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Part 1 of 2 - Dr. Matt Harrison Answers Critics of Groundbreaking Abortion Pill Reversal Treatment

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Abortion pill reversal, or APR, has been catapulted into the abortion conversation over the last few years, drawing strong support from some and scathing criticism from others. Given the recent media coverage of an APR success story in Charlotte, NC, we invited Dr. Matt Harrison, Associate Medical Director of Culture of Life Family Services and one of the pioneers of the APR treatment, to respond directly to the criticisms. This article is the first in a series of two, the second published later this week, in which we share our conversation with Dr. Harrison.

The Critics

The main criticisms of APR treatment focus on the recency of the science, questions about safety and efficacy, and the treatment's impact on women's choice and options. Here are some examples:

- A Media Matters article that claims APR treatment encourages abortion stigma
- An RHRC article in which NARAL claims that APR is insulting to women
- The American Congress of Obstetrics and Gynecology's (ACOG's) official response, which cites lack of scientific evidence to support APR treatment
- An article in *The Atlantic* in which ACOG and pro-choice providers raise questions on efficacy and safety
- An RHRC article by pro-choice physician Dr. David Grimes that refutes the science behind APR treatment

Part 1: The Women

Part 1 of our conversation addresses criticisms related to women's experiences and concerns about their health and choices. Part 2 will address efficacy, safety, and the scientific evidence behind APR. The full transcript and audio from our conversation with Dr. Harrison will be published with Part 2.

SpeakLife: There's an obvious personal investment in deciding to reverse an RU-486 abortion, and women have different options as they participate in the APR treatment. Have the current protocols made the pregnancy experience more difficult for women?

Dr. Harrison: Most of the women that I've talked to that have gone through it have definitely felt more invested in the prenatal period, because they are feeling like they need to do more. They have a little bit more anticipation, a little bit more concern because of what's already happened early in the pregnancy. But, what I have found is that these women are just growing closer and closer to their babies, because every day they are making a decision to save their baby. So every morning when they wake up, they get a positive reinforcement of, "Wow, look what I've done! Look at what I've made a decision to do." So we see that these women are just so excited when they go into delivery and when they get to hold their baby. We see things they have written in their journals about anticipating seeing this baby and getting to hold them. There are a lot of stories on our website where women have shared what they have done through their prenatal periods. So I've seen it as a very positive impact.

Certainly… the progesterone shots do come with some pain. I mean, it's a shot, and it's in an oil-based medium that's deposited down into the muscle. So, it's not comfortable, and we don't tell them anything different. We would love it if we found out that we could be just as effective without shots and that we could use suppositories. That would be great . But, we give them very clear informed consent, before they ever start the procedure, that there is going to be some pain involved, but most of them do fine with it. They are just excited to be able to save their baby.

SpeakLife: Do you see this protocol as a means to offer more ongoing support—the physical and emotional support that impacts the doctor-patient relationship that we are all very concerned about?

Dr. Harrison: Absolutely. This is one of the key points that we talk with our sidewalk counseling team about, through the folks that are bringing the women from the abortion clinics to our offices. But probably the most important relationship is not the one between the patient and the doctor, it's actually between the patient and the person who is bringing them to the doctor's appointment. Because they disciple those women and encourage them. They go pick them up at their houses. They help them with childcare. They take them to the store. They do all types of other things that are needed for support, because a lot of these young women have been shunned by their families, boyfriends, or whoever, and so now, they don't feel like they have any support. In Charlotte, we have sidewalk counselors and a shower ministry. We have people that help with meals. We have people that help with transportation. So there are lots of different ministries that come together and form a network. For some of the women, if they want to—they're not ever forced to—they [help find] a church home, and a lot of them find a lot of support there.

SpeakLife: Even though this is a newer area, are you seeing any trends in the reasons women change their mind? Are you seeing a connection between the reasons why they went in for the abortion in the first place and the reasons why they decide to reverse?

Dr. Harrison: I'll tell you what's interesting. I do inpatient hospital work, and I take care of a lot of patients who have come into the emergency room with overdoses, who have come in from suicide attempts, and I see a lot of the very similar physiological/psychiatric issues that are going on between these women and those patients, and I'll tell you why. They are in a very dark and lonely place. They feel like they don't have support. They feel like they have no other choice and nowhere to turn. So just like a patient who is going to overdose on pills, some of these women make a very rash and quick decision and go get an abortion or attempt to get an abortion, when down deep they really don't want to do that. They just really want help. They just really want someone to help support them. So we see that there's a surprisingly large number of women who go in, take the pill, and immediately regret it. Some physicians who've been commenting on [our work] say that that percentage is very small. Well, I really challenge that, because we see so many women who've said, "Oh, if I'd only known. If I'd only known. I regretted it as soon as I did it." I think there is a much higher percentage than they think there is of women who take the abortion pill and immediately wish that they could reverse it.

These women, once they feel like there might be a chance, they are gung-ho about [it]. But not everyone of them. We have had several women who have come and actually started the reversal process, and then changed their mind again and went and got an abortion. We are sorry to see that happen. And a lot of it is because they're back in the same situation. They're back in their same living circumstances. They have all the people around them who pushed them towards the abortion in the first place. They leave the abortion clinic, change their mind, and they're right back in that same surrounding.

SpeakLife: As more evidence emerges to support and even enhance this protocol, to help you further define it, do you expect that abortion providers will communicate it as an option for women to have?

Dr. Harrison: I think some will. One danger that I see is I don't want women to think that, "Oh well, I can just take RU-486 and if I change my mind, I can reverse it." Preventive medicine is still the best way to keep people alive. So we would obviously rather them not take RU-486 in the first place. We want women to understand RU-486 is a deadly drug, that it kills their babies, and that it is not something to take lightly.

SpeakLife: The critics of this protocol say, in particular, that this is just another attempt to limit abortion and choice at the expense of women's health and safety. And given everything that you have seen and everything medical science knows about RU-486 and progesterone, how do you respond?

Dr. Harrison: Well, I have no problem with limiting abortion because I think abortion is a bad procedure. I think it's bad medicine. So I don't have any problems limiting that. There is never any good reason for the direct killing of a baby, which is what abortion is.

As far as health and safety, there are very few situations where, to cure a woman of a problem that is going to kill her, the death of the child might happen. This is a secondary cause or a secondary effect, but it is not the primary effect of what you are trying to do. [For example], for an ectopic pregnancy that is about to rupture, it's certainly reasonable to go in and cut out the fallopian tube, which contains that baby, that is about to rupture and kill the mother and cause her to bleed to death. Your purpose is not to kill the baby. The purpose is to save the mother and to support the mother. In general terms, [taking] care of the mother is the best way to take care of the baby. So there are situations such as that, which are exceedingly rare, where the death of the baby might happen, but is not something that you want to happen. It is not your goal of the procedure. There are studies going on about, essentially, ectopic transplants— transplanting a baby that is in a fallopian tube, transplanting it safely into the womb where it can continue to develop. [These procedures] support both the mother and the baby, support life on both ends, and not just throw away life. The other example would be an overwhelming infection in the womb [in early pregnancy]. We don't have a way of curing that. The only way to [save the mother] is to clean out the infection. Again, your goal there is to clean out infection and unfortunately, the baby dies when that happens.

Those are the arguments that are brought up [about health and safety]. But if those are the two cases that they want to argue, go ahead and give us the other 99.5% of all the abortions that are done. And then we'll work out those other two cases.

Be sure to catch Part 2 - The Science, which will be published later this week. In the second half of our conversation, Dr. Harrison will address criticisms regarding the science of APR and the potential of this treatment from a physician's perspective.

Sarah Quale, President of SpeakLife