Texas' definition of abortion explicitly excludes miscarriage management, as do the definitions of many other states.

In the case of twins where a woman loses one unborn child and her other child is still living at an early stage in pregnancy, this is not usually treated by an induced abortion because the deceased twin is likely to be absorbed by the mother's body. If the loss happens during the first trimester, generally neither the remaining twin nor the mother has clinical signs or symptoms.[22] In one example from Poland that has received some media attention, a gynecologist who commented on a woman's death stated that the doctors made the right medical decisions since her pregnancy could not have been treated earlier. He also acknowledged that the country's life-protecting law "had no influence or connection" to the woman's situation, and the article noted the woman had tested positive for Covid.[23]

Conclusion:

It is clearly the standard of care for any physician to intervene in a pregnancy that presents a risk to the mother's life. Laws restricting induced abortion will not prohibit such an intervention. Whether abortion is available, or whether a state or country has restricted abortion – even late-term abortions after a baby can feel pain from the procedure, – if a mother is facing medical risks from a pregnancy, her health can, should, and by medical standards must, be addressed. The medical procedures to treat these situations are able to be provided by OB/GYNs who overwhelmingly do not perform abortions. Additionally, when these medical situations arise, it is much safer for the mother to be treated in a medical setting with access to emergency care rather than an abortion facility. Lastly, regardless of the reason for termination of pregnancy, it has been documented consistently that women fare worse emotionally after a destructive abortion procedure for medically indicated situations than delivery by other standard obstetric interventions (e.g., induced labor or C-section).[24]

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[2] AMA Council on Scientific Affairs "Induced Termination of Pregnancy Before and After Roe v Wade: Trends in the Mortality and Morbidity of Women." JAMA. 268 (1992) 3231-3239; Gold. Abortion and Women's Health. Alan Guttmacher Institute. 1990; https://www.cdc.gov/mmwr/preview/mmwrhtml/ss5609a1.htm

[3] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 9: "Ectopic Pregnancy." 2020. Available at: https://aaplog.org/wp-content/uploads/2020/03/Practice-Bulletin-9-Ectopic-Pregnancy.pdf, citing Christian Medical and Dental Association. "Position Statement: Double Effect," 2019. Free full text: https://app.box.com/shared/static/w838xj9pxhf3d6gxibltfynjtxsr35uw.pdf.

[4] Even in cases where induced abortion is reported for life-threatening cases, these situations are rare. Florida is one of two states that report the reason for abortion at different trimesters. See Agency for Health Care Administration, "Reported Induced terminations of Pregnancy (ITOP) by Reason, by Trimester, 2021 – Year to Date," https://ahca.myflorida.com/MCHQ/Central_Services/Training_Support/docs/TrimesterByReason_2021.pdf

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[6] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 10: "Defining the End of Pregnancy." Available at: https://aaplog.org/wp-content/uploads/2020/12/FINAL-AAPLOG-PB-10-Defining-the-End-of-Pregnancy.pdf.

[7] Ibid.

[8] ACOG, "Second Trimester Abortion." Practice Bulletin No. 135, *Obstetrics & Gynecology*: June 2013 ; 121(6): 1394-1406. doi: 10.1097/01.AOG.0000431056.79334.cc

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[10] American Association of Pro-Life Obstetricians & Gynecologists. AAPLOG Practice Bulletin no. 1: "Perinatal Hospice." 2017. Available at: www.aaplog.org.
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