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June 2025

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Judge overturns Michigan's 24-hour waiting period, informed consent abortion laws

Editor's Note: This is the result of the Prop 3 vote.
Did you know this was what we were going to get? Elections have consequences!

By Beth LeBlanc

A Michigan Court of Claims judge [on May 13] ruled that state laws that require a 24-hour waiting period and informed consent before a pregnancy can be terminated violate the state's constitutional right to abortion.

Court of Claims Judge Sima Patel also found unconstitutional the state's prohibition on advanced practice clinicians from performing abortions. But she upheld a fourth section of law that requires medical professionals to screen pregnant women seeking an abortion for signs of coercion, finding the rule did not violate the Reproductive Freedom for All constitutional amendment that voters approved in 2022.

"Most of the statutory requirements burden or infringe upon individuals' reproductive freedom, are not based on a compelling state interest to protect the health of individuals seeking abortion care, are not consistent with the accepted standard of care and evidence-based medicine, and infringe on autonomous decision-making," wrote Patel, an appointee of Democratic Gov. Gretchen Whitmer.

Whitmer said [May 13] the ruling ensures Michigan women can make decisions about their own bodies "without political interference."

"Today's ruling means that patients and doctors are no longer subject to even more of these outdated restrictions on abortion, including the forced waiting period and a ban on advanced practice clinicians from performing abortions," Whitmer said in a statement.

Right to Life of Michigan in a statement called the decision "bad news for women."

"At the same time, abortion complications have skyrocketed, removing standardized informed consent about abortion procedures, possible complications, and alternatives to abortion is a disservice to women," said Genevieve Marnon, legislative director for Right to Life of Michigan. "The injunction demonstrates how radical and abortion obsessed our state has become."

[The] decision, Michigan Catholic Conference CEO Paul Long said, allows the broader public to see the intent of the 2022 ballot proposal was not to maintain protections under *Roe v. Wade*, "but rather to grant constitutional protections to an industry that places itself above the health and safety of women and the lives of pre-born children."

The U.S. Supreme Court in June 2022 struck down *Roe v. Wade*'s nationwide right to abortion as unconstitutional, opening the way for the states to decide whether to grant abortion rights or restrict them. Michigan's laws that Patel reviewed were signed into law under *Roe v. Wade,* which the court decided in 1973.

Fred Wszolek, a Republican consultant who worked to oppose the 2022 ballot initiative, criticized the decision on social media.

"When we opposed the 'reproductive rights' amendment, we argued that the 'autonomous decision making' language would be the source of a lot of judicial mischief," Wszolek said. "The proponents called us liars. They owe us—and the voters they deliberately deceived—an apology."

The permanent injunction on the state abortion laws, issued [May 13], came about 10 months after Patel granted a preliminary injunction to plaintiffs, which halted the 24-hour waiting period and informed

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Michigan Nurses For Life

Our Purpose:

...To raise the consciousness of the nursing profession to protect all human life from conception until natural death

...To form an educated core of nurses who can speak for their profession by acting as a community resource for life issues

...To promote public education and awareness about life issues on both ends of the spectrum, from abortion to euthanasia

...To uphold and defend human life in all stages and conditions of development

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FROM THE PRESIDENT

Diane Trombley, RN, BSN

Dear Colleagues,

In our newsletter and on our website, readers will find an interesting article indicating that there will no longer be a waiting period to obtain an abortion, no longer any information on fetal development, nurses, medical assistants and APCs and "other" health care providers may now do abortions. The judge cites "no compelling reason" to retain any restrictions on abortion access.

Gee, I can think of a few—how about a young girl being brought for an abortion by her trafficker? No need to wait, get this done so she can go back to work.

How about the woman who thinks she needs an abortion but with a little counseling might find a way to keep the baby?

How about a second opinion on the baby's health?

How about dangers to the mother's health that might never be explored if there is an open procedure room right now?

I could list more, but you all get the idea.

I do hope that no one is surprised by these changes in Michigan law. These things are a direct result of the passage of Proposal 3. Many organizations tried to fully explain Proposal 3's impact but the media, a well-funded campaign and a local government that was all in for more abortions muted the efforts to warn voters. We won't give up. We will continue to advocate for women and their babies but remember this—votes have consequences. Know what you are voting for before you pull that lever!!

On another, but related note, this issue is again full of articles on euthanasia (medical aid in dying, assisted suicide, end of life care—it goes by many names). Those who promote killing as heath care never give up. If they are defeated one year, they will come back the next. Look for it to be back here in Michigan in 2026.

Sometimes it seems like no one hears our voice. That does not mean we should remain silent. Silence is seen as acceptance. Some things are simply not acceptable. Love Life, Diane

UPCOMING EVENTS

NATIONAL DAY OF REMEMBRANCE FOR ABORTED CHILDREN
Saturday, September13, 2025 – 1:00 p.m.
White Chapel Cemetery, Troy, MI
Contact RTL – LIFESPAN at 734-524-0162

40 DAYS FOR LIFE, FALL COMPAIGN
September 24 - November 2
Find a location, visit: 40 daysforlife.com

MICHIGAN MARCH FOR LIFE – BUS TRIP
Lansing, MI - $35 per person
Thursday, November 6, 2025
Contact RTL – LIFESPAN at 248-816-1546

New Report Shows 1.1 Million Babies Killed in Abortions as Abortion Pills Flood America

By Laura Pham

The most accurate, current and complete compilation of abortion data shows over 1.1 million abortions took place via licensed providers from July 2023–June 2024, according to new analysis compiled by the Charlotte Lozier Institute (CLI). This establishes a baseline number of recorded abortions nationwide.

This analysis is the first to collect abortion totals from different types of abortionists and examine which estimates are the most complete and definitive. The analysis used the regularly cited data from #WeCount and Guttmacher Institute because the U.S. government doesn't have a complete and thorough reporting system for a comprehensive evaluation. Neither organization publishes the raw data from abortion centers.

While this is the best estimation of total abortions taking place in that time-frame, researchers cannot definitively calculate how many abortions occurred because there's no federal abortion reporting requirement and there's no verifiable way to track certain abortions, such as abortion drugs mailed into the U.S. by foreign abortion organizations.

Mia Steupert, research associate at CLI and author of the study, said:

"Accurate and up-to-date abortion reporting is crucial not only for public health metrics, but to give us clearer insight into the landscape of abortion in the U.S. post-Dobbs. Abortion reporting provides key insight into how laws affect abortion numbers. However, no one except pro-abortion organizations like Society of Family Planning and Guttmacher Institute has access to raw abortion totals reported by abortion centers and organizations themselves. Access to that same information would be invaluable in our analysis of policies that end unborn human life."

Karen Czarnecki, executive director of CLI, said:

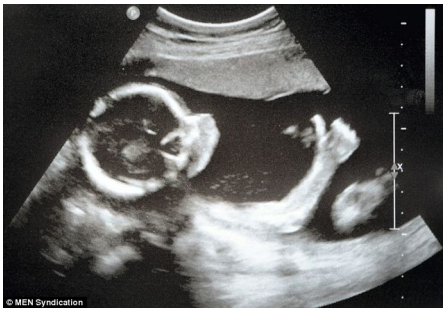
"Our country's lack of federal abortion reporting requirements has always raised the question: 'How many abortions are occurring in the U.S.?' CLI spent the last few months going through many data sources, combining and comparing them, to come up with the most up-to-date and inclusive estimate. No one has done a systematic review like this before.

—LifeNews.com, May 23, 2025

Hospital Backs Down, Won't Force Ultrasound Techs to Do Abortions

By Olivia Summers

The American Center for Law and Justice (ACLJ) is pleased to report a significant victory for religious liberty and pro-life medical professionals. As you'll recall, we recently sent a demand letter to a hospital on behalf of five ultrasound technicians who were concerned that they would soon be compelled to participate in abortion procedures despite their deeply held religious beliefs. Today, we can share that counsel for the hospital—after receiving our demand letter—has informed us that each of our clients will be granted the religious accommodation they requested.



This is a tremendous win, not just for these brave medical professionals, but for the broader principle that no one should be forced to violate their sincerely held religious beliefs in the workplace—especially when their objection is to assisting in the killing of innocent preborn babies.

The First Amendment and federal laws, such as Title VII, protect individuals from being coerced into participating in procedures that conflict with their faith. These protections ensure that religious freedom remains a cornerstone of American values.

The courage of these five ultrasound technicians should not go unnoticed. By standing firm in their beliefs, they have helped reaffirm the rights of medical professionals across the country. Employers must respect these rights and make accommodations where required by law, and we are pleased that the hospital has granted these accommodations.

The ACLJ will continue to fight for life, religious liberty, and the protection of medical professionals from being forced into ethical and moral dilemmas. If you or someone you know is facing similar pressures in the workplace, we encourage you to reach out. We stand ready to defend your rights and have been successful on multiple occasions in winning religious accommodations for medical professionals.

This victory is a reminder that when we stand strong in the face of opposition, the law is on our side. We celebrate this outcome and remain vigilant in protecting the rights of pro-life medical professionals everywhere.

Olivia Summers is Associate Counsel with the ACLJ, focusing on pro-life advocacy and protecting the freedoms of speech and religion.

—LifeNews.com, February 26, 2025

Judge overturns Michigan's 24-hour waiting period, informed consent abortion laws

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consent while the case proceeded through trial. The issue went to trial in February.

The lawsuit, filed in February 2024 by abortion provider Northland Family Planning and the abortion rights group Medical Students for Choice, came months after the Democratic-led Legislature was unable to muster support in the House for a repeal of the 24-hour waiting period or the informed consent laws.

Democratic Attorney General Dana Nessel, who usually would be tasked with supporting state law, instead voiced her support for the suit by Northland Family Planning, which operates three abortion clinics in Metro Detroit. Nessel then built a legal firewall within the department, and Assistant Attorney General Eric Restuccia argued in defense of state law on behalf of the people of Michigan.

Nessel celebrated Patel's decision, arguing the requirements that were overturned "did nothing but burden and obstruct access to abortion."

"This ruling affirms what Michiganders made clear when they voted to enshrine a fundamental right to reproductive freedom in our state constitution: that deeply personal medical decisions belong to individuals and their providers," the attorney general said in a statement.

It is unclear whether Restuccia will appeal the decision to the Michigan Court of Appeals. Nessel's office did not immediately say whether Restuccia would pursue an appeal.

Why three key laws got overturned

The testimony and evidence presented at trial, Patel wrote, indicate Michigan's 24-hour waiting period "burdens and infringes upon patients' rights to reproductive freedom."

"The mandatory delay exacerbates the burdens that patients experience seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a patient will have to disclose their decision to others, and potentially forcing the patient to forgo a medication abortion for a more invasive procedure," Patel wrote.

The judge also found unconstitutional the state's mandatory uniform consent law, which requires a medical professional to provide women seeking an abortion a fetus' gestational age, contact information in case of complications and pregnancy prevention information. The rule also requires patients to be provided with a depiction or illustration of their fetus, a standardized summary of the abortion procedure versus live birth, and a physical copy of a prenatal and parenting information pamphlet.

The informed consent rules, Patel said, amount to the state "metaphorically putting its finger on the scale" to guide a woman away from abortion.

"The informed-consent provisions, read as a whole, are designed to force a patient to consider the alternative of not having an abortion," Patel wrote. "The manner in which the information is presented is not neutral; it is designed to eschew abortion in favor of completing a pregnancy and further stigmatize a patient seeking abortion care."

The judge also found that a state law prohibiting advanced practice clinicians put "arbitrary limits" on abortion that confines the procedure to physicians only.

"The artificial limitation on the available pool of abortion providers imposes logistical barriers to abortion access, increasing patient wait time and travel distances," Patel wrote. "This exacerbates existing provider shortages, leading to large swathes of Michigan without access to nearby abortion care."

Lastly, Patel upheld a section of state law requiring providers to screen for coercion, noting witnesses who testified at trial agreed it is a "necessary step in abortion care" that protects patient rights to reproductive care.

"Contrary to the position of some witnesses, nothing in the statutes requires providers to ask specific or direct questions during a coercion screening," Patel wrote.

"The statutes permit providers to tailor their questions and interact with patients in an organic way."

—The Detroit News, May 13, 2025

Study: Rate of Serious or Life-Threatening Complications After Abortion Pill Is 22 Times Higher Than FDA Claims

By Jordan Boyd

Abortion advocates, their allies in the corporate media, and even the U.S. Food and Drug Administration insist the pill responsible for more than half of the nation's abortions is "safe and effective." A new, wide-ranging analysis of insurance claims regarding the abortion drug regimen, however, found that the rate of life-threatening complications due to mifepristone is at least 22 times higher than what the FDA and Danco Laboratories, manufacturer of mifepristone pill Mifeprex, suggest.

In the "largest known study of the abortion pill," Ethics and Public Policy Center President Ryan Anderson and Director of Data Analysis Jamie Bryan Hall used purchased Medicaid, TRICARE, Medicare, and private medical insurance claim data to determine that 865,727 mifepristone abortion prescriptions for 692,873 women were handed out between 2017 and 2023.

Approximately 10.9 percent of those claims, or 94,605 chemical abortions, involved potentially life-threatening "serious adverse events" such as emergency room visits, hemorrhage, sepsis, infection, and/or follow-up surgeries for the women who had downed the abortion drug within the last 45 days.

That rate, which researchers adjusted to reflect "that some women suffer from adverse events in multiple categories," is 22 times the FDA's <0.5 percent estimation printed on the Mifeprex label. The researchers also suggest that the 45-day timeframe they used is "conservative, as some adverse events may present later (and studies relied on by the FDA used a timeframe as long as 72 days)."

"This study is the statistical equivalent of a category 5 hurricane hitting the prevailing narrative of the abortion industry," Anderson said in a statement to *The Federalist*. "It reveals, based on real-world data, the shocking number of women who suffer serious medical consequences because of the abortion pill.

The FDA, the study notes, derived its mifepristone data from 10 clinical trials. In 2000, the agency used those trials to justify fast-tracking abortion pill approval despite ongoing concerns about dangerous and fatal complications.

The researchers not only warned that some of those trials are outdated and were conducted outside of the U.S., but they also emphasized the trials only included a fraction—approximately 30,966 hand-selected, "prescreened," "generally healthy women"—of the mifepristone patients reflected in the insurance data.

"The women in our dataset receive (or fail to receive) pre- and post-abortion healthcare of the real-world quality that prevails in the U.S. today, not the carefully controlled regimen of care that ordinarily prevails in a clinical trial," the study continues.

For more than two decades, pro-life doctors repeatedly asked the FDA to repeal its approval of the chemical abortion drug due to the life-threatening harm it causes women and babies, as *The Federalist* previously reported. The FDA repeatedly stonewalled the petitioners despite its legal obligation to address their concerns.

By the time the Obama administration was making its exit in 2016, the agency had worked overtime to expand the abortion pill's use by changing its dosing, reducing the required number of doctor visits to obtain the drug, allowing more people than licensed doctors to prescribe the pill, and eliminating reporting standards for non-fatal complications from the pills.

When President Joe Biden took office in 2021, the FDA radically relaxed its already debated regulation to permanently allow abortion pills via mail. To further accommodate the Biden White House's post-*Roe* activism, the FDA also permitted pharmacies like Walgreens and CVS to dispense mifepristone.

The study notes that as of 2023, a woman can obtain a mifepristone-induced abortion with "as little as one telehealth visit with any approved healthcare provider (not necessarily a physician)" and "self-administer drugs obtained from a mail-order pharmacy." Even then, the study warns that a pill prescriber is not mandated to "report any adverse events unless he or she knows that a patient has died."

"The FDA should reinstate the original patient safety protocols that were required when mifepristone was first approved. Doing so will likely reduce the harms to women and permit better monitoring to determine whether this drug should remain on the market," the study concludes.

Changes like reinstating multiple in-person office visits, physician-only prescription, ultrasounds to confirm the gestational stage and rule out ectopic pregnancy, and mandated reporting of complications, the study suggests, could spare suffering women severe and even fatal fallout from the pill.

"The FDA should further investigate the harm this drug causes to women and, based on objective safety criteria, reconsider its approval altogether. Women deserve better than the abortion pill," the researchers conclude.

Last year the Supreme Court declined to weigh in on the merits of the abortion pill's approval, declaring that the coalition of medical professionals who challenged the Biden administration's mail-order expansion of the drug did not have legal standing. The opinion penned by Justice Brett Kavanaugh, however, left the door open for the high bench to consider a stronger challenge if one should emerge.

Jordan Boyd is a staff writer at The Federalist and producer of The Federalist Radio Hour.

—The Federalist, April 28, 2025

How death doulas are changing the conversation about end-of-life care in Michigan

By Hannah Mackay

Andrea Fagan's mother Mitzie Derks, a "good, stoic, Michigander" from Muskegon, would never have considered hiring someone to help with her end-of-life care after getting diagnosed with dementia.

But Fagan, after moving her mother from Michigan to a memory care facility in New Orleans to be closer to her own home in Louisiana, knew she needed the support herself.

"It was really pretty bad, not the facility, but the whole situation, Fagan said. "I would go to see her, and I'd be all happy, my happy, perky self…and when I would leave, three minutes later, my chin would be on my chest, and I was a miserable person."

Doulas have long been used to bring life into the world, but a growing number in Michigan and nationally are helping people and their families as they prepare to leave it. They're called "death doulas," and they work with people and families facing end-of-life care.

Fagan wanted to bring her best self to her mother during the end of her life. She had heard of doulas before and even used one during the births of both of her children. After hearing about death doulas, Fagan began to do research online. She couldn't find any in Louisiana but was pleased to find Christina Wall, a death doula based in Ann Arbor.

"It made me so happy because I'm from Michigan," Fagan said. "We hit it off. She was absolutely invaluable in every way."

The distance between Ann Arbor and New Orleans was not a hindrance. Because Fagan's mother was in a facility, she didn't need any physical help from Wall. It was emotional support that Fagan needed, and that was all done remotely through phone and video meetings.

Wall has been a practicing death doula for about five years. Prior to that, she was an aviation professor at Eastern Michigan University until per parents fell ill and she had to leave to help take care of them. Wall's mother was diagnosed with Alzheimer's, she said.

"I realized I was very good at it organizationally, but also that I had this comfort around death that I did not anticipate," Wall said. "I shifted gears and have been doing this ever since."

What death doulas do

Death doulas, similar to birth doulas, are advocates for their clients. They are often, but not always, hired by people near the end of life—or by their family members—to help with everything from paperwork and hospice to making difficult decisions regarding seeking or stopping different forms of treatment, power of attorney and do-not-resuscitate orders.

Wall even remembered helping a client with stage four cancer walk their dog and going to get them bone broth when they couldn't eat anything else.

"End of life has its own track, and so my role is kind of just showing up to offer the education and help I can, and validating their experience of how challenging it can be, and just kind of holding space for them to have whatever journey they're supposed to have and not being alone in it," Wall said.

Practicing death doulas, several of whom work in Michigan, hope to make the narrative around death

more empowering and meaningful, rather than one of fear and avoidance.

"Really, our mission is to create these places where people could be in community, talk about death and normalize it so it's not something to be feared," said Elizabeth Padilla, executive director of the Conscious Dying Collective, a Golden, Colorado-based organization that offers training on end-of-life care and has trained more than 1,000 end-of-life doulas and coaches. "We work with legacy, too, and how do you want to be remembered? And it's so much fun to help someone figure out that they have a legacy."

The field is gaining popularity, and several national organizations like the Conscious Dying Collective train death doulas through online courses.

"Being an educator in this field, having a company who teaches the end-of-life doula program, I have so many more calls than we used to about needing a doula," Padilla said.

But Wall isn't sure what direction the field will take. None of her services are currently covered by health insurance, which helps her provide a wide range of assistance, but may limit who can afford it. Death doulas typically charge between $40 and $100 an hour, depending on experience and the needs of the client, Wall said.

"I would say many, if not a majority, of end-of-life doulas do operate on some sort of flex-pay planning schedule and want to serve clients that really need it if they can make it work," Wall added.

Insurance coverage also raises the question of licensing. Death doulas are not a regulated or licensed profession, but there are organizations like the National End of Life Doula Alliance that set industry standards and scope of practice, Wall said. The alliance has 78 death doulas listed in its directory in Michigan.

"How is that licensed, when all states have different rules, laws, legislation?" Padilla said. "We just have to figure that out, and maybe that will help with…getting things covered by insurance."

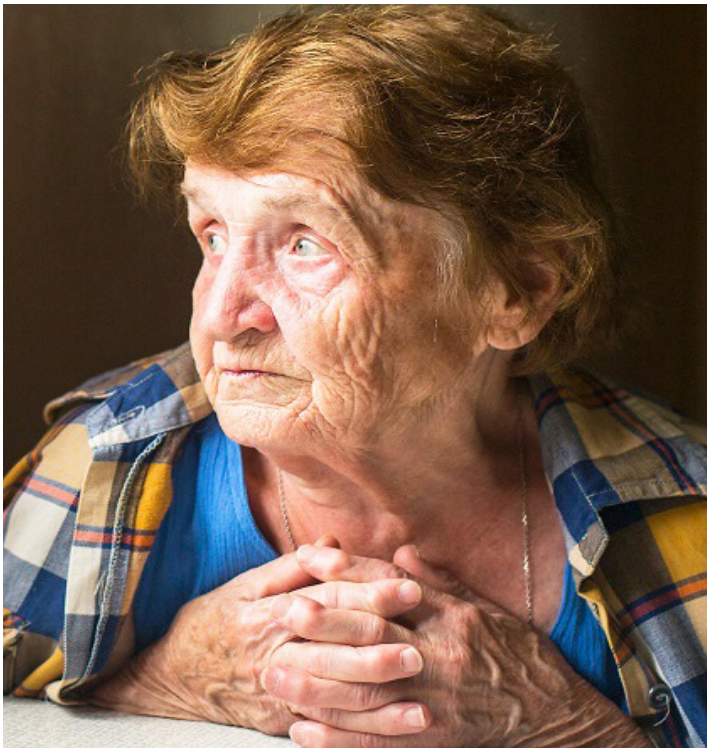
Specialized doula care

Death doulas can specialize in the type of clients they want to work with, from memory care to oncology, and children as well as sudden deaths, Padilla said.

Wall specializes in caregivers and people with dementia, and Fagan found her personal experience with memory care particularly useful. Wall helped her realize she didn't need to be worried about handling her mom's physical care herself.

"With dementia…you're just alone, and here you have this parent who's supposed to be taking care of you," Fagan said. "One thing that she helped me realize was that I wanted to be able to really be present with my mom."

Mary Craft, another Michigan-based death doula, said she likes supporting children and their families but has also helped older people with cancer. Craft previously worked in child life at the Detroit Medical Center's



Children's Hospital of Michigan. After the loss of her first husband from a sudden heart attack, as well as helping her three teenagers through the difficult time, she said she realized most people don't know anything about grief.

"I knew very little about grief and how to really handle it, and just became very interested," Craft said. "As I worked in the hospital and I was helping and supporting families, I'd go to conferences and get [to] take lots of education on how to help people that are grieving, how to support these families, and it finally led me to getting my master's degree in hospice and palliative studies."

While most people may want to pass away peacefully in their sleep, that is rare, Craft explained. Whether it's a slow physical decline or loss of mental acuity, most will need help at some point, she said. Craft's job is to help them plan for scenarios they may not think of or don't want to think of. And she suggested thinking about a doula's care earlier than some would think.

"Anytime you get a diagnosis, whether it's heart disease, stroke, dementia, in the beginning stages, that's when you want to hire an end-of-life doula so they can help you plan your life," Craft said. "If we can make that plan before we get to the crisis stage, it's…much better thought out."

Death doulas can help guide people to local resources, like estate planning or wheelchair ramp installation, she said. They can also help support families after the death of a loved one, sometimes for several years, she said.

"It's hard to talk about this, think about this," Craft said, adding that doulas help clients "get through each hurdle as it comes."

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How clients are treated

While every client is different, Wall typically begins with a free needs assessment to determine how she can help. Sometimes her job involves filling out paperwork, while other times it is advocacy.

"Maybe they are right on the cusp of deciding to continue treatment or go into hospice. So…I'll go to oncology appointments with them and help them ask the hard questions," Wall said. "If they do decide it's time for hospice, I'll be there for the hospice evaluation and ask questions that are important that they might not consider."

She is often contacted by a family member of the dying person, the primary caregiver.

"A lot of times it's their first experience ever being with someone at end of life and so a lot of times we're working with the family almost as much or more so than the person who is actually dying and helping them in their caring process," Wall said.

A strong stigma surrounds talking about death, Wall said. This factor combined with an increasing isolation among people can compound an already difficult process, she said.

"It doesn't have to be this scary thing that you have built up in your head," Wall said. "It's actually like a very natural process of things, and there are ways to approach it, especially if you start thinking about it early on, that makes it a really beautiful, meaningful experience for not just the person dying, but the people around them."

Wall noticed more "solo agers" requesting her services over the past two years, or people who live alone with no close family.

"I think we live in a culture that's really kind of fixated on strength and independence," Wall said. "At any time, if you're going to embrace help, it's end of life when you should."

While death is an uncomfortable subject for most people to talk about, it's something they can have advocacy over, the Conscious Dying Collective's Padilla said.

"A lot of people think, well, it's the universe or your higher power, whatever happens to me. But no, you can advocate to have things your way," Padilla said. "Maybe not the time of death, but everything else about it. And with the exception of accidents and sudden death, you can also have things planned out before then too so it can be easier on the living."

End-of-life planning

While Fagan hired Wall, all of their interactions revolved around her mother, Mitzie. Having someone to normalize the experience, give her concrete things to make the situation meaningful, and help with the loneliness of caregiving was invaluable.

Fagan said she kept in touch with Wall after her mother's death and started attending her online classes to prepare for her own.

"Now it's about…considering what's important to me and why," she said. "What do I value? And am I spending my time doing the things that I value?"

Fagan recently attended one of Wall's classes called, "Transforming Fear of Death into Action," which covered everything from legacy to her worst fears associated with dying.

"One of them would be obvious, which would be the fear of cognitive decline," Fagan said. "I definitely kind of locked that one away, and I think it was just still processing, literally, the trauma of going through, having someone with dementia and dying from dementia, I mean, is incredibly traumatic."

Wall helped her address the fear and begin to make plans, such as recording appreciation videos for family members, she said.

"It was the same thing like with a birth doula…," Fagan said. "You have somebody that is on your team."

—Detroit News, February 17, 2025

AMA Article Pushes for Over-the-Counter Abortion Pills

By Wesley J. Smith

Taking abortion pills can lead to dangerous side effects, perhaps even death. Which is why the process of chemical abortion—called "medical" by pro-abortion advocates—is supposed to occur only under the guidance of a doctor. Indeed, *post-Dobbs,* women died because of improperly supervised chemical abortions, wrongly blamed by the media and pro-abortion advocates on pro-life laws.

But the medical establishment is so invested in unlimited abortion that *JAMA Internal Medicine* just published an advocacy article calling for the two drugs used in chemical abortions to be available over the counter (OTC):

> *A growing body of evidence indicates that mifepristone and misoprostol meet the FDA's criteria for OTC sale. The medications are not addictive, and the user determines on their own whether they have the condition needing treatment, in this case an unwanted pregnancy. The criteria that the FDA is likely to focus on are whether the user can appropriately self-select for use and whether they can use the product correctly over time, often referred to as actual use.*
>
> *Regarding the former, research indicates that people can accurately self-assess their gestational duration and other eligibility criteria for medication abortion. In the event someone uses the regimen significantly past 10 weeks of pregnancy (for example, after 12 weeks' gestation), it is less likely to be effective, but it is unlikely to cause serious medical complications for the pregnant person. For the question about actual use, even with facility-based medication abortion, patients generally take the medications on their own at home, manage adverse events, and determine when they need follow-up care. [Citations omitted.]*

The authors admit that such a system would require the construction of a tremendous support infrastructure that does not now exist:

> *Undoubtedly, there will be challenges to equitable implementation of OTC medication abortion. It remains to be determined what additional resources (such as clinician hotlines, materials, websites, or apps) will be necessary to ensure support throughout an OTC abortion process. Whereas facility-based medication abortion offers a direct line of communication between patients and clinicians, an OTC model would require mechanisms for timely access to clinician support or evaluation for individuals with questions, concerning symptoms, or rare complications such as incomplete abortion requiring uterine aspiration. Access to facility-based care also must remain available to support those who are unsure of their dating, are not candidates for OTC medication abortion, or desire procedural abortion.*

Like that would ever happen.

Chemical abortions are not like taking vitamins. The Cleveland Clinic website providing information on this form of abortion calls it "safe," but that is in the context of medical supervision:

> *You'll meet with a healthcare provider for an evaluation. While the specific steps depend on the state where you're having the procedure, preparation may involve:*
>
> - *Confirmation of pregnancy.*
> - *Urine (pee) or blood tests.*
> - *An ultrasound to determine how far along the pregnancy is.*
> - *An explanation of the procedure, risks and side effects.*

The site also indicates when this type of abortion *should not be undertaken,* which a woman buying an over-the-counter abortion kit might not understand:

> - *A medical abortion isn't a safe option if you:*
> - *Are too far along in your pregnancy.*
> - *Are allergic to the medications used.*
> - *Have a pregnancy outside of your uterus (ectopic pregnancy).*
> - *Use long-term corticosteroids.*
> - *Have an intrauterine device (IUD). (A medical abortion is an option if you have it removed.)*
> - *Have a blood clotting disorder, significant anemia or chronic adrenal failure.*
> - *Don't have access to emergency care.*

Indeed, as Senator James Lankford and Dr. Christina Vance, an OB-GYN noted last October:

> *Contrary to the claims that chemical abortions are as safe as Tylenol, these pills can lead to life-threatening complications. According to the FDA's own warning label, one in 25 women who take abortion pills will end up in the emergency room. Without consulting with a doctor, evaluations to rule out ectopic pregnancies or other serious medical conditions expose women to significant risks, complications in future pregnancies, and even death.*

One need not be a doctor to recognize the utter recklessness of this proposal. Allowing over-the-counter access to abortion pills values ending pregnancies over the safety of women. It should be rejected out of hand regardless of what one thinks about the moral propriety of abortion.

—National Review Online, February 5, 2025

Life-Affirming Principles for Medical Decision-Making

1. No matter what life-sustaining procedure/medical treatment is in question, when in doubt, **err on the side of life**. A medical intervention can be tried with the option of stopping it if it proves ineffective or excessively burdensome *for the patient*.

2. It is the physician's obligation to truthfully and fully, in layperson's terms, discuss with the patient/proxy/family/guardian the benefits, risks, cost, etc. of available medical means that may improve the patient's condition/prolong life. The focus should be on what the person making medical decisions needs to know in order to give *truly informed consent*.

3. The patient or the patient's legal representative makes the decision whether a treatment is too burdensome. (Note: The patient's life must never be ended because it is considered a burden to the patient or others.) If a patient wishes to fight for every moment of life, this is a legitimate interest to be respected.

4. It is impossible to make morally sound, sensible, informed health care decisions based on guesswork about some future illness or injury and possible treatment options. Health care decisions must be based on *current* information.

5. Two extremes are to be avoided:

- Insistence on physiologically useless or excessively burdensome treatment even when a patient may legitimately wish to forgo it.
- Withdrawal or withholding of treatment with the intention to hasten/cause death.

6. The object and motive for administering **pain medication** must be to relieve pain. Death must not be sought or intended. (See HALO's fact sheet "Drugs Commonly Used in Hospice and Palliative Care.")

7. Nutrition and hydration, whether a person is fed with a spoon or through a tube, is basic care, not medical treatment. Insertion or surgical implantation of a feeding tube takes medical expertise, but it is an ordinary life-preserving procedure for a person who has a working digestive system but is unable to eat by mouth.

- Acceptable - During the natural dying process, when a person's organs are shutting down so that the body is no longer able to assimilate food and water or when their administration causes serious complications, stopping tube-feeding or spoon-feeding is both medically and morally appropriate. In these circumstances, the cause of death is the person's disease or injury, not deliberate dehydration and starvation.
- Unacceptable - When a person is not dying—or not dying quickly enough to suit someone—food and fluids are often withheld with the intent to cause death because the person is viewed as having an unacceptably low quality of life and/or as imposing burdens on others. The direct cause of death is then dehydration and starvation.

New Jersey Program Aims to Prevent Suicide—Just Not All Suicides

By Wesley J. Smith

New Jersey has started an admirable program to prevent suicide. From the NJ.com story:

A new state program will send trained mental health professionals and people with lived experience to respond to adults who contact the 988 Suicide and Crisis Lifeline.

The Mobile Crisis Outreach Teams, which consist of one peer and one professional, will be dispatched through the state's 988 Suicide and Crisis Lifeline centers to help adults struggling with mental illness and substance use disorder, without the need for police.

"Today's announcement underscores that—in New Jersey—help is truly only a phone call or text message away," Gov. Phil Murphy said in a statement announcing the program's launch.

That's great. Too bad the effort won't apply to all suicides.

You see, assisted suicide is legal in New Jersey. The self-terminations of people with a prognosis of six months or less ceases to be "suicide" when facilitated by a doctor. Indeed, the terminology of the law has been engineered to create a false narrative: The request for suicide facilitation is redefined as a desire to "end my life in a humane and dignified manner."

The drugs used in prescribed intentional lethal overdoses are renamed "medications." Even the cause of death in such cases will be mendaciously reported as "natural" on death certificates when the real reason is the ingestion of barbiturates.

Suicide is suicide—it is a what, not a why. The state can claim it wants to prevent suicides, but people who ask for assisted suicide rarely (if ever) receive these important interventions—even though suicide prevention is supposed to be an essential hospice service.

This is so wrong. Statistics demonstrate that suicidal terminally ill patients opt for assisted suicide generally because of existential issues, such as fears of burdening family, losing dignity, about how one will be remembered, and so on. It isn't about untreatable pain (nor do laws so require). These are important matters that should and can be ameliorated through intensive social interventions like those that will be offered to other suicidal people under the New Jersey plan. Moreover, studies have demonstrated that legalization may increase other suicides, which would seem to undermine suicide prevention efforts generally.

Because New Jersey has legalized assisted suicide, its prevention program will not be universally applied. That is akin to saying to smokers, "Don't smoke," but then adding, "However, if you do, use a filter cigarette." The anti-suicide message is utterly inconsistent and, therefore, likely to be less effective.

—National Review Online, April 23, 2025

Will We Starve Dementia Patients?

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ual can modify their expressed preferences and more importantly their actions in the moment, while the person without decisional capacity depends on their surrogate and caregivers to execute the directive.

And they argue that the patient be so bound regardless of his current desires, as expressed, for example, by his actually eating and drinking—and even if the reduced sustenance causes discomfort:

There are certainly circumstances in which, regardless of whether a patient experiences discomfort once SED [stop eating and drinking] has begun, adherence to SED directives is acceptable to all concerned, including those providing direct care. But it is not uncommon that a person completing a SED advance directive has been insufficiently educated about real-world considerations to clearly consider the potential for vacillating preferences or the ethical concerns and obligations of the individuals executing the directive on their behalf, many of whom may have strong personal and cultural beliefs that will make strict adherence to the directive difficult, if not impossible.

Notice that the point is to hasten death:

Here MCF constitutes a fortunate compromise, allowing what caregivers provide to be both compassionate and loyal to the patient's wishes. In comparison with completely stopping eating and drinking, we hypothesize that MCF would extend by only weeks the life with severe dementia that the patient does not want. Once understood as an option, it may even be preferred by those who would otherwise complete an advance directive for SED. MCF has two key advantages over SED by advance directive. First, it offers assurance that discomfort due to hunger and thirst will be addressed with minimal oral nutrition and hydration. Second, it better considers and addresses the ethical concerns of others.

No, this practice would seek to make palatable that which should be beyond the pale—starving and dehydrating dementia patents to death.

So, this is where we are as a society. If we reduced a sick pet's sustenance so that they died over time, it would be deemed cruel and inhumane. But doing the same thing to a human being who would willingly eat is increasingly deemed "palliative" in the world of bioethics.

But, Wesley, one might say, we would put the animal down rather than slowly starve it.

Exactly.

Which is where all of this is heading if we continue down the "throwaway culture" path—as it already has in countries that permit lethal jab euthanasia, such as Belgium and the Netherlands.

This much is sure: With millions of people likely to experience dementia in the coming years, we had better get our ethics straight.

—National Review Online, February 4, 2025

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Will We Starve Dementia Patients in Slow Motion?

By Wesley J. Smith

Moves are afoot in bioethics to require caregivers to withhold food and water by mouth from a patient made incompetent by dementia if that patient, while compos mentis, has signed such a request—and even if the patient willingly eats, enjoys meals, or asks for food. It is sometimes called "voluntary stop eating and drinking [VSED] by advance directive," in the parlance. I have frequently criticized VSED by directive as inhumane to the patient, cruel to caregivers (as it forces them to starve people to death), and designed to open the door to lethally jabbing those with advanced dementia as the less onerous alternative to their being made to starve to death.

Now, as supposedly some form of compromise, there is a proposal on the table to barely feed—i.e., malnourish—dementia patients who have previously signed such a directive. From, "Mr. Smith Has No Mealtimes," published in the *Journal of Pain and Symptom Management* (citations omitted):

Minimal Comfort Feeding (MCF)…is the provision of only enough oral nutrition and hydration to ensure comfort. With MCF, eating and drinking is not scheduled; rather, caretakers offer food and liquids only in response to signs of hunger and thirst. Patients are neither wakened for regular mealtimes nor encouraged to eat or drink. Instead, they are offered frequent, fastidious mouth care, continued social contact, therapeutic touch, sensory distraction, and medications to relieve distress associated with apparent thirst or hunger before being provided with minimal amounts of liquid or food.

This sure seems to be the same as VSED by directive, only more slowly. And it's all so subjective, based on observation rather than a caregiver's testing to see if the patient actively refuses to eat. Indeed, often medications can in themselves keep the patient from appearing hungry.

These supposed protections are weak and would be easily ignored in practice:

MCF is initiated only (1) after a patient's advanced dementia is established (e.g., is consistently at Stage 7A

or beyond using the FAST, or at stage 7 on the Global Deterioration Scale) and (2) after thorough discussion with the surrogate confirms the patient's prior preference not to continue living with advanced dementia.

Please.

The patient, as he or she is now, should be what matters, a fully equal human being deserving of sustenance if desired. For example, if an individual's advanced directive said, "Don't keep me warm or clean if I lose competence," would we comply? Of course not! So, what's the difference?

Accordingly, the provision of food and water—which is part of basic humane care—should be offered to see whether the patient wants to eat. Sometimes that means experimenting. When my mother was dying of Alzheimer's, she stopped eating. Her visiting nurse companion brought over canned peaches. Mom scarfed them down with great pleasure. So, we fed her what she liked as long as she was able to eat.

The authors argue that the "now self" should be bound to the desires of the "then self"—even if the "now self" wants sustenance—with the complicity of surrogates.

The "now-self" is analogous to the person with decisional capacity who attempts VSED and either ceases their efforts or requires some nutrition and hydration on the path to eventually obtaining their goal of hastening death. The difference is that the decisional individ-

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