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Ingrid Skop's responses to Questions for the Record
July 5, 2024

Senator Hirono's QFR:

1. *You testified that "pro-life laws," like those in Texas, do not prevent life-saving healthcare for pregnant patients when there are life-threatening pregnancy complications. How do you reconcile that statement with Lauren Miller's experience demonstrating otherwise? If the law in Texas is clear that there is a life-saving exception, why could Ms. Miller not find a doctor who would perform an abortion for her when she needed one to save her life?*

As I explained extensively in *Abortion Policy Allows Physicians to Intervene to Protect a Mother's Life*,[1] Texas law allows an exception if a "medical emergency" is present: "[if] in the exercise of reasonable medical judgment, the pregnant female…has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced." Nowhere in this law is a requirement that the threat be imminent, and the Texas Supreme Court has twice affirmed this. "As our Court recently held, the law does not require that a woman's death be imminent or that she first suffer physical impairment.[..] The law permits a physician to intervene to address a woman's life-threatening physical condition before death or serious physical impairment are imminent."[2] It should also be noted that a 1925 Texas law prohibiting abortion includes a similar provision: "Nothing in this chapter applies to an

[1] Abortion Policy Allows Physicians to Intervene to Protect a Mother's Life, available at https://lozierinstitute.org/abortion-policy-allows-physicians-to-intervene-to-protect-a-mothers-life/.
[2] Texas Supreme Court 23-0629. Available at https://www.txcourts.gov/media/1458610/230629.pdf.

abortion procured or attempted by medical advice for the purpose of saving the life of the mother."[3] So, based on the facts presented, the failure of Lauren Miller's physician to act indicates her physician did not understand Texas law. The solution to physician confusion is to give guidance to physicians to alleviate the confusion, as the Texas Medical Board has recently done.[4]

2. *During the hearing, Lauren Miller testified about her experience trying to receive abortion care in Texas after Dobbs. She stated that several weeks into her pregnancy, she ended up in the emergency room after 36 hours of vomiting. She went on to say that at her 12-week ultrasound, she tragically discovered that 1 of the 2 twins she was carrying was unlikely to survive because half of his brain was full of fluid. Her medical team concluded that this twin would die— it was simply a matter of when. The longer she waited to get an abortion, the more her life and the life of the other twin were put at risk. Ms. Miller then experienced more health complications, again ending up in the emergency room, shaking uncontrollably, and risking organ damage to her kidneys and brain.*

    a. *If Ms. Miller were your patient, what would your professional medical advice have been to her?* I have not seen Ms. Miller's medical records, so I am not able to give an opinion on whether the symptoms she reported posed a risk to her life, kidneys or brain. As mentioned earlier, Texas law allows intervention if these symptoms represented a "life-threatening physical condition" or "pose(d) a serious risk of substantial impairment of a major bodily function". If, in her treating physician's "reasonable medical judgment" such a risk existed, intervention could have been performed at that time.

    b. *More specifically, how sick (near organ damage or death) would she have had to be before you would have recommended she receive an abortion?* As recorded in the Texas law and twice affirmed by the Texas Supreme Court, "immediacy" or "imminency" is not required, nor does a doctor need to wait until a woman is dying before he intervenes. If, in her treating physician's "reasonable medical judgment," that is, using their clinical expertise, Lauren had a pregnancy complication posing a risk to her life or substantial impairment of a major bodily function, they could have offered intervention at the time the condition was diagnosed.[5]

    c. *In all the pregnant patients you have seen over the years, have you ever seen pregnancy complications so severe that you recommended a patient get an abortion?* I have diagnosed pregnancy complications so severe that the pregnancy needed to end to protect the mother's life. Abortion is defined in Texas law as "the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause

[3] 1925 Penal Code of the State of Texas. Available at https://www.sll.texas.gov/assets/pdf/historical-statutes/1925/1925-3-penal-code-of-the-state-of-texas.pdf
[4] TMB rules. Available at https://www.tmb.state.tx.us/idl/B83AF6D7-C6E7-FD3F-BDE0-3719D43BE5FF.
[5] Texas Supreme Court 23-0629, available at https://www.txcourts.gov/media/1458610/230629.pdf.

the death of an unborn child of a woman known to be pregnant."[6] In those situations, I treated the complication and ended the pregnancy by separating the mother from her child, usually by induced labor, and occasionally, if appropriate, by cesarean section. I have never had a mother prefer a dilation and evacuation abortion procedure, which dismembers her baby, in that circumstance. Usually, these serious complications occur later in pregnancy, past the gestational age of viability, when the baby can be saved with the intervention of the neonatology team. Yet, even if he is too young or premature to survive, I have taken action to save the mother's life even at the expense of the unborn child's life. In these cases, my intent was to save his mother's life.

d. *As a doctor, how would you have weighed the prognosis of nonviable twin with the grave medical risks of healthy twin and the mother?* Lauren Miller's situation was complex and heartbreaking. The risks, benefits and alternatives of all the available treatment options must be considered for each of the three patients: Lauren, her healthy twin child, and her unhealthy twin child. Notably, Trisomy 18 is a serious life-limiting condition, but not uniformly fatal, thus he was not necessarily "non-viable". The prognosis is different for each baby. In the U.S., when babies with Trisomy 18 underwent surgery to treat heart issues, they had a median survival of 15-16 years.[7] It is not necessary that all doctors agree on the management, just that the doctor who makes the decision to intervene does so based on his "reasonable medical judgement" and can document based on professional guidelines why he made the decision that he did. Since I have not seen Lauren's medical records, any recommendation I make now would be hypothetical. But if in their reasonable medical judgement, her doctor felt that pregnancy complications posed a risk to Lauren's life, and a risk to the life of the healthy twin, balanced against the likelihood that none of the treatment options would provide much benefit to the unhealthy twin, then her doctor could have justified intervention under Texas law.

Senator John Kennedy's QFR:

1. *The Women's Health Protection Act (S. 701) would codify a right to "terminate a pregnancy after viability."*

a. *When we talk about a baby being "viable," what does that mean from a medical perspective?* The term "viability" has various definitions, and the WHPA does not specifically define what it means by "viability." Some define "viability" as currently living and having the potential to survive until a live birth. For example, a woman experiencing bleeding in early pregnancy may present for an ultrasound. The absence of a heartbeat might lead her physician to call her unborn child "non-viable" whereas the presence of a heartbeat would lead him to call the child

[6] Texas Health & Safety Code § 245.002(1). Available at: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.245.htm.
[7] Five Facts about Life-Limiting Fetal Conditions. Available at https://lozierinstitute.org/five-facts-about-life-limiting-fetal-conditions/.

"viable," even though the child could not survive delivery at that early gestational age. Alternatively, sometimes the term is used to indicate that an unborn child has reached the gestational age that he may survive with assistance at delivery. In this example, "viability" is considered to occur around 22- or 23-weeks gestational age, because many children born at these gestational ages can survive if provided medical assistance such as artificial ventilation and other interventions. Pioneering medical teams are attempting to save extremely premature children at 21 weeks gestation, and multiple babies born around 21 weeks have survived with medical intervention.[8] Finally, sometimes "viability" is used to describe a prediction that the child will survive. Specific to the WHPA, "viability" is determined by the "medical provider," that is, the abortionist. Since his intent in performing the abortion is that the child be delivered dead, he can predict that every unborn child he interacts with will be "non-viable." Thus, without additional clarification, the WHPA appears to allow abortion at any gestational age that the abortionist is willing to perform the action. It should be noted that the American College of Obstetricians and Gynecologists opposes the use of the term "viability" in abortion legislation due to its many possible interpretations.[9]

b. *When, if ever, is it medically necessary to abort a viable baby*? I have never found it necessary to abort a baby after the age of viability (22- to 23- weeks gestational age). When a severe pregnancy complication requires a pregnancy to end so the complication can be treated, the unborn child can be separated from his mother by induced labor, or if indicated, c-section. Upon delivery, he can be treated by a neonatologist, and usually his life can be saved. Since abortion is defined legally as an action performed "with the intent to cause the death of an unborn child," abortion is never necessary after the child has reached the gestational age where he can survive separation from his mother. All state pro-life laws allow an exception permitting abortion to protect a mother's life.[10] These laws are usually silent on abortion after viability, perhaps due to the assumption that a compassionate society would not unnecessarily end a life when the action needed is merely the delivery of the child. As mentioned above, abortion is unnecessary in this circumstance to protect the mother, and unnecessarily deadly for the child.

c. *Do the laws of any state allow for a baby to be aborted after viability? Please elaborate.* The companion case of *Roe v. Wade*, *Doe v. Bolton*, held that states could not restrict abortion at any gestational age if performed for the "health" of the mother, defined as any factor related to her "well-being," including physical health, mental health, emotional health, familial issues and age. This led to some abortion facilities performing extremely late abortions after the gestational age where the child could survive delivery.[11] Unfortunately, in the aftermath of the

[8] "Weeks 21 & 22," Voyage of Life. https://lozierinstitute.org/fetal-development/weeks-21-and-22/. See also "Saving Extremely Premature Babies," https://lozierinstitute.org/dive-deeper/saving-extremely-premature-babies/.
[9] ACOG Facts are Important: Understanding and Navigating Viability. Available at https://www.acog.org/advocacy/facts-are-important/understanding-and-navigating-viability.
[10] Pro-Life Laws Protect Mom and Baby: Pregnant Women's Lives are Protected in all States. Available at https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/.
[11] Operation Rescue: Late Term Abortion. Available at https://www.operationrescue.org/about-abortion/late-term-abortion/.

Dobbs decision, abortion advocates, led by the Guttmacher Institute, have begun to unapologetically advocate for the repeal of any gestational restrictions on abortion, stating, "it is critical that people have access [to abortion] throughout pregnancy to protect bodily autonomy and ensure equity."[12] Thus, there are increasing numbers of states that have no gestational limits on abortion. [13] It has been noted that the U.S. is one of only eight countries in the world that allows, at the federal level, elective abortions without any gestational limits.[14]

2. *Please answer the following questions about state law to the best of your ability.*

a. *Does any state prohibit an abortionist from performing an abortion when one is necessary to save the mother's life?* No**.** Along with an attorney, I have evaluated every state abortion limitation, documenting that they all allow an exception when an abortion is needed when a complication threatens the life of a pregnant woman. Although not all states add the additional wording of "or poses a serious risk of substantial impairment of a major bodily function," both are describing the same serious complications. Doctors do not have the ability to foresee whether a serious complication will cause the death of a woman or cause the loss of a major bodily function, as the same conditions can lead to either outcome, but doctors do know what these conditions are. All laws grant an exception allowing physicians to intervene at the time of diagnosis of these serious conditions, without waiting for a woman to be dying.[15]

b. *Does Texas law allow a woman who receives an abortion to be criminally prosecuted?* No. No state's abortion law prosecutes a woman for seeking or obtaining an abortion, whom most consider to be a second victim, due to the frequent harms that occur to her. However, every pro-life state law will criminally prosecute the abortionist who violates the law to perform an elective abortion.[16]

c. *If a woman is diagnosed with a life-threatening condition, does Texas law require that the woman's death or serious physical impairment be imminent before an abortion can be performed?* No. As noted above, Texas law records, and has been twice affirmed by the Texas Supreme Court, that "immediacy" or "imminency" is not required, nor does a doctor need to wait until a woman is dying before he intervenes.[17]

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[12] See: https://www.guttmacher.org/2023/01/eight-ways-state-policymakers-can-protect-and-expand-abortion-rights-and-access-2023

[13] Pro-Abortion States Accelerate Their Race to the Bottom. Available at https://lozierinstitute.org/pro-abortion-states-accelerate-their-race-to-the-bottom/.

[14] Gestational Limits on Abortion in the United States Compared to International Norms. Available at https://lozierinstitute.org/gestational-limits-on-abortion-in-the-united-states-compared-to-international-norms/.

[15] Pro-Life Laws Protect Mom and Baby: Pregnant Women's Lives are Protected in all States. Available at https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/.

[16] Pro-Life Laws Exempt Women from Prosecution: An Analysis of Abortion Statutes in 27 States. Available at https://lozierinstitute.org/pro-life-laws-exempt-women-from-prosecution-an-analysis-of-abortion-statutes-in-27-states/

[17] Abortion Policy Allows Physicians to Intervene to Protect a Mother's Life. Available at https://lozierinstitute.org/abortion-policy-allows-physicians-to-intervene-to-protect-a-mothers-life/; Texas Supreme Court 23-0629, available at https://www.txcourts.gov/media/1458610/230629.pdf.

3. *What procedures do abortionists commonly use when performing a surgical abortion in the second or third trimesters?*

The most common method of performing an abortion after the first trimester is dilation and evacuation (non-intact D&E), accounting for about 95% of later abortions. The layman's term for this procedure is "dismemberment" abortion because the calcified bones of the fetus at this later stage of development necessitate his removal in pieces, as he is too large to be removed by suction alone. An alternative method of dilation and evacuation (intact D&E), or "partial birth" abortion, is illegal by federal law. Presumably this means it is not performed in the U.S., although the lax supervision of abortion centers means it cannot be known for certain that it is not being performed. Recent photos of some abortion victims from D.C. late-term abortionist Dr. Cesare Santangelo suggest that it may, indeed, be occurring in our nation's capital.[18] Extremely late abortions are likely to be performed by labor induction**,** as it becomes hard to dismember a fetus who is near-term. Late abortion procedures are very dangerous for a woman, as well as likely to cause severe pain to the unborn human undergoing dismemberment. Additionally, it has been documented that 69% of late-term abortionists do not routinely perform feticide to kill the unborn child before performing the abortion[19], so it is also likely that infants are born alive following later induced abortion, and then die by active or passive infanticide.[20]

4. *During the hearing, Senator Welch suggested that those who advocate for pro-life policies "are committed to providing protection from conception to birth, but after that you're on your own." Based on your experience, is this an accurate statement?*

No. For over 50 years, the pro-life movement has sought to provide alternatives to abortion for women in crisis pregnancies. Surveys demonstrate that the majority of women with a history of abortion would have preferred to give birth, if they had only had more support. In fact, nearly ¼ described their abortion as "unwanted or coerced" and 2/3 described it as "inconsistent with their values."[21] Today, there are over 2,750 pregnancy centers providing emotional and material support to women in problematic pregnancies and even beyond birth. In 2022, these centers provided over $367 million in free goods and services to women and their children.[22] Policymakers at the state and federal levels have joined this effort by adopting a wide range of policies to improve financial and material resources for women and families.[23] The state of Texas, for example, awarded $62,001,580.74 in 2023 to contractors under its

[18] The Daily Signal. 'Active Investigation': DC Police Still Probing Deaths of 5 Preemie-Size Aborted Babies. Available at https://www.dailysignal.com/2022/09/27/dc-police-still-investigating-five-premie-sized-aborted-babies/.
[19] White KO, Jones HE, Shorter J, et al. Second-trimester surgical abortion practices in the United States. Contraception. 2018;98(2):95-99.
[20] Immediate Physical Complications of Induced Abortion. Available at https://lozierinstitute.org/immediate-physical-complications-of-induced-abortion/.
[21] Hidden Epidemic: Nearly 70% of Abortions Are Coerced, Unwanted or Inconsistent With Women's Preferences. Available at https://lozierinstitute.org/hidden-epidemic-nearly-70-of-abortions-are-coerced-unwanted-or-inconsistent-with-womens-preferences/.
[22]Pregnancy Center 2024 Update. Available at https://lozierinstitute.org/wp-content/uploads/2024/05/Pregnancy-Center-2024-Update.pdf.
[23] Expanding State and Federal Support for Decisions for Life. Available at https://lozierinstitute.org/expanding-state-and-federal-support-for-decisions-for-life-2/.

"Thriving Texas Families" programs, offering services such as education, care coordination, material services, housing, and maternity homes.[24] Texas parents or guardians are eligible for this program while the woman is pregnant up to three years after the baby is born.[25]

5. *During the hearing, you were not given the opportunity to respond to questioning of your credibility in the case of Planned Parenthood of Southwest and Central Florida v. State of Florida. Please describe your role and expertise related to that case.*

I testified as a medical expert for the state of Florida in this case. In Judge Cooper's *Order Granting Plaintiff's Motion for an Emergency Temporary Injunction and/or a Temporary Injunction, Entering a Temporary Injunction, and Setting Bond*, dated July 5, 2022, Judge Cooper noted, correctly, that my testimony regarding Florida's abortion limitations and the testimony of the abortionist plaintiff, Dr. Shelly Hsiao-Ying Tien, differed substantially. He found her testimony to be more persuasive than mine, in part because it affirmed the common narrative promoted by the abortion industry regarding the "safety" of abortion. He called my testimony "not credible," in part because it differed from the public statements of many pro-choice medical organizations, and because I do not perform elective abortions. Although I do not perform these procedures on living fetuses to cause their deaths, in accordance with my Hippocratic Oath, I have performed all procedures that can be used to provide an abortion, when I have provided care for women who have tragically already lost their child before birth. In addition, I am well acquainted with the peer-reviewed literature on abortion and the limitations of data collection within the U.S. I am well qualified to testify on the topic, despite Judge Cooper's statement. In fact, the Supreme Court of Florida, in their April 1, 2024, opinion overruled Judge Cooper's ruling, validating the arguments that I and others made in the case.[26]

Although it is tempting to believe that widely known and respected medical organizations are non-biased on abortion and willing to follow abortion science regardless of where it leads, I will demonstrate that these organizations have a bias toward promoting abortion and are willing to disregard the poor quality of abortion data in the U.S. in order to promote their ideological agenda.

1. *American College of Obstetricians and Gynecologists (ACOG)*: The leadership of ACOG avidly supports abortion on demand, even though they have never surveyed their members about whether the membership supports ACOG's abortion advocacy. In fact, surveys demonstrate only 7-14% of practicing ob/gyns would perform an abortion if requested by their patient, negating the statement that "abortion is essential reproductive health care."[27] If essential, this care would be provided by every ob/gyn,

[24] Alternatives to Abortion Report for Fiscal Year 2023. Available at https://www.hhs.texas.gov/sites/default/files/documents/alternatives-abortion-fy2023-rider68.pdf.
[25] Thriving Texas Families. Texas Health and Human Services. Available at https://www.hhs.texas.gov/services/health/women-children/thriving-texas-families.
[26] Florida Supreme Court. Available at https://supremecourt.flcourts.gov/content/download/2285282/opinion/Opinion_SC2023-1392.pdf.
[27] Desai S, Jones R, Castle K. Estimating abortion provision and abortion referrals among United States obstetricians and gynecologists in private practice. Contraception 2018;97:297-302; Stuhlberg DB, Dude AM, Dahlquist I, Curlin FA. Abortion provision among practicing obstetrician-gynecologists. Obstet Gynecol 2011;118(3):609-614.

not a small minority. An obstetrician's commitment to the life and health of both of his patients (two-patient paradigm) has been replaced by a commitment to the woman's desires only (one-patient paradigm) in the eyes of ACOG. This is demonstrated by ACOG's 2016 *Committee Opinion: Ethical Decision-Making*, "The principle of beneficence, which literally means doing or producing good, expresses the obligation to promote the well-being of others. It requires a physician to act in a way that is likely to benefit the patient. Nonmaleficence is the obligation not to harm or cause injury." The fact that ACOG promotes beneficence and nonmaleficence for their patients, ignoring the fact that abortion does no good for, and in fact, harms the fetus, demonstrates that they no longer believe the fetus is their patient in need of protection.[28] ACOG's 2022 *Abortion Policy* states they are "committed to protecting and increasing access to abortion" and they "strongly [oppose] any effort that impedes access to abortion care."[29] ACOG's 2020 *Committee Opinion: Increasing Access to Abortion* states that "[s]afe, legal abortion is a necessary component of comprehensive health care" and they call "for advocacy to oppose and overturn restrictions [on abortion][and] to improve access." They go on to refer to abortion as "mainstream medical care."[30] ACOG does not support the conscience rights of its members to decline to perform a life-ending procedure to which they are morally opposed. ACOG's 2016 *Committee Opinion: The Limits of Conscientious Refusal* states that "conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients… Physicians … have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request."[31] Finally, the interim chief executive of ACOG recently stated in the Washington Post, "Abortion…must be available without restrictions, without limitations and without barriers."[32] Clearly, ACOG is an ideologically pro-abortion organization that does not represent the views of all of its members, and should not be depended upon as a reliable source of abortion information.

2. Other medical organizations have made similar statements demonstrating their commitment to abortion. *American Psychological Association (APA):* "Be it resolved, that termination of pregnancy be considered a civil right of the pregnant woman."[33]

3. *American Medical Association (AMA):* "The *Dobbs* decision represents 'an egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen

[28] ACOG Committee Opinion 390: Ethical Decision-Making. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology.
[29] ACOG Abortion Policy. Available at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy.
[30] ACOG Committee Opinion 815: Increasing Access to Abortion. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion.
[31] ACOG Committee Opinion 385: The Limits of Conscientious Refusal. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine.
[32] In the abortion debate, honesty matters. Available at https://www.washingtonpost.com/opinions/2023/08/30/abortion-debate-honesty-matters/.
[33] APA Abortion Resolutions. Available at https://www.apa.org/about/policy/abortion.

violation of patients' rights to evidence-based reproductive health services'."[34]

Expressing a different interpretation of the abortion literature from ACOG and other pro-abortion medical organizations does not automatically make my interpretation wrong. In fact, since ACOG does not acknowledge the abysmal quality of U.S. abortion data, this casts doubt on ACOG's credibility, not mine.

1. While other public health metrics are tracked and mandated to be reported to the Centers for Disease Control and Prevention (CDC), abortion reporting in the United States –incidence, complications, and deaths –is entirely voluntary at the national level. Six states (CA, MD, NJ, MI, NH and ND) do not report any data from their health departments to the CDC.[35] The states have variable reporting requirements, but all states have an inability to track data related to abortion drugs, because they may now be ordered online and distributed by mail. Most U.S. abortions are paid for privately and women are often hesitant to report a history of abortion, causing many preceding abortions to remain unknown when a complication occurs. The paucity of U.S. data may be contrasted with other countries whose data is so complete, voluminous, and accurate that studies drawing from this data are considered the gold standard. These countries often have single payer healthcare systems that cover elective abortions, so that an abortion can be accurately linked to subsequent complications and deaths.[36] In my testimony, I relied upon these higher quality records-linkage studies, whereas Dr. Tien and other pro-abortion plaintiffs relied upon poor quality U.S. abortion industry studies. Biased abortion industry researchers report the number of abortions they have sold but have been criticized for limiting their consideration to only severe complications (such as intra-abdominal surgery, transfusion, hospitalization or death); often considering hemorrhage not requiring transfusion, infection not requiring intravenous antibiotics, and surgical aspiration of retained pregnancy tissue unworthy of noting.[37] Additionally, they ignore the large numbers of women lost to follow-up (as many as half),[38] for whom abortion outcomes are unknown. They also fail to perform research to detect mental health complications or future pregnancy complications.

2. Judge Cooper criticized the age of some studies I used, but the reality is that the CDC does not often perform studies focused on maternal mortality related to abortion. I referenced the only available CDC studies out of necessity, due to the paucity of studies and lack of curiosity by researchers. Additionally, the abortion-related maternal mortality data collected by the CDC is widely acknowledged to be dramatically

[34] AMA Advocacy in action: Protecting reproductive health. Available at https://www.ama-assn.org/delivering-care/public-health/advocacy-action-protecting-reproductive-health.
[35] The State of Abortion Reporting in 2024 America: Still Striving Toward a Better National Standard. Available at https://lozierinstitute.org/the-state-of-abortion-reporting-in-2024-america-still-striving-toward-a-better-national-standard/
[36] *Id.*
[37] Cleland K, Creinin M, Nucatola D, et al. Significant Adverse Events and Outcomes After Medical Abortion. Obstet Gynecol. 2013;121:166-171.
[38] Simons HR, Diemert S, Passman R, Dean G. An Assessment of Clinical Outcomes of Medication Abortion without Pretreatment Ultrasonography in Planned Parenthood, United States, 2020-2021. Contraception. 2024;136:110469.

incomplete, as they primarily rely upon death certificate documentation to detect a maternal death. High quality studies from Finland document that 94% of abortion-related deaths and 73% of all maternal deaths are *not documented on a death certificate* and can only be detected by linkage of all pregnancy outcomes with all deaths in reproductive-aged women.[39] In the U.S., we do not keep data regarding all pregnancy outcomes, only those that progress past 20 weeks gestation, when they are assigned a birth certificate, so we do not have the ability to perform records-linkage to accurately identify abortion-related deaths for investigation.[40] I have provided an extensive discussion regarding the data deficiencies related to abortion-related mortality in *Fact Check: Abortion is 14 Times Safer than Childbirth*. When high quality records-linkage data rather than the poor-quality CDC data is used, far more maternal deaths are documented following abortion than following childbirth.[41]

[39] Gissler M, Berg C, Bouvier-Colle MH, Buekens P. Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000. Am J Obstet Gynecol. 2004;190(2):422-427; Reardon DC, Thorp JM. Pregnancy associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses: A systematic review with a narrative synthesis and meta-analysis. SAGE Open Med. 2017;5:2050312117740490.

[40] Horon IL. Underreporting of maternal deaths on death certificates and the magnitude of the problem of maternal mortality. Am J Public Health 2005;95:478-482.

[41] Fact Check: Abortion is 14 Times Safer than Childbirth. Available at https://lozierinstitute.org/fact-check-abortion-is-14-times-safer-than-childbirth/.