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"Protecting Women's Health: Exposing the Dangers of Chemical Abortion Drugs"

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Abortion is an important subject of intense interest, debate and legislative action among the people of the United States and their elected representatives, and due consideration should be given to its risks and purported benefits. In particular, chemical abortion using mifepristone and misoprostol, is now the predominant method of abortion, accounting for 57.6% of the estimated 770,000 abortions performed in the United States in 2022 (CDC data) and 63% of abortions in 2023 (Jones RK, Friedrich-Karnik A. Medication abortion accounted for 63% of all US abortions in 2023). Data are now available to examine outcomes associated with chemical abortion and ways to strengthen regulatory oversight in order to protect the health of women and children.

Abortion, defined as intentional feticide, is carried out either surgically (using suction and sharp dilation and curettage or dilation and evacuation), or using the drugs mifepristone and misoprostol. The typical protocol for chemical abortion uses mifepristone (Mifeprex, RU-486) 200 mg orally on day 1. Mifepristone is a progesterone antagonist. Progesterone is a hormone produced initially by the ovary and then by the placenta. It is essential to the growth and development of the embryo and fetus. Mifepristone blocks progesterone receptors in the uterus, depriving the unborn child of nutrients and oxygen and resulting in his or her death.

Misoprostol (Cytotec) is then given 800 mcg buccal (in the cheek pouch) 24-48 hours later. It induces contractions to expel the embryo. The use of the combined drug regimen results in bleeding and cramping, often significant. Bleeding lasts an average of 9 to 16 days, and some women (8%) bleed for more than 30 days (Mifeprex label, U.S. Food and Drug Administration, January 2023). The woman passes her baby at home in the toilet, in the shower, in a dorm room, etc., and the woman must then dispose of the fetal remains, in municipal water systems or by discarding them. Women may choose chemical abortion

because of a perception of greater safety and privacy than with surgical abortion, a desire to avoid surgery, or perceived greater convenience.

Abortion, defined as intentional feticide, is associated with significant short- and long-term physical and mental health harms to women. First trimester abortion is always lethal to a developing human and is associated with risks to the mother. First trimester surgical abortion carries immediate risks of hemorrhage, infection, continuing pregnancy, death, perforation of the uterus, damage to organs including hysterectomy and undiagnosed ectopic pregnancy. These complications, and the need to discuss them in counseling for informed consent, are described in the National Abortion Federation 2024 Clinical Policy Guidelines for Abortion Care.

First trimester chemical abortion is associated with risk for hemorrhage, infection, continuing pregnancy, need for surgery for retained fetal and/or placental parts, undiagnosed ectopic pregnancy and death. Though uterine perforation is not a risk with chemical abortion alone, an estimated 6% or more of women require surgical intervention following chemical abortion, and these women are exposed to the risks of both chemical and surgical abortion.

Undiagnosed ectopic pregnancy when intrauterine pregnancy has not been confirmed is a risk in both chemical and surgical abortions (NAF 2024 Clinical Policy Guidelines, Management of Pregnancy of Uncertain Location), and a. A young woman, Tia Parks, died in 2019 from a ruptured ectopic pregnancy the day after undergoing a first-trimester abortion at Preterm abortion clinic in Cleveland, OH (Sullenger S. Autopsy report. Operation Rescue. September 13, 2019). Other women who have died following chemical abortion:

- In 2022, a 19 year old Canadian girl died of septic shock after taking mifepristone-misoprostol (Source: https://run-with-life.blogspot.com/2023/01/medical-abortion-is-fatal-for-19-year.html).
- In 2022 Candi Miller (GA), 41 years old, died after taking mifepristone that she ordered online. (Source: https://www.liveaction.org/news/autopsy-report-candi-miller-abortion-pill-questions.
- Also in 2022, Amber Nicole Thurman died of complications following a chemical abortion (Sources: https://www.nationalreview.com/corner/media-mislead-on-tragic-death-of-amber-thurman/; https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death)
- Alyona Dixon also died in 2022 following a chemical abortion. Notably, one of the complaints in the lawsuit against the hospital is that she did not undergo a pelvic examination at the time of admission (see Dixon et al. v. Dignity Health et al., Case no. A-23-877731-C).

Carlsson et al used data from Skaraborg Hospital in Sweden to examine complications associated with abortion abortion (Carlsson I, Breding K, Larsson PG. Complications related to induced abortion: a combined retrospective and longitudinal follow-up study. BMC Womens Health. 2018;18(1):158). All women had a visit with a gynecologist at clinic, a pelvic exam, ultrasound and screening for infection. The authors found that among women undergoing chemical abortion at less than 12 weeks from 2008 to 2015, the overall complication rate was 7.3% and the rate of incomplete abortion was 4.1%. Extrapolated to the United States, where They noted, however, that complication rates almost doubled from 4.2% to 8.2% during that time period. Carlsson et al attributed this to the increasing use of self-managed abortion.

Niinimaki et al used data from Finland's health service administrative database, which included all women in Finland undergoing abortion from 2000 to 2006 (42,619 women) and collected follow up data for 42 days post abortion (Niinimäki M, Pouta A, MD, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. Obstet Gynecol 2009;114:795–804). 52.5% of women underwent chemical abortion and 47.5% underwent surgical abortion. 20% of women in the chemical abortion group and 5.6% of women in the surgical-abortion group had at least one type of adverse event. 15.6% of women undergoing chemical abortion suffered hemorrhage, compared with 2.1% of women undergoing surgical abortion. Rates of infection were comparable between the two groups (1.7%). Rates of incomplete abortion were 6.6% for chemical abortion and 1.6% with surgical abortion. 5.9% of women in the chemical abortion group required follow up dilation and curettage for retained fetal and placental parts, compared with 0.4% of women undergoing surgical abortion. Women undergoing medical abortion had 8 times the risk for hemorrhage from medical abortion compared to those undergoing surgical abortion, 5 times the risk for incomplete abortion (i.e. retained fetal and placental parts), and double the risk for surgical intervention. Niinimaki et al concluded that "Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy".

In a study by Ireland et al comparing complication rates among women undergoing chemical versus surgical abortion (Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. Obstet Gynecol 2015;126:22–8), the risk of "abortion failure" was four times higher for women undergoing chemical abortion compared with surgical abortion. Persistent pain and/or bleeding were the most common reasons for a second abortion procedure after chemical abortion. Of note, the use of the term "abortion failure" underscores the fact that the goal of an abortion is the death (and expulsion, for chemical abortion) of a living human being.

There are three reasons why it is likely, as the authors of the Niinimaki study noted, that the overall incidence of abortion-related morbidity will increase with increasing use of mifepristone-misoprostol. The first is that based on that study, one in seven women will experience hemorrhage following chemical abortion, a higher rate than occurs with surgical abortion. The second is that as noted in both the Ireland et al study and the Niinimaki et al studies, women who need surgical intervention for incomplete abortion following chemical abortion are exposed to the risks of both chemical abortion and surgical abortion. The third reason is that self-administered abortion is increasingly being recommended for women.

A study by Cleland et al (2013) examined adverse outcomes after chemical abortions performed at Planned Parenthood sites (Cleland K, Creinin MD, Nucatola D, Nshom M, Trussell J. Significant adverse events and outcomes after medical abortion. *Obstet Gynecol*. 2013;121(1):166-171). The authors found that the rate of "significant adverse events and outcomes". However, the study only included data on adverse outcomes that were reported to Planned Parenthood. It also did not report rates of loss to follow up or retained fetal or placental parts.

Federal reporting of chemical abortion-related complications remains problematic. FDA uses the Federal Adverse Event Reporting System (FAERS) to monitor drug safety post-marketing. Until 2016, under the FAERS, dispensers of the abortion pill were required to report any serious adverse effects to the manufacturers of mifepristone. FDA collects these data and adds them to the FAERS dashboard. However, since most women seek care for abortion-related complications at an emergency room, and since reporting was not mandated for these hospitals or providers, the true incidence of chemical abortion related complications cannot be ascertained from FDA data. The low rates of follow up at abortion clinics is emphasized in ACOG's Current Commentary: Routine Follow up Visits After First-Trimester Induced Abortion (2004), which states that "In practice, attendance at abortion follow up visits is usually low, generally about 50%". Further, the FDA removed the requirement to report any serious adverse event besides death in 2016, resulting in an even less clear picture of abortion complications.

A study by Aultman et al examined FDA adverse event reports data related to the use of mifepristone from September 2000 to February 2019, using FOIA data (Aultman A, Cirucci C, Francis C, Beran B, Lockwood M, Seiler S. Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019. Issues in Law & Medicine, Volume 36, Number 1, 2021). This analysis brought to light serious concerns about the safety of mifepristone abortion.

The authors noted that “Significant morbidity and mortality have occurred with the use of mifepristone as an abortifacient, including at least 24 US deaths reported by the FDA from September 2000 to February 2019”. These researchers also noted a significant number of ectopic pregnancies diagnosed in women after they had undergone chemical abortion; “Of the 75 reported ectopic pregnancies in the FDA AERs we analyzed, over a third were known to be ruptured including one death”. The second concerning trend was hemorrhage requiring transfusion. The authors note that “Four hundred and eighty-one patients required blood transfusion following medical abortions”. The third was infection with unusual bacterial infections, including a specific organism called Clostridium sordelii, which causes rapidly fatal infections.

There are also concerns regarding the FAERS. In a study by Cirucci et al (Cirucci, Christina A., Kathi A. Aultman, and Donna J. Harrison. "Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained through the Freedom of Information Act." Health Services Research and Managerial Epidemiology 8 (2021), the authors compared data from the FAERS dashboard, the study by Cleland et al, and the study by Aultman et al. for 2009 – 2010. During this time period, Cleland et al reported 1530 adverse events, FAERS reported 664, and Aultman et al’s FOIA analysis reported 330. Thus, the “significant adverse events and outcomes” reported by Planned Parenthood, which performed less than half of U.S. abortions in this timeframe, outnumbered FDA adverse event reports from all providers. There is a need to strengthen regulatory oversight of abortion complications by FDA.

Emergency room visits are another gauge of abortion pill safety. A UK-based research organization, Percuity, noted in 2021 that “Ranbaxy (UK) Limited is the manufacturer of…the mifepristone/misoprostol combination treatment provided by BPAS [the British Pregnancy Advisory Service] to its pills-by-post [mail-order abortion] clients. (Duffy K. Non-negligible risk of failure. Percuity. October 12, 2021). In its SmPC (summaries of product characteristics), Ranbaxy states that: ‘The non-negligible risk of failure … makes the follow-up visit mandatory in order to check that abortion is complete.’” (https://www.medicines.org.uk/emc/product/3380/smpc)

In addition, Percuity found that “complications arising from the failure of medical abortion treatment result in 590 women presenting at the emergency department of their local NHS hospital in England every month” (Duffy K,. Emergency ambulance responses three times higher for pills-by-post. Percuity. November 16, 2021 2024). and that in both 2022 and 2023, “more than ten thousand women were treated at an NHS hospital for complications arising from an abortion.” (Duffy K. FOI requesting Hospital Episode Statistics data on the treatment of abortion complications in England, and that in both 2022 and 2023 “more

than ten thousand women were treated at an NHS hospital for complications arising from an abortion" " (Duffy K. FOI requesting Hospital Episode Statistics data on the treatment of abortion complications in England 2017 to 2023. Percuity, December 2024). Percuity found that "the treatment failure rate is 5.9%, 1-in-17".

Percuity also cites NHS data showing that "emergency ambulance responses for complications arising after a medical abortion are three times higher for women using pills-by-post at home [mail-order abortion], compared to those who have their medical abortion in a clinic (Duffy 11/16/21). The "pills by post" program began in 2019, and between 2018 and 2020, the percent of abortions carried out at home increased from 0% to 34% to 67%".

With a much larger population in the United States than England, the number of women experiencing complications is likely much larger with clear public health impact. These findings clearly demonstrate both safety concerns and why it is mandatory that women undergoing abortion – whether chemical or surgical – must meet with the physician performing the procedure.

Liu et al performed a study using Canadian data comparing first trimester abortion morbidity with mifepristone-misoprostol vs. surgical abortion (Liu N and Ray JG. Short-term adverse outcomes after mifepristone–misoprostol versus procedural induced abortion. Ann Intern Med. 2023;176:145-153). They noted that "Within a universal health care system, there was a slightly higher risk for SAEs [serious adverse events] up to 42 days after an IA [induced abortion] with mifepristone–misoprostol compared with outpatient procedural IA in the first 14 weeks of pregnancy…On comparing mifepristone–misoprostol with ambulatory procedural IA done in hospital up to an estimated 9 weeks' gestation, the risk for SAEs did not differ, but mifepristone–misoprostol was associated with a higher risk for any adverse outcome, ED [emergency department] use, and subsequent procedural IA".

Rates of complications associated with second trimester abortion are higher than for first trimester abortion. For example, Turok et al (Turok D, Gurtcheff SE, Esplina MS, Shahb M, Simonsena SE, Trausch-Van Horn J, Silvera RM. Second trimester termination of pregnancy: a review by site and procedure type. Contraception 77 (2008), pp. 155–161) studied differences in complications between second trimester abortions performed in 475 women, in hospitals vs. free-standing clinics. The authors found that major complications (defined as death, uterine perforation, hysterectomy, transfusion, clotting disorders, deep venous thrombosis, pulmonary embolus, stroke or heart attack, need for exploratory surgery, and prolonged hospitalization) occurred in 11% of women undergoing hospital D&E, 10% of women undergoing hospital induction of abortion, and 1% of women undergoing abortion in clinics. Other complications included: need for readmission, need for curettage after abortion for retained placenta and/or fetal parts, infection of the fetal

membranes after initiation of the procedure, and uterine infection. The authors also note that complications may have been underreported due to loss to follow-up.

Edlow et al. (Edlow AG, Hour MY, Maurer R, Benson C, Delli-Bovi L, Goldberg A. Uterine evacuation for second-trimester fetal death and maternal morbidity. Obstetrics and Gynecology 2011;117:307–16) noted that "[higher] gestational age was significantly associated with maternal morbidity", with women undergoing abortion at > 20 weeks' being 2 ½ times more likely to suffer a complication than women undergoing abortion at < 20 weeks' gestation.

Bartlett et al found that the risk of a woman dying from abortion increased exponentially by 38% for each week of gestational age (Bartlett L, Berg C, Shulman H, Zane S, Green X, Whitehead S, Atrash H. Risk Factors for Legal Induced Abortion–Related Mortality in the United States. Obstet Gynecol 2004;103:ka9 –37). Abortions performed between 16 and 20 weeks had a mortality risk 30 times greater than abortions performed in the first trimester. Abortions performed at or after 21 weeks had a mortality rate 76 times greater than abortions done in the first trimester.

This is relevant to a discussion of chemical abortion because the Society of Family Planning and the Society for Maternal-Fetal Medicine issued a joint recommendation in 2024 which stated that "Appropriately trained and credentialed advanced practice clinicians [not just M.D.s] can provide medication abortion between 14 0/7 and 27 6/7 weeks of gestation with appropriate backup within the confines of local regulations and licensure".

Abortion also has long-term consequences for women's health. Two recent meta-analyses have confirmed the association between abortion and preterm birth (Saccone G, Perriera L, Berghella V. Prior uterine evacuation of pregnancy as independent risk factor for preterm birth: a systematic review and metaanalysis. Am J Obstet Gynecol. 2016;214(5):572–591; Lemmers M, Verschoor MA, Hooker AB, et al. Dilatation and curettage increases the risk of subsequent preterm birth: a systematic review and metaanalysis. Hum Reprod. 2016;31(1):34–45).

Quoting AAPLOG's Practice Guideline #11 PB-5-Overview-of-Abortion-and-PTB.pdf (aaplog.org), "PTB [preterm birth] is defined as delivery before term, i.e. before 37 weeks and affects about one in ten deliveries in the United States. The majority (70%) of babies born before 37 weeks are born at 34 to 36 weeks. About 10% of PTB (1-2% of all U.S. deliveries) occur before 32 weeks and are termed "very preterm births." Very preterm births pose greater risks to the neonate and greater costs to the family and system." In my experience, preterm birth is heartbreaking to families and takes an enormous toll on them,

as well as on clinical professionals. Approximately 160 studies have examined the association between abortion and preterm birth.

ACOG's Practice Bulletin #234 (2021) also states that "A history of dilation and curettage (D&C) [used to perform surgical abortion] has been associated with an increased risk of preterm birth in some, but not all, studies. A meta-analysis of 21 studies including almost 2 million women found an association between subsequent preterm birth and history of D&C (odds ratio [OR], 1.29; 95% CI, 1.17–1.42), with slightly greater odds after multiple D&C procedures compared with no procedures (OR, 1.74; 95% CI, 1.10–2.76)", "Prediction and Prevention of Spontaneous Preterm Birth: ACOG Practice Bulletin, Number 234. *Obstet Gynecol*. 2021;138(2):e65-e90).

These studies indicate that women undergoing abortion are at increased risk for preterm birth. The overall preterm birth rate in the United States US was 10.4% in 2024 (Hamilton BE, Martin JA, Osterman MJK. Births: Provisional Data for 2024. Centers for Disease Control and Prevention, National Vital Statistics System. April 2025). Among black women, who have the highest rates of abortion, it was 14.97%.

Future pregnancy complications other than preterm birth may be caused by surgical abortion-related uterine damage. Baldwin et al (2018) found that uterine curettage (as occurs with surgical abortion) approximately doubled the risk of abnormal placental attachment, which is associated with catastrophic hemorrhage at delivery. (Baldwin H, Patterson J, Nippita T, Torvaldsen S, Ibiebele I, Simpson T, Ford J. 2018. Antecedents of abnormally invasive placenta in primiparous women. Obstet Gynecol 131(2):227-233). While the evidence on preterm birth after chemical abortion is still evolving, some research suggests that women who require dilation and curettage for retained fetal and placental parts after failed chemical abortion may be at increased risk for future preterm birth (Calhoun B. Medication Abortion and Preterm Birth. Issues in Law & Medicine, Volume 38, Number 2, 2023).

Abortion is associated with increases in the risk of long-term and less direct causes of death. Risk of death associated with abortion increases over time (due to substance abuse, cancer, pregnancy complications, suicide) while risk of death following term pregnancy is lower. A 2022 US study spanning 8 years in California found a 62% increase in all cause deaths, 154% increased risk in suicide (Reardon DC, Cougle J, Ney PG, Scheuren F, Coleman PK, Strahan T. Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. Southern Medical Journal 2002;95:834-41).

A Finnish study in 1997 found death rates 4 times higher after abortion compared to childbirth up to 1 year. (Gissler M, Kauppila R, Merilainen J, Toukomaa H, Hemminki E.

Pregnancy associated deaths in Finland 1987-1994: Definition problems and benefits of record linkage. Acta Obstetricia et Gynecologia Scandinavica 1997;76:651-57). Subsequent studies in Finland showed maternal mortality-childbirth 28.2/100,000, while abortion mortality was 83.1/100,000 or 3 times higher (Gissler M, Ber C, Bouvier-Coll M, Buekins P. Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland 1987-2000). The risk of suicide was 6 times higher following abortion abortion (Gissler M, Berg C, Bouvier-Colle MH, Buekens P. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *Eur J Public Health*. 2005;15(5):459-463).

Morgan et al in UK found that there were 8.1/1,000 suicide attempts in patients undergoing abortion versus 1.9/1,000 suicide attempts in those giving birth (Morgan C, Evans M, Peters JR. Suicides after pregnancy: Mental health may deteriorate as a direct effect of induced abortion. Br Med J 1997;314:902) .

Auger et al carried out a population-based study in Canada in 2025. This study included 1.2 million pregnancies for up to 17 years. Compared to live birth and stillbirth, women who underwent induced abortion had higher risks of hospitalization for psychiatric disorders, substance use disorders, and suicide attempts, with the highest risks among women under age 25 and those with pre-existing mental health problems. The cumulative rate of mental health hospitalization was 14.3 per 100 induced abortions versus 6.8 per 100 deliveries over 17 years.

Large record-based studies show that women who have undergone abortion have an increased death rate due to accidents, compared to women who were not pregnant and compared to women who carried a pregnancy to term (Reardon DC, Ney PG, Scheuren FJ, Cougle JR, Coleman PK, Strahan T. Deaths associated with pregnancy outcome: A record linkage study of low income women. Southern Medical Journal. 2002;95:834).

The above data show that abortion is not a procedure without substantial risks Many deaths from abortion have been documented, as noted, even at early gestational ages, and the mental health impacts of abortion may linger for decades. Further, there are no comprehensive data on abortion complications. In part, this is because rates of follow up after abortion are low. The American College of Obstetrician-Gynecologists Current Commentary: Routine Follow up Visits After First-Trimester Induced Abortion (2004) noted that “In practice, attendance at abortion follow up visits is usually low, generally about 50%. Studies of first trimester aspiration abortion complications observing consecutive series of patients show follow-up proportions from 35% to 60%, although a few series report proportions as high as 80-90%”(Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. Obstet Gynecol.

2004;103(4):738-745). Further, most women with complications from abortion seek help at emergency departments, not at abortion clinics, which are not open 24 hours per day. Equally important, despite these facts, there is no systematic, mandated, uniform data collection process at either the state or federal levels.

As noted, death is a known outcome from chemical abortion. Below are listed some reported deaths associated with chemical abortion.

- In 2022, a 19 year old Canadian girl died of septic shock after taking the abortion pill (https://run-with-life.blogspot.com/2023/01/medical-abortion-is-fatal-for-19-year.html).
- In 2022 Candi Miller Candi Miller (GA), 41 years old, died after taking mifepristone-misoprostol obtained online https://www.liveaction.org/news/autopsy-report-candi-miller-abortion-pill-questions.
- Also in 2022, Amber Nicole Thurman died of complications following chemical abortion https://www.nationalreview.com/corner/media-mislead-on-tragic-death-of-amber-thurman/. Ms. Thurman's tragic death underscores the need for physicians to follow up patients after an abortion.
- Alyona Dixon also died in 2022 following chemical abortion (https://abortiondocs.org/wp-content/uploads/AlyonaDixonAutopsy-searchable.pdf).

No study using patient data has ever demonstrated that abortion improves women's health. Abortion does not decrease maternal mortality. Plausibly reported increases in maternal mortality in states with abortion restrictions are not due to those restrictions, but rather to likely increases in risk factors for maternal death, including obesity, substance abuse and mental health, social factors and pregnancy in older women, as well as health services factors such as patient access to and utilization of maternity care, and the distribution of health care professionals. In fact, African American women have the highest rates of abortion and the highest rates of maternal mortality.

Abortion also does not decrease infant mortality rates. Data purporting to show that abortion increased infant mortality in Texas did not mention that infant mortality likely increased because of increases in the numbers of infants born, and an increase in the number of infants born with congenital abnormalities.

There are significant racial-ethnic disparities in abortion rates and risk for adverse outcomes is not distributed equally across racial-ethnic groups. Nationally, African American women simultaneously have the highest rate of abortion and the highest rates of

abortion-related death. Abortion is markedly more dangerous for African American than for European American women. Bartlett et al (2007) found that "The second most significant risk factor for death [from abortion, after gestational age] overall was race. Women of black and other races were 2.4 times as likely as white women to die of complications of abortion…At all gestational ages, women of black and other races had higher case mortality rates than white women." Finding that "women of black and other races tend to have abortions at later gestational ages", the authors used statistical methods to account for this difference and found that women of African American and other races-ethnicities were still twice as likely as European American women to die from abortion at any gestational age. Zane et al also reported that the abortion "mortality rate was 0.4 for non-Hispanic white women, 0.5 for Hispanic women, 1.1 for black women and 0.7 for women of all other races…Black women have a risk of abortion-related death that is three times greater than that for white women".

These ethnic disparities in abortion-related deaths point to even more remarkable disparities in abortion rates The racial disparity in abortion rates between African American and European American women is present in many states.

- African American women comprise about 12% of the population, but 45.2% of abortions in Delaware in 2023 were performed in black women.
- African American women comprise about 10.2% of the population, but 34.8% of abortions in Virginia in 2023 were performed in black women.
- African American women comprise about 3.4% of the population, but 32% of abortions in Wisconsin in 2023 were performed in black women.

Regardless of intent or motivation, it is a fact that these statistics indicate eugenic outcomes for the African American population in many states. Long-term, birth and fertility rates among black non-Hispanic women have been declining for decades.

"Telemedicine" and self-administered abortion are unsafe and endanger women. "Telemedicine abortion" is inappropriate because it cannot ensure that patients receive the same standard of care and safety oversight as in-person procedures. This includes critical safeguards such as ultrasound to rule out ectopic pregnancy, Rh testing, and physical exams. These safeguards are essential to prevent misdiagnosis, delayed care, or failure to detect life-threatening conditions such as ectopic pregnancy.

An understanding of mifepristone's approval provides a foundation for understanding why chemical abortion must be dispensed in person. Per AAPLOG (https://aaplog.org/wp-content/uploads/2023/01/PG-8-Medication-Abortion.pdf), "The FDA failed to follow its own

rules on numerous occasions to approve this drug. A new drug must have at least two randomized, blinded placebo-controlled trials documenting its safety and efficacy, but the submitted trials had no placebo groups… Mifepristone was approved under a special category, "Subpart H: Accelerated Approval Regulations" which are intended for serious/life-threatening illnesses such as advanced cancer and HIV…Also, the FDA based approval on the combined action of the mifepristone with misoprostol…over the objections of its [misoprostol's] manufacturer, Searle. The FDA is required to test a drug in a pediatric population but waived this requirement without explanation despite adolescent women comprising 1/4-1/3 of its users…Finally, the approved regimen does not mimic clinical trial conditions as it lacked a required ultrasound, experienced surgeon dispensing, and nearby hospital admitting privileges. The FDA approved Mifepristone for U.S distribution in 2000 under SubPart H, which was the only mechanism at the time which allowed FDA to require post-marketing restrictions of drugs considered at high risk for complications if not used in accordance with the FDA label. In 2006, the FDA instituted a Risk Evaluation Mitigation Strategy (REMS). This is a safety strategy applied to medications that have a known or potential serious risk associated with them…Under this strategy, the risk of complications such as ruptured ectopic pregnancies, hemorrhage, infection and retained pregnancy tissue, which require surgery in as many as one in 20 women…might be minimized. To decrease the likelihood of these negative effects, Mifepristone was initially only approved up to 49 days gestational age, the provider was registered after specific training, it was only to be dispensed in certain healthcare settings and the patients were to be informed of the risk of serious side effects. Mifepristone abortion providers were required to be able to accurately determine the gestational age, confirm an intrauterine location of the pregnancy, and intervene surgically if the abortion was unsuccessful or a complication resulted (or alternatively the abortionist could have an agreement with another doctor and facility capable of providing this care). Complication reporting was mandated, as was a 14-day follow-up visit for the woman…Finally, a black box warning was assigned. "If mifepristone/misoprostol results in incomplete abortion, surgical intervention may be necessary. Prescribers should determine in advance and give clear instructions whom to call and what to do in case of emergency. Medication abortion is contraindicated if there is no access to medical facilities for emergency services." The REMS was last updated in 2021.

While some of these provisions were subsequently (and controversially) changed by FDA, they document awareness of the complications associated with the use of mifepristone-misoprostol, potential safeguards against those complications, and the lack of any basis for its use in telemedicine. Restoring the in person requirement of the REMS would provide safeguards for women's health by prohibiting "abortion telemedicine".

There are additional reasons why "telemedicine abortion" is unsafe and endangers women, which are described below.

Abortion has been associated with coercion, sex abuse trafficking and domestic violence. Informed consent, in-person and other requirements are necessary to help prevent coercive abortions, which are all too common in abusive relationships and sex trafficking. Coercion is a hallmark of sex trafficking, rape, domestic violence and child sex abuse. For example, the 24-hour waiting period can increase safety and support autonomous decision-making related to abortion by increasing the likelihood that coercion will be detected.

ACOG Committee Opinion No. 554, "Reproductive and Sexual Coercion," recommends that "Because of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for IPV and reproductive and sexual coercion at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup [emphasis added])."

Sex trafficking is a concern nationally. The US is reportedly the number one sex trafficking destination in the world. While trafficking is being aggressively addressed by state and national legal, criminal, youth services and other agencies, it remains a crisis.

However, clinical professionals, especially OB/GYNs, are on the front lines of detecting sex trafficking, because they have an opportunity to interview patients privately and because reproductive health care may be one of the few interactions with a health professional that pimps, traffickers and abusers will allow. Because abortion clinics may perform abortions on women who are victims of sex trafficking, informed consent and 24-hr waiting provisions of the are very important. For both chemical and surgical abortion, traffickers and abusers will often not allow their victims to meet privately with a physician because they risk disclosure of abuse, coercion or trafficking. Especially in the case of "tele-abortion", there are no safeguards whatsoever against coercion and abuse. The prescriber has no idea whether the woman seeking abortion is being threatened or coerced, how far along she is in pregnancy (or whether she is even pregnant), and whether she is being victimized by trafficking or abuse.

Research and testimony from survivors show that girls and women trapped in abuse and sex trafficking are frequently subjected to forced abortion, and that abortion is often used to cover up sex trafficking and child sexual abuse. In Laura Lederer and Christopher Wetzel's 2014 study of trafficked women, 71% of trafficked women reported at least one pregnancy while being trafficked. 21% reported having 5 or more pregnancies. 55%

reported at least one abortion and 30% reported multiple abortions. 66 of the women surveyed who responded to abortion questions stated that a total of 114 abortions had been performed on them during their trafficked state. One young woman had 17 abortions. Lederer states, “Notably, the phenomenon of forced abortion as it occurs in sex trafficking transcends the political boundaries of the abortion debate, violating both the pro-life belief that abortion takes innocent life and the pro-choice ideal of women’s freedom to make their own reproductive choices” (Lederer L and Wetzel C. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Annals of Health Law, Vol 23(1)).

AAPLOG Committee Opinion 5: Pornography, Sex Trafficking and Abortion, July 26, 2019, discusses this issue in detail. According to this report, “Though…pro-abortion advocates proclaim abortion empowers and liberates women, it is a tool of enslavement and control for the trafficker. Victims of sex trafficking are not empowered by abortion, they are deprived of their human dignity and rights. In 2017, a survivor group undertook an informal survey of other survivors of sex trafficking, who were minors at the time. The survey was only done by and for survivors. It was not a formal survey for a specific organization. Though the survey was vast in the scope of questions, it did include some questions on who missed them, how many have had abortions as a result of their exploitation, how many were forced to be on birth control, take abortifacient drugs, and how many were minors at the time. Surveys were sent to 1123 women who identified as survivors. Of the 1123 women surveyed, 758 responded they were trafficked as children (67%). But child sexual abuse was prevalent in nearly 96% of them.

• Of the 758, nearly 90% (683) had had one abortion as a minor (ages 11-17).

• Of the 90% (683), 628 (92%) had had multiple abortions, sometimes at the same facility.

• When brought in for an abortion, none of them were separated from the traffickers or bottom who brought them in.

• None of them were asked for ID.

• All of them were given the abortion and not screened for trafficking or abuse.

• All of them were sent home with their trafficker after the abortion, with birth control or some sort of prophylactic.

• Nearly 88% of the original respondents said a Planned Parenthood facility was where they were seen.

• Nearly 85% of the original respondents were taken for some sort of STI, UTI, or reproductive issue multiple times. K. Dore, Survivor (Personal communication May 20, 2019)".

Based on these findings, there is reason to believe that abortion is common in trafficked women. Notably, each abortion in the women noted above was a failed interaction with the medical system, in many of these cases Planned Parenthood, that likely led to continued victimization, rather than an opportunity for them to escape trafficking. Identifying trafficked women and children is a critical safety issue. In particular, abortion providers are mandated reporters.

In my own clinical experience, not long ago, I was aware of a young girl, a minor, who had come to the hospital with sepsis, and who stated that she had taken abortion pills. She was very ill with fever, abdominal pain and inability to keep food down. She was found to have retained products of conception as the cause of her sepsis. After some days on antibiotics, a discussion was held with her, even though it was felt by some clinicians that she had the right to reproductive freedom, i.e. to undergo an abortion without any questions asked. In the course of a gentle, detailed, and compassionate discussion what emerged was she had been impregnated by a teacher; that the teacher had given her the pills and left town. And it was only through talking with the girl that the crime was discovered and reported.

The literature on coercion and abortion suggests that coercion is common in women seeking abortion. Data from the National Longitudinal Survey of Adolescent to Adult Health indicated that an estimated 20% of women with a history of induced abortion stated that one or more of their abortions were coerced (Sullins DP: Affective and substance abuse disorders following abortion by pregnancy intention in the United States: a longitudinal cohort study. Medicina (Kaunas). 2019, 55:10.3390/medicina55110741). In another study of induced abortion decisions by Reardon et al., 29% of participants stated that their abortions were unwanted or coerced (Reardon D, Rafferty K, Longbons T. The Effects of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health. Cureus May 11, 2023).

The authors (Reardon et al) noted that "[a] majority of women who had abortions (60%) reported they would have carried to term if they had received more support from others and/or had more financial security." These findings are consistent with the results of other investigations reporting high rates of perceived pressure to abort and ambivalence regarding abortion decisions (Moore A, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. Soc Sci Med 2010 Jun;70(11):1737-44).

A second important social problem that is associated with abortion is domestic violence. As noted above, coercion is a hallmark of domestic violence. A study by Glander et al. (Glander S, Moore M, Michielutte R, Parsons L. The prevalence of domestic violence among women seeking abortion. Obstetrics & Gynecology 91(6), 1002-1006, 1998) showed that, shockingly, 40% of women seeking abortion were victims of domestic abuse. Requiring that women meet with physicians alone, and requiring a 24-hr waiting period, provides a potentially important opportunity to identify women and girls trapped in sex trafficking, domestic violence, or sexual abuse. This protects the health of these vulnerable women.

The above research suggests that many women's decisions to undergo abortions are not autonomous, they are coerced. As noted in the Reardon study, a majority of women would prefer to parent their child if they had the financial and other support they needed to do so, and in-person requirements offers them an opportunity to explore that option, if they so choose. In-person requirements do not stigmatize abortion. In fact, they promote autonomous decision-making on the part of the woman seeking abortion, because autonomous decision-making, by definition, cannot occur in the presence of coercion.

Mifepristone-misoprostol is not safer than Tylenol and should not be available over the counter (OTC). It is inaccurate and misleading to state that mifepristone is safer than Tylenol. Tylenol is an OTC medication, and it does not have a black box warning. Most adverse effects of Tylenol are related to accidental or deliberate overdose, that is, when it is not used as instructed. Mifepristone is a prescription medication with a black box warning, which notifies clinicians and patients of serious and even fatal complications from its use.

As noted by Drugwatch (https://www.drugwatch.com/fda/black-box-warnings/), "A black box warning is the FDA's most stringent warning for drugs and medical devices on the market. Black box warnings, or boxed warnings, alert the public and health care providers to serious side effects, such as injury or death. The FDA requires drug companies to add a warning label to medications that have a black box warning… Before adding a boxed warning to a medication or medical device, the FDA must have evidence that the drug poses a significant risk. This evidence comes from observations and studies conducted after a drug has been on the market. After determining that a drug needs a black box warning, the FDA contacts the drug company to add a warning to its labeling. The drug company then submits its language for FDA approval. Once the FDA approves the language, it is printed on the drug or device's package and on the medication insert".

Below is the black box warning for mifepristone.

WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING

See full prescribing information for complete boxed warning.

Serious and sometimes fatal infections and bleeding occur very rarely following spontaneous, surgical, and medical abortions, including following MIFEPREX use.

- **Atypical Presentation of Infection. Patients with serious bacterial infections and sepsis can present without fever, bacteremia or significant findings on pelvic examination. A high index of suspicion is needed to rule out serious infection and sepsis. (5.1)**
- **Bleeding. Prolonged heavy bleeding may be a sign of incomplete abortion or other complications and prompt medical or surgical intervention may be needed. (5.2)**

MIFEPREX is only available through a restricted program called the MIFEPREX REMS Program (5.3).

Before prescribing MIFEPREX, inform the patient about these risks. Ensure the patient knows whom to call and what to do if she experiences sustained fever, severe abdominal pain, prolonged heavy bleeding, or syncope, or if she experiences abdominal pain or discomfort or general malaise for more than 24 hours after taking misoprostol.

Advise the patient to take the MEDICATION GUIDE with her if she visits an emergency room or another healthcare provider who did not prescribe MIFEPREX, so that provider knows that she is undergoing a medical abortion. (5.1, 5.2)

An article published in the journal Biotech (Louttit C, The Origins and Proliferation of Unfounded Comparisons Regarding the Safety of Mifepristone. BioTech 2025, 14(2) provides further evidence undermining the claim that mifepristone is safer than Tylenol, or indeed other drugs. The author notes that "Indeed, we are now inundated with claims that the safety of this regimen [mifepristone-misoprostol] compares similarly or favorably to that of many common pharmaceuticals, including acetaminophen (Tylenol), ibuprofen (Advil), aspirin, penicillin, and sildenafil (Viagra). These claims can be found not only in the mass media [2– 14] but also in journal articles [15 – 20] and other academic outputs [21 – 23], legal documents [24 –29], statements from government officials and their offices [30 – 39], and patient-facing informational material [40– 46]. In recent years, perhaps influenced by the short form of social media, the claim has often coalesced to a concise and oft-repeated refrain that "mifepristone is safer than Tylenol", to which varying combinations of the other listed drugs are at times appended…" The author carries out a careful and rigorous evaluation of the claim using data and statistics. The author finds, for example, in the clinical context regarding Tylenol, that two of the articles (one in Contraception and one in ANSIRH) compared Tylenol risk (from liver failure) with mifepristone risk for adverse outcomes, based on 2 studies (Ostapowicz, G, Fontana, R.J., Schiødt, F.V., Larson, A., Davern, T.J., Han, S.H.B., McCashland, T.M., Shakil, A.O., Hay, J.E., Hynan, L., et al. Results of a Prospective Study of Acute Liver Failure at 17 Tertiary Care Centers in the United States. Ann. Intern. Med. 2002, 137, 947–954; and Nourjah, P.; Ahmad, S.R.; Karwoski, C.; Willy, M. Estimates of Acetaminophen (Paracetamoll)-associated Overdoses in the United

States. Pharmacoepidemiol. Drug 2006, 15, 398–405). However, these 2 studies note that Tylenol overdose was “the cause of the observed liver failure, with a median dose of 13.2 grams per day consumed against the labeled maximum of four [grams]. In this study, 36.67% of overdoses were described as intentional, 56.67% as accidental (occurring without intention for self-harm), and 6.67% unknown. A larger study of U.S. mortality and emergency databases found that intentional acetaminophen overdose accounted for between 55% and 74% of fatal cases, with 8–26% attributed to unintentional overdoses…”. Of note, the authors of the study by Ostpowicz et al wrote that “there is very little evidence of liver injury when acetaminophen is used according to package recommendations”. Louttit states that claims that mifepristone is safer than Tylenol are “wholly unfounded, offering deficient and disingenuous representations of safety for any of the drugs compared"(https://www.mdpi.com/2673-6284/14/2/39). The adverse effects associated with mifepristone are inherent to the drug’s pharmacology and occur with routine, prescribed use. Mifepristone, used as prescribed, can and has caused serious complications and death. It is also clear that there are significant risks associated with the use of mifepristone which require close monitoring, like the REMS, to prevent harms to women. The known risks of death and serious complications from mifepristone-misoprostol make it inappropriate for consideration as an OTC medication.

Elective abortion is not healthcare; it is intentional feticide. No procedure which destroys human life can be called healthcare. It is a scientific fact that the embryo or fetus, the unborn child, is human. He or she is a member of the human family, a unique living being with human DNA distinct from his or her parents. He or she is not a “clump of cells” or a “potential life,” but an unborn child, a child assuming the human form.Clinicians caring for pregnant women have two patients: the mother and her unborn child.

Intentional feticide is not the same as miscarriage care, because in a miscarriage, the embryo or fetus is demised. It is not the same as care for ectopic pregnancy, because a procedure to treat ectopic pregnancy is not elective and is done to save the life of the mother. Intentional feticide is not the same as care for in utero demise, because, again, the fetus is demised. Finally, intentional feticide is not the same as a termination of pregnancy for the life of the mother, because the intent of the procedure is to save the mother, not to kill the unborn child.

Abortion reporting requirements at the federal and state levels should be strengthened to help protect the health of women and girls. As explained by the Washington State Department of Health: “Abortion data surveillance is necessary to examine trends in public health. It is used to calculate pregnancy, teen pregnancy, and abortion rates. It helps evaluate the success of programs promoting equitable access to

contraceptive services. It helps monitor changes in clinical practice patterns, procedures used, weeks of gestation, as well as procedure complications and management" (https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/pregnancy-and-abortion).

Such data collection supports public health efforts to better understand abortion and its utilization by women. As noted by CDC, specifically related to abortion, "[o]ngoing surveillance of legal induced abortion is important," in part because "[u]p to 42% of pregnancies in the United States are unintended…and use of effective contraception is a strategy to reduce unintended pregnancy…Efforts to improve contraceptive access have been associated with declines in the rate of abortion" – suggesting that decreasing abortion rates is a positive public health goal (Page 9, Abortion Surveillance — United States, 2021 | MMWR (cdc.gov)". The latter report goes on to say that "routine abortion surveillance can be used to assess changes in clinical practice patterns over time. Information in this report on the number of abortions performed through different methods (e.g., medication or surgical) and at different gestational ages provides the denominator data that are necessary for analyses of the relative safety of abortion practices…Finally, information on the number of pregnancies ending in abortion is used in conjunction with data on births and fetal losses to estimate the number of pregnancies in the United States and determine rates for various outcomes of public health importance.

However, abortion surveillance is fragmented across the nation. California, Maryland, New Hampshire, and New Jersey do not submit abortion data to CDC. In 2022, 20 states did not report data on race-ethnicity to CDC including Colorado, Maryland, New Jersey, Massachusetts, New Hampshire, Connecticut, and Washington State (Table 6, https://www.cdc.gov/mmwr/volumes/73/ss/ss7307a1.htm#T6_down). Colorado, Maryland, New Jersey, Massachusetts, New Hampshire, Connecticut and Washington State do not report data on race-ethnicity. The changing abortion-related legislative landscape emphasizes the importance of uniform reporting standards, as well as mandatory reporting, which would greatly improve our understanding of abortion epidemiology.

Abortion can be a tool of eugenics. Abortion is frequently eugenic if not by intent, then by outcome. Discrimination abortion is more property called eugenic abortion. Eugenics has as its goal the "weeding out" of the unfit by killing those individuals who are deformed, weak, unwanted or considered less than human. "More children from the fit, fewer from the unfit – that is the chief issue in birth control" was the eugenic sentiment contained in an editorial written by the editors of American Medicine. They were reviewing Margaret

Sanger's article "Why Not Birth Control Clinics in America?" published in Birth Control Review, May 1919.

As many are aware, the history of the eugenics movement is a sordid chapter in American history, which culminated in the sterilization and even castration of those who were felt to be unfit, including those who were minorities, those categorized as disabled, mentally handicapped or who had “hereditary diseases”. The American eugenics movement also inspired the Nazis’ pursuit of the master race. Asbury has noted that “Building upon eugenics’ origins in Britain and its wide appeal in the United States, Nazi Germany is most notorious for changing the course of medical genetics…”.

The early eugenicists made the argument that contraception and sterilization were solutions to the medical and public health problems of the day, such as pellagra, epilepsy and malnutrition. By reducing the number of the “unfit”, they claimed, the health of the American population would be improved, and programs were introduced to achieve these goals. Such programs focused overwhelmingly on society’s outcasts and marginalized, especially the poor, and from a legal perspective, culminated in the infamous Supreme Court opinion in Buck v. Bell, 274 U.S. 200 (1927).

The eugenic mindset continues in the present day with disability abortions, also called eugenic terminations. As Julian Savulescu has noted “When a pervasive professional practice (or law) only allows TOP [termination of pregnancy] when there is fetal abnormality, this discriminates against abnormal fetuses. While pregnancy termination may not be compulsory, its effect is eugenic. In a similar way to that in which active and passive euthanasia are distinguished, active eugenics can be defined as offering the option of an intervention which directly promotes some eugenic outcome, for example offering financial inducements to the “fit” to reproduce. Passive eugenics is the closing off of options with the result that a eugenic outcome is more likely, for example not offering child support to people who choose to have a disabled child. Allowing LTOP [later termination of pregnancy] for serious abnormality but disallowing it for minor or no abnormality is passive eugenics… Many would object that current practice is not eugenic because the intention is to offer choice regarding continuing a pregnancy with a major abnormality, and not to promote a healthier population…It is true that practice may not be driven by primary eugenic intention, but the effect is the same”. Savulescu, Julian. “Is Current Practice around Late Termination of Pregnancy Eugenic and Discriminatory? Maternal Interests and Abortion.” Journal of Medical Ethics 27, no. 3 (2001): 165–71.

Asbury makes an explicit connection between eugenics and genetic counseling. He states that “genetic terminations are unlike ordinary abortions in that they result in the end of an initially wanted pregnancy, and unlike stillbirth or other perinatal loss insofar as the mother

makes the decision to end her fetus's life". He also critiques genetic counseling, stating that it not only fails to be nondirective, but is doubly eugenic. Asbury states that

> While it is possible that the expanded availability of prenatal genetic analysis will produce no meaningful increase in the detection of fetal anomalies among this population [poor black women], there will likely be a significant rise. Should these women decline to engage meaningfully with genetic counseling providers upon learning of a fetal abnormality, the vast majority will terminate. Should they enter genetic counseling in good faith reliance upon their provider's expertise, pro-white and anti-poor biases will inevitably seep in, resulting in encounters that are generic (rather than intimate) at best or directive toward uninformed terminations at worst. The dystopian gloss on either of these latter possibilities would be a two-tiered genetic counseling regime in which the increasing sensitivity to disability rights results in an increase anomalous births among the privileged, while poor, black fetuses with genetic abnormalities are routinely, through the neglect or indifference of genetic counseling, deemed not worthy of life.

Abortion is eugenic by intention (for disabled or "anomalous" unborn children), and by outcome (for African Americans). Eugenic abortions, or eugenic terminations are those performed based on a fetal characteristic. As note, in this context, eugenics has as its goal the "weeding out" of the unfit by killing those individuals who are deformed, weak, unwanted, or considered less than human. In 2019 Justice Thomas explained abortion's ties to the eugenics movement, noting that "technological advances have only heightened the eugenic potential for abortion." (Concurring Opinion in Box v. Planned Parenthood of Indiana and Kentucky, Inc.). Thus, there is a "compelling interest in preventing abortion from becoming a tool of modern-day eugenics." Abortion in this context is therefore a tool of eugenics.

In the case of fetuses with Down syndrome this point becomes especially important, because a majority of these unborn children undergo eugenic abortion. In the United States, a majority of unborn children with Down syndrome undergo eugenic abortion. Hume et al noted an abortion rate for Down syndrome fetuses of 94.4% in 2015 (Trends in timing of prenatal diagnosis and abortion for fetal chromosomal abnormalities. H Hume, ST Chasen - American Journal of Obstetrics and Gynecology, 2015).

Natoli et al performed a systematic evidence review to study "the published literature on pregnancy termination following a prenatal diagnosis of Down syndrome in the United States. The weighted mean termination rate was 67% (range: 61%–93%) among seven population-based studies, 85% (range: 60%–90%) among nine hospital-based studies, and 50% (range: 0%–100%) among eight anomaly-based studies" (Natoli JL, Ackerman DL, McDermott S, Edwards JG. Prenatal diagnosis of Down syndrome: a systematic review of termination rates (1995-2011). Prenat Diagn. 2012;32(2):142-153. doi: 10.1002/pd.2910).

Down syndrome is diagnosed using prenatal screening. However, as noted by a Senate report "…these prenatal tests do not address the extent of the disability or the symptoms that the baby might have. Misconceptions about Down syndrome and a lack of counseling following a positive screening likely leads to more children being aborted than otherwise would have been had the parents had better information. As testing becomes more prevalent, even more abortions of children with Down syndrome will likely occur" https://www.jec.senate.gov/public/index.cfm/republicans/2022/3/down-syndrome-and-social-capital-assessing-the-costs-of-selective-abortion).. They go on to note that:

> "All people with Down syndrome are intrinsically and immeasurably valuable. In addition, people with Down syndrome are happy with their lives and make their families and communities better off. Medical advancements have helped increase life expectancy of people with Down syndrome from about 10 years in the 1960s to over 50 years in 2020 according to JEC Republican estimates, but at the same time have led to expanded screening during pregnancy that opens the door to a rise in selective abortions… Misconceptions about people with Down syndrome lead to a disproportionate number of diagnosed children being aborted. It is estimated that 60 percent to 90 percent1 of children diagnosed with Down syndrome are aborted in the U.S., compared to 18 percent of all pregnancies ending in abortion…Weighing the impact of selective abortion is especially important given the incalculable intrinsic value of all human life. For individuals with Down syndrome, it is particularly important to understand that they have high life satisfaction, improve the lives of their family members, and contribute to their communities through work and other activities."

As noted, advances in medical science have extended the lives of children with Down syndrome. But any such advances are currently impeded by perceptions about these children and the fact that most are aborted. Because they are often assigned a bleak prognosis, they have not benefited from the same intensive research efforts on prevention and clinical care that are associated with improved outcomes in other children with severe and life-limiting disabilities. In particular, the perception of children with Down syndrome as disabled and subhuman likely hinders efforts in this direction and results in parents being pushed to abort them. For example, there are animal studies showing that nutritional and other interventions can prevent the brain abnormalities, and learning and developmental delays that are associated with Down syndrome. Yet despite this extremely promising research, some of which was published over a decade ago, there is limited effort in this area. It stands in stark contrast to the voluminous literature on abortion, and underlines how this perception of unborn children with disabilities as being subhuman has led to the popularity of eugenic termination.

(https://www.jec.senate.gov/public/index.cfm/republicans/2022/3/down-syndrome-and-social-capital-assessing-the-costs-of-selective-abortion). Abortion of fetuses with disabilities is a human rights violation, and a tool of eugenics to eradicate disabled unborn children. The same is true of abortions motivated by the sex of the child.

Abortion in African Americans. In 2022, the last year for which CDC data were available, black women had 4.3 times as many abortions as white women. The racial disparity in abortion rates between African American and European American women is present in many states, some of which do not report data on abortion, or do not report on abortion rates by race-ethnicity.

- African American women comprise about 12% of the population, but 45.2% of abortions in Delaware in 2023 were performed in black women.
- African American women comprise about 10.2% of the population, but 34.8% of abortions in Virginia in 2023 were performed in black women.
- African American women comprise about 3.4% of the population, but 32% of abortions in Wisconsin in 2023 were performed in black women.
- African American women comprise about 0.85% of the population, but 4% of abortions in Vermont in 2023 were performed in black women.

Regardless of intent or motivation, it is a fact that these statistics indicate eugenic outcomes for the African American population in many states. Abortion is one of the single largest cause of death in African Americans. An estimated 187,927 abortions, 24.4% of the total, were performed in black women in 2022. In contrast, there were 511,439 births to black women, indicating that an estimated 27% of pregnancies are aborted in black women and that for about every 3 African American children born, one is aborted. Long-term, black non-Hispanic fertility rates, births and the number of school-aged children have been declining for decades and continue to do so in tandem with increasing rates of abortion.

Physicians in pro-abortion states must follow the laws of the states where women fill their prescriptions, including where abortion is restricted. Physician practice is regulated by state boards of medicine. State boards of medicine oversee the licensure, behavior and practice of physicians and require them to adhere to state law. In order to prescribe a medication in a state, a physician must have a license to practice medicine within that state (interstate compacts allow physicians licensed in one state to hold licenses in other states). If a physician is not licensed to practice in a state, they are not allowed to prescribe medications in that state (see for example https://legalclarity.org/can-an-out-of-state-doctor-prescribe-medication for an explanation). While prescribing in a state, the physician is bound by the laws of that state. Prescribing abortion pills in states

where it is not legal, thereby violating the laws of that state, is inconsistent with the ethical practice of medicine. It also violates the standard of care, because where a physician-patient relationship has been established, that physician has a responsibility to oversee the care of that patient. This situation is analogous to cross-border prescribing of narcotics, which in the past contributed to the opioid epidemic. In those cases, state and federal regulators had to step in to enact strict laws to address the opioid crisis.

"Telemedicine" abortion, mail-order abortion, and self-administered abortion, as noted, are unsafe and endanger women. In fact, licensed physicians do not prescribe medications to individuals without specific requirements including verifying a patient's identity, medical history and making a diagnosis.

The practice of telemedicine is highly regulated, and therefore the prescribing of abortifacient drugs virtually should not be legitimized by calling it telemedicine. This is more properly termed remote abortion. Safeguards which are a part of standard telemedicine are absent in remote abortion services. For example, strict physician licensure requirements are essential to verify that medical professionals providing abortion services in-person possess the necessary qualifications, training, and ongoing competency to do so. Remote abortion services cannot ensure that the person dispensing the abortion pill is even a physician, or that patients receive the same standard of care and safety oversight as in-person procedures. The latter ensures adherence to medical standards and protects patient safety. These requirements are particularly important in reproductive health, where the complexity of abortion services and potential for complications demand a high level of clinical oversight and professional accountability. This also includes critical safeguards such as ultrasound to rule out ectopic pregnancy, Rh testing, and physical exams. These safeguards are essential to prevent misdiagnosis, delayed care, or failure to detect life-threatening conditions such as ectopic pregnancy and cannot be done with remote abortion.

There are additional reasons why remote abortion is unsafe and endangers women:

- Abortionists providing remote abortion cannot assess a patient for ectopic pregnancy. It is mandatory that providers assess for ectopic pregnancy prior to abortion, to reduce the risk of this potentially fatal complication. In fact, ectopic pregnancy is a contraindication to chemical abortion according to mifepristone's prescribing information. Ectopic pregnancy occurs in 1 in 50 pregnancies. It cannot be diagnosed virtually. It is one of the leading causes of maternal death in 1st trimester, often due to delays in care. 50% of women diagnosed with ectopic pregnancy will not have any known risk factors.

- Abortionists providing remote abortion cannot confirm the identity of the woman or assess for coercion, trafficking or abuse. As noted above, these issues may be associated with abortion because traffickers and abusers desire to hide the evidence (pregnancy in their victims) of their crimes.
- Abortionists providing remote abortion cannot assess the gestational age of the unborn child, or if the mother is even pregnant. ACOG (Committee Opinion 700) states "Accurate dating of pregnancy is important to improve outcomes and is a research and public health imperative…A pregnancy without an ultrasound examination…should be considered to be suboptimally dated." Because some of the signs of pregnancy are subtle or not easily distinguishable from normal physical signs (constipation, fatigue), it is common for women to not have an accurate idea of how far along they are in pregnancy. For example, a patient for whom I cared recently came to the hospital unaware that she was at 23 weeks' gestation. The use of chemical abortion at advanced gestational ages is associated with severe and potentially fatal outcomes.
- Remote abortion increases the risk of complications because of a lack of clinical assessment.
- Abortionists providing remote abortion cannot assess a patient's Rh status and administer Rhogam, a blocking antibody. Women who are Rh negative and who have an Rh positive fetus can develop antibodies which will attack and injure or kill a future Rh positive fetus in utero, if they do not receive injections of Rhogam at the time of abortion, miscarriage, vaginal bleeding in pregnancy, and birth, all situations where the mother may be exposed to the embryo's or fetus' blood, and become sensitized. Despite abortionists' attempts to change this longstanding medical precedent, these injections remain the standard of care. Women who become Rh sensitized may suffer repeated early miscarriages, and their unborn children may develop severe disease or die in utero or soon after birth, as noted.
- Informed consent is a cornerstone of medical care, and it is essential to protecting patients and allowing them to make a fully informed decision prior to them undergoing a proposed intervention. Full informed consent for an intervention such as chemical abortion that has many associated risks, cannot be safely or appropriately given virtually. Remote abortion therefore negates true informed consent
- Abortionists providing remote abortion cannot supervise safe administration of the drugs, nor provide adequate follow up.

- Abortionists providing remote abortion have no idea who is in the room, whether a woman is being threatened, and who is actually receiving the pills (disgruntled boyfriend or husband, pimp, trafficker).

AAPLOG notes that "A study on obtaining abortion pills from international distributors found that no prescription or clinical information was required, the pills averaged two weeks to arrive, analysis of the medications obtained demonstrated that some misoprostol pills contained only 15% of the advertised amount of medication, the packages often arrived damaged, and no instructions were contained in any of the packages.

In a 2019 survey of abortion providers by University of Iowa researchers, published in Contraception, "Thirty-five percent of respondents had witnessed complications following self-managed abortion with misoprostol and/or mifepristone…The most frequently observed complication was incomplete abortion and retained products of conception, which comprised 34.7% of the reported types of complication, with hemorrhage following at 25.8%". (Courtney A Kerestes, Colleen K Stockdale, M Bridget Zimmerman, Abbey J Hardy-Fairbanks. Abortion Providers' Experiences and Views on Self-Managed Medication Abortion, an Exploratory Study. Contraception. 2019 August ; 100(2): 160–164. doi:10.1016/j.contraception.2019.04.006).

Other complications noted in this study included ongoing pregnancy, sepsis, preterm birth, undiagnosed ectopic pregnancy, and uterine rupture. Rates of these complications were reported in graph form, as opposed to exact numbers. Two findings stand out in this study. The first is that **clinician estimates of adverse outcomes associated with mifepristone-misoprostol abortion were much higher than the numbers reported in the literature.** The second is that **46.7% of abortion providers – nearly half – felt that the use of misoprostol with or without mifepristone for self-administered abortion was not safe.** It is a telling admission regarding the lack of safety of self-administered, or "telemedicine abortion" when a significant proportion of abortionists, who might be most likely to advocate for its use, express in writing that they feel it is unsafe.

Multiple cases of coerced abortion are associated with mail-order abortion, for example:

- In 2025…Emerson Evans was arrested and charged with two counts of intentional homicide of an unborn child. He allegedly put abortion pills in his girlfriend's vagina without her knowledge or consent. His girlfriend was approximately 7 weeks pregnant at the time. Evans claimed he bought mifepristone pills for $50 "from a girl on campus." Evans reportedly told police that he "made the decision for her."
- Also in 2025, "Justin Anthony Banta was taken into custody to be charged with capital murder and tampering with evidence. Upon learning she was pregnant…

Banta allegedly ordered abortion pills online and crushed the pills into her coffee later that day without her knowledge. Several days later she went to an emergency room after experiencing heavy bleeding, discovering that her unborn child was dead. The county sheriff's office also alleges that Banta remotely reset his phone, which had been seized as evidence, "deleting crucial evidence related to the case."

- In early 2025, Christopher Cooprider's girlfriend became pregnant with a baby girl…Cooprider obtained pills from AidAccess—a website operated by a Dutch doctor, Rebecca Gomperts, who illegally ships pills into the United States from international sources. Eventually Cooprider…laced her hot chocolate with the abortion pills he purchased from AidAccess. According to the complaint, she started cramping and hemorrhaging withing 30 minutes…When his girlfriend finally made her way to the ER, it was too late for her baby.
- In 2022, Mason Herring was charged with assaulting a pregnant woman and assault-forced induction after repeatedly slipping an abortion drug into his wife's beverages to forcibly abort their unborn child. She went to the hospital with severe cramping and bleeding. She eventually gave birth to her baby prematurely. The forced induction charge was downgraded to injury to a child. In 2024 Herring was sentenced to 180 days in prison and 10 years probation.
- Wisconsin 2022…Jeffrey Smith was sentenced to five years in prison for attempted first degree homicide of an unborn child. He crushed up an abortion pill and put it in his girlfriend's water bottle. She was about 20 weeks pregnant at the time.
- Virginia 2018…Doctor Sikander Imran, a doctor, was sentenced to three years in prison for fetal homicide. He spiked his girlfriend's tea with an abortion pill. She was 17 weeks pregnant at the time.
- Kansas 2015…Scott Bollig was sentenced to nearly 10 years in prison for conspiracy to commit intentional first degree murder for crushing an abortion pill into his girlfriend's pancakes. She was about 8-10 weeks pregnant when she lost her child.
- Wisconsin 2007…Manishkumar Patel was sentenced to 22 years in prison for first-degree intentional homicide after trying to trick his girlfriend into drinking a smoothie spiked with a crushed abortion pill.
- Massachusetts 2024…Robert Kawada "was charged with poisoning, assault and battery with a dangerous weapon on a pregnant person and assault and battery on a household or family member." Kawada allegedly gave his girlfriend iron and vitamin pills, however at least one pill was actually misoprostol. The victim lost the pregnancy after ingesting the drugs.
- Florida 2014…John Weldon was sentenced to 14 years in prison after tricking his girlfriend into taking an abortion pill. She was about 7 weeks pregnant at the time.

He forged the signature of his father – a fertility doctor – on a prescription and swapped the abortion pills into a bottled labeled as an antibiotic.

- Dr. Hassan Abbas allegedly wanted his girlfriend to get an abortion, but she refused. According to a state medical board document, he ordered mifepristone and misoprostol from an online abortion provider using his estranged wife's information, without her knowledge. The pills were shipped to his house from out of state. Roughly a week later in the middle of the night he held his girlfriend down and forced crushed powder in her mouth. She tried to call 911 but he took her phone. She drove to an ER herself. Abbas admits to these events but claims his girlfriend agreed to take the pills. She currently has a protective order against him. Abbas is currently under investigation by the State Medical Board of Ohio and his license is suspended. WTOL 11 Investigates confirmed with the sheriff that "at this time, no charges have been filed in the case."
- Washington 2024…David Coots, a nurse practitioner, was charged with assault, third degree rape, and witness tampering after allegedly forcing a misoprostol pill into a woman's vagina during sexual intercourse. Coots claimed that he prescribed the misoprostol for himself…After days of bleeding and stomach pain, she was no longer pregnant. In summer 2025 Coots pleaded guilty to both second and fourth-degree assault as well as tampering with a witness. He was sentenced to one year and one day in prison and may not contact the victim for 10 years.
- Louisiana 2024…New York abortionist Dr. Margaret Carpenter, along with a Louisiana woman, were indicted by a Louisiana grand jury for violating the state's law prohibiting abortion pills. According to the district attorney, the Louisiana woman obtained the pills via Dr. Carpenter and told her pregnant daughter, a minor, that "she had to take the pill or else." The young girl reportedly ended up in the emergency room after suffering significant bleeding….allegedly [having been] coerced to take have an abortion she didn't want with pills…prescribed by a doctor who had reportedly never even evaluated her or spoken with her.
- Florida 2023: Haley Raborn was charged with solicitation and attempted murder on an unborn child by injury to the mother, and tampering with/fabricating physical evidence. Raborn allegedly attempted to have the ex-fiance of the victim kill his 11-week old unborn child with an abortion pill. Instead, the ex-fiance turned the pill over to law enforcement. Raborn claimed that she got the pill from an online telemedicine doctor, which is illegal under Florida law.
- Louisiana 2023: Rosalie Markezich found out she was pregnant and wanted to keep her child. Her boyfriend, originally supportive, decided he did not want her to have their child and coerced her to have an abortion…In a sworn declaration, Rosalie described how her boyfriend's sister advised him how to order drugs from an online

pharmacy. He filled out a form online using her information; the only interaction Rosalie had with a medical provider was to send payment for the drugs, which were shipped from California via USPS [Ms. Markezich lost her child].

- California 2022…Jagmeet Sandhu was sentenced to a year in jail for involuntary manslaughter. He had held his girlfriend at gunpoint after entering her home while she slept and forced her to take abortion pills, killing her child. She was about 12 weeks pregnant at the time.
- Nebraska 2021…Ronald Powell, a high school security guard, was accused of sexually abusing a 15-year old student over the course of several years. And a result, the student became pregnant. According to court records he posed as her father at Planned Parenthood, where she had a chemical abortion.
- Connecticut 2016…Sage Lanza, an adult male, had a sexual relationship with a 14-year old victim who became pregnant. He pressured her to have an abortion and made an appointment for her at Planned Parenthood. When she was about two months pregnant, he and his father took her to Planned Parenthood for a chemical abortion. Connecticut does not have parental notification or consent laws for minors seeking an abortion.
- New York 2015…Joshua Woodward was sentenced to nine years in prison for attempted murder after giving a woman abortion drugs without her knowledge during a sexual encounter. She had previously refused his request that she have an abortion. The woman was 13 weeks pregnant at the time; Woodward had tried to slip her the drug twice before his third attempt was successful (see https://www.heritage.org/life/commentary/abortion-pills-coercion-and-abuse)

Abortion pill websites provide bulk shipping, also known as “pills in advance” https://aidaccess.org/en/page/2880027/advance-provision). There is no clear reason for bulk amounts of chemical abortion drugs to be provided for direct-to-consumer sales, other than for trafficking, illegal abortion where abortion is occurring outside of a set of clinical encounters, or women planning to self-manage abortion with no clinical guidance whatsoever.

To summarize, AAPLOG notes (ibid) that “There are many potential negative consequences to these recommendations…For example, underestimation of gestational age may result in higher likelihood of failed abortion. Undetected ectopic pregnancies may rupture leading to life-threatening hemorrhages. Rh negative women may not receive prophylactic Rhogam resulting in isoimmunization in future pregnancies. Potential for misuse and coercion is high when there is no way to verify who is consuming the medication and whether they are doing so willingly. Sex traffickers, incestuous abusers and coercive boyfriends will all

welcome more easily available medication abortion. Catastrophic complications can occur, and emergency care may not be readily available in remote areas".

As with the opioid epidemic, state and regulatory authorities should continue to enact efforts to help decrease the medical and social risks to women from mifepristone-misoprostol. FDA should strengthen the REMS by restoring the original safeguards. An understanding of mifepristone's approval provides a foundation for understanding why chemical abortion must be dispensed in person. Per AAPLOG (https://aaplog.org/wp-content/uploads/2023/01/PG-8-Medication-Abortion.pdf), "The FDA failed to follow its own rules on numerous occasions to approve this drug. A new drug must have at least two randomized, blinded placebo-controlled trials documenting its safety and efficacy, but the submitted trials had no placebo groups… Mifepristone was approved under a special category, "Subpart H: Accelerated Approval Regulations" which are intended for serious/life-threatening illnesses such as advanced cancer and HIV…Also, the FDA based approval on the combined action of the mifepristone with misoprostol…over the objections of its [misoprostol's] manufacturer, Searle. The FDA is required to test a drug in a pediatric population but waived this requirement without explanation despite adolescent women comprising 1/4-1/3 of its users…Finally, the approved regimen does not mimic clinical trial conditions as it lacked a required ultrasound, experienced surgeon dispensing, and nearby hospital admitting privileges. The FDA approved Mifepristone for U.S distribution in 2000 under SubPart H, which was the only mechanism at the time which allowed FDA to require post-marketing restrictions of drugs considered at high risk for complications if not used in accordance with the FDA label. In 2006, the FDA instituted a Risk Evaluation Mitigation Strategy (REMS). This is a safety strategy applied to medications that have a known or potential serious risk associated with them…Under this strategy, the risk of complications such as ruptured ectopic pregnancies, hemorrhage, infection and retained pregnancy tissue, which require surgery in as many as one in 20 women…might be minimized. To decrease the likelihood of these negative effects, Mifepristone was initially only approved up to 49 days gestational age, the provider was registered after specific training, it was only to be dispensed in certain healthcare settings and the patients were to be informed of the risk of serious side effects. Mifepristone abortion providers were required to be able to accurately determine the gestational age, confirm an intrauterine location of the pregnancy, and intervene surgically if the abortion was unsuccessful or a complication resulted (or alternatively the abortionist could have an agreement with another doctor and facility capable of providing this care). Complication reporting was mandated, as was a 14-day follow-up visit for the woman…Finally, a black box warning was assigned. "If mifepristone/misoprostol results in incomplete abortion, surgical intervention may be necessary. Prescribers should determine in advance and give clear instructions whom to

call and what to do in case of emergency. Medication abortion is contraindicated if there is no access to medical facilities for emergency services."

The REMS have been progressively weakened over the last few decades. In 2000, rapid approval of mifepristone occurred. It was to be used up to 49 days (7 weeks), with 3 office visits required, physician only dispensing, and was to be dispensed in a health care facility (https://www.guttmacher.org/gpr/2000/12/mifepristone-rollout-begins-fda-okays-new-contraceptive-shot). Reporting was required for all serious adverse events.

In 2016, changes were made to the REMS. The abortion pill could be now used up to 70 days (10 weeks) and only 1 office visit was required. Any health care provider could prescribe it; reporting was only required for deaths (https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf).

In 2021, further changes were made. No office visit was required and the abortion pill could be delivered via mail (https://www.sba-list.org/wp-content/uploads/2021/04/govdoc20210412-226601.pdf).

n 2023, it could be dispensed at a local pharmacy https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2023_03_23_REMS_Full.pdf) .

The Comstock Act, which prohibits the mailing of abortifacient drugs through USPS, should be enforced. Self-administered and telemedicine abortion, as noted above, are associated with serious medical and social risks to women and girls. Similar to the mailing of illicit narcotics, the mailing of abortifacient drugs should be restricted in order to protect the health of women and children and prevent coercion, trafficking, abuse and forced abortion.

To conclude, abortion in the majority of cases constitutes intentional feticide. As discussed above, there are significant risks associated with abortion at any gestational age and with any method. A number of studies show consistent associations between chemical abortion and adverse outcomes, many of which are serious. Because of this, laws regulating the practice of abortion, and mandating abortion reporting, serve to protect the health of women and children. In addition, coercion, domestic violence, abuse and sex trafficking have been associated with abortion as a means for abusers and traffickers to hide their crimes. The prevention and prosecution of coercion and abuse should be a priority, with a focus on helping vulnerable women obtain the help they need.

A high percentage of unborn children who have disabilities undergo abortion. This is eugenic by intention. Abortion is carried out disproportionately in black women. This is eugenic by outcome. Both are destructive because the unborn child, the embryo or fetus, is a human being and has human dignity. It is a fact, based on scientific consensus, that life

begins at conception; and a physician caring for a pregnant woman has 2 patients, because the fetus is the patient within the patient. Eugenic abortion ignores these facts and violates human dignity. Such abortions are often carried out at or near fetal viability, when the risks of maternal complications and death are greater than in the first trimester.

Arguments have been advanced that mifepristone-misoprostol should be less regulated, not more, because of access to abortion. But access to any intervention must never come at the expense of safety.

Finally, the Dobbs decision, as noted, returned legislative decisions about abortion to the people of the United States and their elected representatives. We have seen that it has resulted in vigorous, often difficult, debates about abortion. But debate is positive. In medicine, we do not see debate as necessarily adversarial, because our enemies are sickness and untimely death. The health and safety of the patient – or in the case of the mother and child, the 2 patients – and the fetus, the patient *within* the patient – are our concern and the focus for care. This debate and discussion, and our actions, should be informed by our values as they relate to inherent human dignity, compassion, justice, and scientific and clinical data. Stronger regulatory frameworks are necessary to protect the health of women and children and to promote human flourishing.

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