2026

Public Policy Manual

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Who We Are

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) is a fifty-year-old professional medical organization that represents more than 7,500 women's healthcare professionals across the country.

We were founded to represent the vast majority of OB/GYNs who do not perform induced abortion, which intends the death of our fetal patients and often harms our maternal patients. We recognize, based on the medical evidence, that this practice is not healthcare. We decline to use death as a therapeutic option, instead respecting the dignity of all human life from fertilization onward.

We exist to encourage and equip our members and other concerned medical practitioners to provide an evidence-based rationale for defending the lives of both the pregnant mother and her preborn child. We aim to make known the evidence-based effects of induced abortion on women as well as the scientific fact that human life begins at the moment of fertilization, with the goal that all women will be empowered to make healthy and life-affirming choices.

We are the medical voice of the pro-life movement.

Increasingly in this post-Dobbs era, medical voices are the ones trusted when it comes to induced abortion and care for pregnant women. We are actively speaking out to dispel the disinformation endangering pregnant women, promulgated by the media and mainstream medical organizations like the American College of Obstetricians and Gynecologists (ACOG). In 2024, we formed AAPLOG Action, a 501(c)(4) advocacy arm to mobilize our members' medical voices in advocating for both our patients' holistic well-being.

With this public policy manual, we want to not just push back on the lies and harmful public policy from the other side, but also promote life-affirming policies that are good for our patients and our profession. We know that addressing one of our patient populations is not mutually exclusive to caring for the other in the public policy space.

While there are a host of public policy areas that are important and worth prioritizing, we have identified **ten** that are core to our organizational mission and membership expertise. These are further broken down into the priority areas for us at both the state and federal level. Several of the policy areas are listed under both state and federal since actions can be taken at both levels.

Policy Priorities

State Level

- Conscience rights protection
- Continuing medical education for physicians practicing in states with abortion regulations
- Abortion ballot initiatives
- Abortion training: opt-in versus opt-out
- Maternal health outcomes
- Pregnancy resource centers (PRCs) and other life-affirming services
- The humanity of the preborn child

Federal Level

- Conscience rights protection
- Abortion training: opt-in versus opt-out
- Drug-induced abortions
- Data collection
- Maternal health outcomes
- Taxpayer funding of induced abortion
- The humanity of the preborn child

These are all areas in which we see firsthand a need for solutions, through the care we provide on the ground to our patients and in communicating with our fellow medical professionals.

In promoting these policy area recommendations, we do not have specific model language to provide at this time, but we have collaborated with key partner organizations and congressional offices who have drafted bills that would advance these policies to help create life-affirming changes.

Policy Priorities

State Level

Conscience rights protection

One of the most crucial pieces of protecting our profession and ability to practice in a life-affirming way is through protection of conscience rights. Sixty-two percent of Americans support conscience rights for healthcare professionals.[i] Failing to protect these rights will result in a less diverse profession and exacerbate the medical care crisis our country already faces. While state level provisions are in place, they often only cover induced abortion and physicians, neglecting other types of treatment and other healthcare professionals. Often these provisions do not include a private right of action, meaning that the enforcement and repercussions for a violation are weak and retroactive.

Policy Goals

- Protect the right of conscience for all healthcare professionals and entities at the state level, including strong enforcement mechanisms.
- Include medical students and residents, as these are more vulnerable in their burgeoning careers.

Continuing medical education for physicians practicing in states with abortion regulations

Recent news is filled with stories of women who received substandard care, with the blame being set squarely on abortion regulations.[ii] In truth, if doctors truly are withholding care, it is due to faulty implementation and missing education as to what these laws actually permit and prohibit. Other major medical organizations, like ACOG, have not helped clarify this confusion - for physicians, the public, or the media – and have, in fact, contributed to it. With any other law passed that affects the medical practice, groups like ACOG step in to provide guidance for physicians; however, with state abortion regulations that limit induced abortion, they have been unwilling to provide such guidance. In an effort to educate physicians and the public so that no woman is left behind, AAPLOG has created our own evidence-based medical education course.[iii] But states must step in to clear up the confusion surrounding their laws and their implementation for on-the-ground physicians. States such as Texas and South Dakota have already taken such steps.[iv]

Policy Goals

- Gain clarification from state-level entities (medical boards, health departments, etc.) as to what abortion regulations permit and prohibit for physicians practicing in those states.
- With this clarification, require that physicians are actually accessing such additional tools as training materials or medical education to help them understand how to interpret and apply these laws in caring for their patients.

Abortion ballot initiatives

In the years since Dobbs v. Jackson Women's Health was decided, states have seen a wave of pro-abortion ballot initiatives proposed and adopted, often enshrining a right to unlimited abortion in their state constitutions. These are extreme and dangerous, both for our pregnant patients and their preborn children. In November 2024, the pro-life movement finally saw ballot initiative victories, including defeat of radical amendments in Florida and South Dakota and passage of an abortion regulation amendment in Nebraska. However, we know this push will continue. Already it is anticipated that Arkansas, Florida, Idaho, Missouri, North Dakota, Nebraska, Nevada, Oklahoma, South Dakota, Utah, and Virginia will have some sort of abortion-related initiative on their ballots in 2026.

Policy Goals

- Stop legislature-initiated pro-abortion ballot measures before they can actually reach the ballot, and promote pro-life ballot measures.
- Mobilize for or against abortion-related ballot initiatives once they are on the ballot.

Abortion training: opt-in versus opt-out

For medical students, training in abortion used to be opt-in – it was offered for those who wanted such training but not part of the mainstream curriculum nor required. In 2018, this was shifted to an opt-out system by the Accreditation Council for Graduate Medical Education (ACGME), meaning that now if residents do not want to train in abortion for any reason, they must approach those higher in authority than themselves, and who are responsible for their evaluations and future career trajectories, to opt out of such training. While this should be straightforward enough, it can be accompanied by intimidation and retaliation. This shift has also fundamentally altered how abortion training is now viewed - as standard and mainstream. For the sake of our profession, we must return to an opt-in system, where such training is available for those who are interested but not mandatory and not mainstream.

Policy Goals

- Return abortion training to an opt-in versus opt-out system.
- Encourage appropriate enforcement of the Coats-Snowe Amendment for protection of medical students and schools that do not want to participate in or offer abortion training.

Maternal health outcomes

It is a priority for us as physicians to provide excellent, evidence-based healthcare for women. Even as we want to see our preborn patients protected from induced abortion, we place equal priority on the promotion of healthy outcomes for our maternal patients. The Centers for Disease Control and Prevention (CDC) data indicate that the U.S. maternal mortality rate was 18.6 per 100,000 live births between 2022 and 2023.[v] While this is a decreasing rate compared to past years, sadly the majority of these deaths are preventable.[vi] Black women have maternal mortality rates 3.3 times higher than white women.[vii] The quality of U.S. pregnancy-related mortality data is poor, relying on death certificates to determine maternal deaths, and these have proven unreliable.[viii] This is confirmed by other countries, such as Finland where 73% of maternal deaths were not identified on death certificates.[ix] Relatedly, induced abortion mortality rates are inaccurate because the total number of induced abortions performed yearly in the U.S. is not known.[x] The actual abortion-related mortality rate is undoubtedly much higher than reported.[xi] Abortion advocates often assert that maternal mortality rates inevitably increase when women cannot readily access abortion, but very poor data exist to support this claim.[xii] Other data suggest abortion is associated with higher mortality rates, and restrictions may result in improved maternal outcomes.

Additionally, the closure of labor and delivery units and rural hospitals is only making quality care more difficult for women to access, with 36% of counties nationwide considered maternal health deserts.[xiii]

See AAPLOG's Committee Opinion 6 "Induced Abortion & the Increased Risk of Maternal Mortality" for more information. Visit aaplog.org/CO6

See AAPLOG's Committee Opinion 10 "State Restrictions on Abortion: Evidence-Based Guidelines for Policymakers" for more information. Visit aaplog.org/CO10

Policy Goals

- Address maternal mortality and morbidity rates, including the racial disparities that exist.
- Ensure better data collection, including required documentation of early pregnancy events.
- Require mandatory reporting of abortions performed, abortion complications, and abortion-related deaths, with an enforcement mechanism.
- Consider social determinants of health disparities, particularly as they contribute to the increased mortality of certain ethnic/racial mothers.
- Increase access to early prenatal care for identification and treatment of high-risk medical conditions.
- Encourage paternal engagement and increased familial support.

Policy Goals (continued)

- Research should be conducted by maternal mortality and morbidity review committees, as well as other entities, on contributing factors to maternal mortality and morbidity:
    - The long-term association with abortion-linked complications, including preterm deliveries and mental health impacts
    - The association of induced abortion with subsequent pregnancy complications requiring obstetrical interventions that increase the risk of maternal mortality
- Promote mobile prenatal care for women who live in rural areas or in maternal health deserts.
- Utilize midwives in addressing maternal health deserts.
- Expand telehealth, in a life-affirming way, to provide access to women in rural communities or with limited availability for in-person appointments.

Pregnancy resource centers (PRCs) and other life-affirming services

Pregnancy resource centers (PRCs) have served vulnerable women and their families since the late 1960s.[xiv] There are over 2,750 PRCs across the U.S.[xv] Eighty-three percent of Americans support PRCs.[xvi] These centers come alongside women in a way that almost no other entity does, most especially unlike abortion providers like Planned Parenthood. PRCs provide a range of medical and social services to their clients, including sonograms, STI testing, contraception, diapers, formula, job skills training, and counseling. These centers assist women during pregnancy and for years post-birth. Since the Dobbs decision, PRCs have seen an increase in utilization of their services. In 2022, the total value of material goods and services such life-affirming centers provided is conservatively estimated at $367,896,513, up from a calculated $266 million in 2019 pre-*Dobbs*.[xvii]

Policy Goals

- Promote methods that encourage private funding of PRCs.
- Support government reimbursement of medical and social service provision by PRCs.
- Protect PRCs from infringements of First Amendment rights.
- Protect PRCs from threats and actions of physical violence.
- Promote the work of PRCs as the life-affirming alternative to induced abortion.
- Protect the activity of PRCs from burdensome and unnecessary regulations.

The humanity of the preborn child

We know that as OB/GYNs, we are caring for two patients – the pregnant woman and her preborn child. We want excellent healthcare for both patients. For our preborn patients, this starts with a fundamental recognition of their humanity, a unique individual with his or her own DNA from the moment of fertilization and worthy of our legal attention and moral protection. Regardless of the circumstances of their birth, we want to see the same level of care provided to all neonates of the same gestational age. While medicine and treatment have come a long way, we still cannot treat every disability, including for preborn children. However, even a potentially life-threatening disability should not be a death sentence in utero, and there are better ways to care for these preborn children and their families.

Policy Goals

- Protect from induced abortion preborn children with adverse prenatal screening or diagnosis results or disabilities.
- Increase the awareness and utilization of perinatal palliative care for families whose child is diagnosed with a truly life-limiting diagnosis, as well as encouraging appropriate medical care for all children – including those with disabilities.
- Ensure babies who survive an attempted abortion have access to the same level of care as any other neonate of the same gestational age.
- Utilize policy tools to highlight the humanity of the preborn child.

Federal Level

Conscience rights protection

One of the most crucial pieces of protecting our profession and ability to practice in a life-affirming way is through protection of conscience rights. Sixty-two percent of Americans support conscience rights for healthcare professionals.[xviii] Failing to protect these rights will result in a less diverse profession and exacerbate the medical care crisis our country already faces. While federal conscience statutes are in place, they are not all-encompassing regarding types of treatment or healthcare professionals covered. These also lack a private right of action, meaning that enforcement and repercussions for a violation are weak and retroactive.

Policy Goals

- Protect the right of conscience for all healthcare professionals and entities at the federal level, including strong enforcement mechanisms.
- Include medical students and residents, as these are more vulnerable in their burgeoning careers.
- Enforce existing federal conscience rights protections statutes.

Abortion training: opt-in versus opt-out

For medical students, training in abortion used to be opt-in – it was offered for those who wanted such training but not part of the mainstream curriculum nor required. In 2018, this shifted to an opt-out system, meaning that now if residents do not want to train in abortion for any reason, they must approach those higher in authority than themselves, and who are responsible for their evaluations and future career trajectories, and opt out of such training. While this should be straightforward enough, it can be accompanied by intimidation and retaliation. This shift has also fundamentally altered how abortion training is now viewed - as standard and mainstream. For the sake of our profession, we must return to an opt-in system, where such training is available for those who are interested but not mandatory and not mainstream.

Policy Goals

- Return abortion training to an opt-in versus opt-out system.
- Encourage appropriate application of the Coats-Snowe Amendment for protection of medical students and schools that do not want to participate in or offer abortion training.

Drug-induced abortions

The majority of induced abortions in the United States today are drug induced, with the CDC reporting 53.3% in 2022.[xix] A drug-induced abortion is accomplished via a two-drug regimen: mifepristone and misoprostol. These drugs are a separate category from contraception and the morning-after pill (though a newly-published study finds that high doses of Ella [ulipristal acetate] can be effectively used instead of mifepristone in drug-induced abortions).[xx] Initially approved in 2000 under restricted distribution regulations to ensure safe use, the U.S. Food and Drug Administration (FDA) has since rolled back the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone. Initial requirements on the regimen included adverse event reporting, use up to 49 days since the start of her last menstrual period (LMP), and three in-person visits. In 2016, these regulations were loosened, with adverse event reporting required only if use of the drugs resulted in the woman's death, use up to 70 days LMP, one in-person visit, and allowing non-physicians to become prescribers. In 2021 even more safety regulations were removed, including the in-person visit requirement before dispensing of the drugs, now permitting these to be mailed directly to women without any in-person physician interaction, as well as the allowance of pharmacies to dispense the drugs. An in-person visit before taking these drugs is crucial. Without it, there is no way to confirm how far along in pregnancy the woman is, which is necessary in determining if she is still within the timeframe appropriate for taking the drugs, and to determine the location of her pregnancy. Additionally, women are not typically evaluated for their Rh status, which can impact future fertility if not properly addressed. If a woman has an ectopic pregnancy, the drugs will not be effective; this is problematic because an untreated ectopic pregnancy will rupture and is life-threatening.

In addition to ending the life of the preborn child, these drugs pose significant dangers to women. Pregnant women often cannot accurately determine how far along in pregnancy they are before starting a drug-induced abortion. ACOG itself states that only half of women accurately recall their last menstrual period.[xxi] Drug-induced abortions have four times the risk of complications as compared with surgical abortion.[xxii] Taking these drugs without medical supervision has led to preventable maternal deaths.[xxiii]

One important note is that misoprostol is used routinely for non-abortive purposes, and so fully prohibiting or scheduling its use will prove problematic. Misoprostol is regularly used in obstetrical care and for assisting in the labor and delivery process.

See AAPLOG's Committee Opinion 9 *"Dangers of Relaxed Restrictions on Mifepristone"* for more information. *Visit aaplog.org/CO9*

See AAPLOG's Committee Opinion 8 *"Medication Abortion"* for more information. *Visit aaplog.org/CO8*

See AAPLOG's Committee Opinion 10 *"State Restrictions on Abortion: Evidence-Based Guidelines for Policymakers"* for more information. *Visit aaplog.org/CO10*

Policy Goals

- Strengthen safety regulations governing the use of mifepristone, including a review of its original approval process and a reinstatement of in-person visits, the pre-2016 REMS, and full adverse event reporting.
- Require an ultrasound to confirm gestational age and rule out ectopic pregnancy, and evaluation for Rh status with availability of Rh D immune globulin if indicated before a drug-induced abortion.
- Promote and educate about Abortion Pill Reversal (APR) as a viable alternative for pregnant women who have begun the abortion process but do not want to continue.
- Prohibit the mailing of abortion pills that dangerously cuts out medical oversight.

Data collection

The United States does not have accurate data on how many induced abortions take place every year. While this is partly attributable to illegal abortion drugs being brought or shipped into the country, the primary reason is that some states, including California, Maryland, New Hampshire, and New Jersey, do not report induced abortion data to the CDC because such data is reported voluntarily. Additionally, there is a dearth of data regarding drug-induced abortions and their complications. This is partially due to the FDA removing adverse event reporting requirements on mifepristone unless it resulted in death. Without the gaps in the data being filled, informed public policy cannot be crafted.

Policy Goal

- Standardize induced abortion reporting required from every state, including the number of drug-induced abortions and the rate and types of abortion complications that occur.

Maternal health outcomes

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Policy Goals

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    - Increase access to early prenatal care for identification and treatment of high-risk medical conditions.
    - Encourage paternal engagement and increased familial support.
- Research should be conducted by maternal mortality and morbidity review committees, as well as other entities, on contributing factors to maternal mortality and morbidity:
    - The long-term association with abortion-linked complications, including preterm deliveries and mental health impacts
    - The association of induced abortion with subsequent pregnancy complications requiring obstetrical interventions that increase the risk of maternal mortality

Policy Goals (continued)

- Promote mobile prenatal care for women who live in rural areas or in maternal health deserts.
- Utilize midwives in addressing maternal health deserts.
- Expand telehealth, in a life-affirming way, to provide access to women in rural communities or with limited availability for in-person appointments.

Taxpayer funding of induced abortion

Fifty-seven percent of Americans do not support taxpayer funding of induced abortion domestically, and 73% oppose such use internationally.[xxxiv] Funding for entities that promote and provide induced abortion, especially at the expense of quality healthcare for women, should not be subsidized with taxpayer dollars.[xxxv]

Policy Goals

- Stop government funding of organizations like Planned Parenthood that provide and promote induced abortion, both domestically and internationally.
- Increase awareness of the ideological colonialization that U.S. non-governmental organizations (NGOs) have been imposing internationally.

The humanity of the preborn child

We know that as OB/GYNs, we are caring for two patients – the pregnant woman and her preborn child. We want excellent healthcare for both patients. For our preborn patients, this starts with a fundamental recognition of their humanity, a unique individual with his or her own DNA from the moment of fertilization and worthy of our legal attention and moral protection. Regardless of the circumstances of their birth, we want to see the same level of care provided to all neonates of the same gestational age. While medicine and treatment have come a long way, we still cannot treat every disability, including for preborn children. However, even a potentially life-threatening disability should not be a death sentence in utero, and there are better ways to care for these preborn children and their families.

Policy Goals

- Protect preborn children with disabilities from induced abortion.

Policy Goals (continued)

- Increase the awareness and utilization of perinatal palliative care to families whose child is diagnosed with a truly life-limiting diagnosis, as well as encouraging appropriate medical care for all children – including those with disabilities.
- Ensure babies who survive an attempted abortion have access to the same level of care as any other neonate of the same gestational age.
- Utilize policy tools to highlight the humanity of the preborn child.

Glossary of Terms

Life-affirming medical professionals share the objective of promoting optimal healthcare for both pregnant women and preborn children. To achieve this goal, it is essential that we use precise, medically accurate language to describe the pregnancy-related practices which intentionally harm patients. It is especially necessary to distinguish these practices from medical interventions that separate a mother and her preborn child in the case of life-threatening pregnancy complications.

We need to use this factual language consistently with patients, colleagues, and in the public square. Failure to do so may result in confusion about the legality of life-saving medical care and ultimately hurt the very people we endeavor to protect. We hope this helps to shed some light on the confusing language intentionally used by the media and pro-abortion organizations.

This glossary can be found online at *aaplog.org/glossary*

Glossary of Recommended Terms	
✓ **Intentional feticide** - any drug, device or procedure used to ensure the death of the preborn human being before, during or in the process of separation of the mother and her embryo or fetus. Can further clarify by adding the means used to affect the death: - Intentional feticide by chemical agent - Intentional feticide by vacuum disruption - Intentional feticide by dismemberment - Intentional feticide by lethal injection - Intentional feticide by labor induction	× **Abortion** – this is a vague term with a multitude of definitions depending on the context in which it is being used. Also has the potential to be conflated with miscarriage and is often distressing for patients in this scenario. - If "abortion" used, preface with "induced" (consistent with CDC definition used to collect surveillance data) and, if possible, use a clarifier from the list to the left
✓ **Endpoint or completion of pregnancy**	× **Termination of pregnancy**

Glossary of Recommended Terms	
✓ **Miscarriage, fetal death, embryonic death** - referencing a spontaneous loss of embryonic/fetal life. Qualifiers can include miscarriage with retained tissue or inevitable/impending miscarriage	× **Spontaneous/incomplete/ inevitable/missed abortion** × **Nonviable embryo** (it is inaccurate but common for this word to be used to mean "unable to survive" and "already dead," which are very different concepts but are synthesized in a utilitarian view of embryos or fetuses)
✓ **Vaginal bleeding in the first/second trimester**	× **Threatened abortion**
✓ **Fetal/embryonic tissue, other pregnancy tissue** - Tissue remaining after an incomplete miscarriage or incomplete intentional feticidal procedure	× **Products of conception**
✓ **Medically-indicated maternal-fetal separation** - Done to prevent the mother's death or immediate, irreversible bodily harm, which cannot be mitigated in any other way. Examples include treatment of ectopic pregnancy, previable delivery for early pre-eclampsia with severe features, or previable delivery for other life-threatening conditions in pregnancy. - Further discussion below under "Other Important Considerations" as well as in AAPLOG's "Concluding Pregnancy Ethically" Practice Guideline.[1]	× **Medically-indicated or therapeutic abortion**
✓ **(Potentially) Life-limiting prenatal diagnosis, (potentially) life-limiting fetal anomaly**	× **Lethal** × **Incompatible with life** (the fetus being diagnosed is alive, so this is not incompatible with being alive!)

Glossary of Recommended Terms	

- Considerations of what constitutes a potentially life-limiting prenatal diagnosis:
  ○ There are several different ways to interpret the description of a fetal anomaly or condition as lethal (see below). A review of the published literature[2] on "lethal malformations" revealed no consensus on which of these definitions should be applied.
  ○ Possible definitions[3] of a life-limiting prenatal condition:
  - Causing fetal death: a condition that invariably leads to death in utero
  - Causing fetal death/neonatal death: a condition that invariably leads to death either in utero or in the newborn period regardless of treatment
  - Usually causing fetal/neonatal death: a condition that leads to death in utero or in the newborn period in most cases
  - Associated with death: a condition that leads to fetal or neonatal death in some cases
  ○ Must consider what the threshold is for percent lethality of a condition – many conditions with up to 50% survival rates have been labeled as "lethal"	

✓ **Pre-viable –** indicates preborn child has not yet reached the gestational age of viability	× **Nonviable**

Glossary of Recommended Terms	
✓ **Human zygote/embryo** - new human life that comes into existence at the moment of fertilization	× **Fertilized egg**
✓ **Embryocidal or embryotoxic** – a procedure or pharmaceutical agent that causes death of a human embryo (before or after implantation)	× **Abortifacient**
✓ **Fertilization** – pregnancy and a new human life begin at fertilization	× **Conception** – avoid using as this (along with pregnancy) has been redefined as beginning with implantation
✓ **Intentional embryo-/feticide (or induced abortion) by chemical or pharmacologic agent or via mifepristone**	× **Medication abortion** – medication implies that an illness is being treated and that there is therapeutic benefit
✓ **Continuing viable pregnancy** - when a preborn human being survives an attempt to intentionally end his/her life ✓ **Intentional feticide with retained tissue –** when fetal or other pregnancy tissue remains but feticide was successful	× **Failed abortion**
✓ **Embryonic/Fetal heartbeat, cardiac activity or cardiac motion**	× **Electrical impulse**
✓ **Abortion regulation** – laws that protect the health/safety of women as well as preborn human beings	× **Abortion ban/restriction, restrictive law**
✓ **Physician, medical/healthcare professional, Advanced Practice Practitioner (APP)**	× **Provider** – Implies that our role is to provide a service if it is technologically available, legal, and the patient chooses it

Glossary of Recommended Terms	
✓ **Healthcare –** to preserve and restore health, never to act in contradiction to that. Health can be defined as "the well-working of the organism as a whole, realized and manifested in the characteristic activities of the living body in accordance with its species-specific life-form" (Kass)	
✓ **Medical emergency** - A medical condition of sufficient severity, such that the absence of medical attention could reasonably be expected to result in either of the following: 1. Jeopardy to the life of a patient, including a pregnant woman or a fetus. 2. Serious and irreversible impairment to major bodily functions.	

Other Important Considerations	
Medically-indicated maternal-fetal separation	This may be done prior to or after fetal viability. It is preferably done in a way that does not directly induce fetal death and respects the fetus' bodily integrity (unless doing so would further endanger the life of the mother). Medically indicated separation of the mother from her embryo or fetus in the previable period should not be referred to as "abortion." Such separations fall under two broad categories: 1. *Ethically and legally appropriate to prevent the mother's death.* Some examples of this would include an intrauterine infection, severe hemorrhage, or severe hypertensive disorders. If there exists a true threat to the mother's life, then the separation is considered ethically appropriate because the risk the mother faces

Other Important Considerations	
	is proportional to the impact on the fetus. Moreover, as a practical matter, a previable fetus cannot possibly survive if the mother dies. 2. *Legally appropriate to avoid a significant risk for permanent injury to a maternal organ system.* Some examples of this would include previable PROM without infection, WHO Class 3 cardiac lesions, pre-eclampsia without severe features. Ending the pregnancy in these types of situations is generally legal under state regulations. While legal, thoughtful people might debate when such clinical situations would be truly ethical. The most common scenario is PROM in the previable period. A stable patient would have around 10 to 15% chance for the fetus to remain in utero long enough to survive. A number of factors affect the precise odds. Attempting to maintain the pregnancy would also involve maternal risk for infection, hemorrhage, and damage to her reproductive organs. Those maternal risks can be mitigated (but clearly not eliminated) by separating the fetus from the mother.
Informed consent is critical	Includes knowing the reality of fetal development, the risks of intentional feticide/induced abortion and the availability/benefits of perinatal palliative care (in cases of life-limiting diagnoses)
Always use person-first language	For example, a “fetus with a life-limiting diagnosis,” rather than “the life-limited fetus”

Research Language Considerations	
✓ **Use "relationship," "correlation," or "association"** (e.g. "prior abortion is associated with a higher relative risk of preterm birth")	× **Avoid using “link”** (e.g. abortion-breast cancer link, abortion-preterm birth link)

✓ **"Adverse events" and "Significant adverse events"** - defined as an unanticipated problem that arises following, and is a result of, a procedure, treatment or illness - Mental health adverse events - requiring medical evaluation, medication, therapy, hospitalization, or resulting in self-harm or accident from substance abuse - Common Terminology Criteria for Adverse Events (CTCAEv3). The five levels of coding are: ○ **Grade 1** "Mild": asymptomatic or mild symptoms; clinical or diagnostic observations only; intervention not indicated-bleeding, pain and gastrointestinal sx. ○ **Grade 2** "Moderate": minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL*-outpatient clinic or telemedicine management for bleeding, pain or low-grade infection. ○ **Grade 3** "Severe or medically significant but not immediately life-threatening": hospitalization or prolongation of hospitalization indicated due to grade 3 AE; disabling; limiting self-care or ADL; emergency room evaluation, surgical aspiration procedure (clinic or hospital), intravenous antibiotics. ○ **Grade 4 "**Life-threatening consequences": urgent intervention, indicated hospital or ICU admission from grade 4 AE, transfusion, surgical laparoscopy or laparotomy, adjacent organ repair. ○ **Grade 5 "**Death related to AE" ✓ **Side effects** - unwanted, undesirable effects that are possibly related to a drug - "Physical side effects"-unpleasant but anticipated physiologic responses to medications - "Emotional side effects"-transient mood symptoms, do not require treatment ✓ **Long-term sequelae** - permanent physical disability, infertility, future pregnancy complications including incompetent cervix/preterm delivery and abnormal placentation	**× Complications**

Research Language Considerations	
✓ **Hemorrhage** - quantified by 500 cc EBL, drop in H/H by 1 g/3%, post-abortion H/H 9 g/27% if prior H/H unknown, or transfusion required	
✓ **Infection** - quantified by requiring oral antibiotics (genital vs other sources: urinary, respiratory), requiring intravenous antibiotics, sepsis, or ICU admission	
✓ **Embolus** - amniotic fluid or air, venous thrombosis (DVT, PE, cerebrovascular)	
✓ **Discussion of Complication Incidence:**[4] - Very common - 1 in 1 to 1 in 10 (incomplete chemical abortion in second trimester) - Common - 1 in 10 to 1 in 100 (incomplete chemical abortion first trimester requiring surgery, hemorrhage, infection, continuing viable pregnancy) - Uncommon - 1 in 100 to 1 in 1000 (significant adverse events) - Rare - 1 in 1000 to 1 in 10,000 (ruptured ectopic pregnancies) - Very rare - Less than 1 in 10,000 (death - as reported by CDC, excludes mental health deaths)	

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Frequently Asked Questions

1. Does any state prohibit a D&C (dilation and curettage) or D&E (dilation and evacuation) procedure?

No state prohibits a physician from performing a D&C or D&E procedure. Some states do prohibit the use of these procedures in the sole case that it is performed for an induced abortion.

2. Does any state prohibit physicians from intervening to save a pregnant mother's life?

No state prohibits a physician from intervening to save a pregnant mother's life. No state requires that her death be imminent before a physician can take action. No physician has been prosecuted for taking action to save a pregnant mother's life.

3. Does any state prosecute pregnant women for seeking or obtaining an abortion?

No state prosecutes pregnant women for seeking or obtaining an abortion.

4. Does any state prohibit treatment for an ectopic pregnancy or miscarriage?

No state prohibits treatment for an ectopic pregnancy or miscarriage. Though the procedures used to treat miscarriage can be the same as those used for an induced abortion, the intent behind the procedure's use is different. A physician must treat an ectopic pregnancy or it could rupture, putting the pregnant woman's life in danger. For a miscarriage, the preborn child has already passed away and so this is not an induced abortion, in which the intent is to end the preborn child's life.

5. What is an ectopic pregnancy?

An ectopic pregnancy is a situation where implantation occurs outside the uterine cavity. If not treated, it can rupture and result in life-threatening bleeding.

6. What is the difference between a miscarriage and a stillbirth?

Both are tragic circumstances in which the preborn child passes away naturally in utero. Miscarriage is used to define such cases before 20 weeks gestation and stillbirth for cases of 20 weeks gestation or later.

Frequently Asked Questions (continued)

7. What is an induced abortion?

Induced abortion, as defined by the CDC in collecting surveillance data, is "an intervention...intended to terminate a suspected or known intrauterine pregnancy and that does not result in a live birth."[xxxvi] This definition excludes management of intrauterine fetal death, early pregnancy failure/loss, ectopic pregnancy, or retained products of conception. It should be noted that the intent is that it would not result in a live birth.

8. Do the majority of OB/GYNs perform induced abortions?

No, the majority of OB/GYNs do not perform induced abortions. Only 7% of obstetricians in private practice perform abortions, suggesting that abortion is not essential to women's health if over 90% of women's health physicians do not offer it.[xxxvii]

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