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Obstetricians & Gynecologists

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8.0MHz
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General
90dB S1/+1/2/4
Gain= -8dB Δ=2

6C2-S
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TOP 10 MYTHS ABOUT ABORTION

By Ingrid Skop, M.D.

FAMILY RESEARCH COUNCIL
Washington, D.C.

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A NOTE FROM THE AUTHOR:

I hope the points I have raised in this paper will cause those who consider themselves to be “pro-choice” to question some of the assumptions they have made about abortion. Abortion is a difficult topic to talk or even think about. It has invaded deeply into the fiber of our society precisely because most of us do not want to address it until it confronts us directly. While most Americans have ignored it and while our health departments and medical societies have turned a blind eye to it, abortion has adversely affected far too many women, injured many physically and emotionally, destroyed families, and damaged the psyche of our country. Pro-abortion rhetoric sounds so benign (“women’s rights”; “reproductive freedom”; “women’s health care”) that many times we fail to think about what these terms represent. You don’t have to believe like I do—that abortion is harmful to women, families, and society. But please have the courage to look into it yourself. Follow the leads I have provided in the citations to study this subject more deeply. Begin to have difficult conversations with friends and family so you can help others to really confront this issue too. It is time that our country sees abortion for what it really is—for the sake of women and children yet unborn.

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April 23, 2018

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MYTH 01

“ABORTION DOES NOT DESTROY A HUMAN LIFE.”



MYTH #1: “ABORTION DOES NOT DESTROY A HUMAN LIFE.”

In the ongoing abortion debate, pro-life advocates frequently cite the “Right to Life,” while pro-abortion advocates invoke the “Right to the Pursuit of Happiness.” The Declaration of Independence states, “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.”¹

The first question that must be addressed, it seems, is “**Is the fetus a human life?**” From a scientific perspective, this is not a controversial question. The term “fetus” (from a Latin word meaning “offspring”) is a medical term that refers to a human being in the prenatal stage of development in the womb. Life is commonly defined as organisms that “maintain homeostasis, are composed of cells, have a life cycle, undergo metabolism, can grow, adapt to their environment, respond to stimuli, reproduce and evolve.”² These are incontrovertible properties of a fetus. This definition, however, does not cover organs, which although they are a part of a living organism, cannot reproduce; or egg and sperm, which are single living cells that do not have the ability to fulfill these functions unless they combine to form an embryo.

ANY BASIC PHYSIOLOGY TEXTBOOK WILL CONFIRM THAT WITH FERTILIZATION, A COMPLETE COMPLEMENT OF 46 HUMAN CHROMOSOMES COMES INTO EXISTENCE THAT IS UNIQUELY DIFFERENT FROM THAT OF EITHER PARENT.

The next question is, “**When does the fetus become alive?**” Again, scientifically, there is not much controversy here. Any basic physiology textbook will confirm that with fertilization, a complete chromosomal complement of 46 human chromosomes results (uniquely different from that of either parent), and the one-celled embryo begins dividing rapidly.³ Even before

implantation, local secretions provide nutrition for the zygote. Basic obstetrics textbooks tell us that “a biomolecular communication system is established between the zygote/blastocyst/embryo/fetus and mother that is operative from before the time of nidation (implantation) and persists through the time of parturition (birth).”⁴

So, at first glance, it seems straightforward. From conception/implantation, the fetus is a living human; the Declaration of Independence states that all humans in our country have a right to life; and common morality agrees that it is wrong to kill an innocent living human being; so it seems the fetus should be allowed to live.

To summarize, let’s briefly outline the stages of fetal development: **Conception** occurs within 24-48 hours after intercourse, when the egg and sperm unite to form a **zygote, a one-celled embryo**. This organism has a unique genetic makeup formed by the combination of the mother’s and father’s chromosomal material. He has the genetic blueprint that will determine the characteristics of the person he will become. This highly complex information will guide the development of this unique human from now until death. The only thing necessary for his growth and development is oxygen, food, water, and a healthy interaction with his natural environment.⁵

Implantation occurs after the embryo travels through the fallopian tubes and implants into the uterine wall about 5-7 days after fertilization. Biochemically, the pregnancy hormones can be detected in the blood at this point.

The embryo rapidly grows and differentiates. The precursor to the nervous system appears between days 12 and 17. By 21 days after conception, the heart starts beating and pumping blood; by 30 days, arms, legs, and brain begin to form; and by 35 days, mouth, nose, and ears begin to develop.⁶

Within 40 days, measurable brain waves begin, and by 42 days (6 weeks), the skeleton and internal organs are present, and the brain controls limb movement. By 8 weeks, the hands have formed and fingerprints are forming; by 9 weeks, fingernails are forming and he can be seen on the sonogram sucking his thumb; by 10 weeks, he squints, swallows, and frowns; by 12 weeks, he smiles and has intricate hand and feet movements. At this point, all his organs are present.⁷

Viability occurs when the baby has the ability to survive separately from his mother. Currently, this occurs around 22 weeks based on “last menstrual period,” only 20 weeks after conception (ovulation—and thus conception—usually occurs about two weeks after the menstrual period). At the time of *Roe v. Wade* in 1973, viability occurred around 28 weeks. Viability is a subjective measurement dependent on the availability of technology that can assist the baby’s breathing and eating, and it is a standard that is continuing to develop to accommodate younger and younger babies. New technology, including the development of an artificial womb, causes the point of viability to become even more uncertain.⁹

This discussion should make it clear that a fetus is a living human being. To “terminate a pregnancy” of a living fetus is killing a human being. It is frustrating to hear a fetus being described as a “mass of tissue” or “tumor” or “parasite” by pro-abortion activists. There are many

of these activists who feel that this killing is justified due to the demands the fetus places on his mother, but this argument ignores the fact that a newborn baby places demands on the mother as well through nursing, changing diapers, etc. Some pro-abortion activists apply the principles of “just war.” But none can deny that the fetus is alive.¹⁰ In order to have an honest discussion on this issue, we need to come to terms with what we are talking about.

Thus, we have seen that “fetus” and “infant” are names for sequential stages in the development of a single human being. Yet, the law serves to protect the life of one, while neglecting to protect the life of the other. Philosophically, we should be willing to ask ourselves, what is the difference between a fetus and an infant? What makes one’s life worth protecting, while the other’s is not? Is it a question of size? Surely not. We don’t value tall people over short people.

Is it a question of the level of development? As previously mentioned, many young children don’t exhibit complex mental functions. We usually don’t advocate killing children or mentally disabled adults because they don’t measure up to a certain mental or developmental standard. Why should we apply this standard to the fetus, who is certainly less developed, but with time will reach this standard?

Is it a question of environment? How does a passage from one location to another confer a greater value to a human being? How can we assign a different worth to a baby in his mother’s arms versus a baby in her uterus?

Is it a question of the length of life thus far? Why does a 24-week undesired intrauterine fetus have no right to life, whereas a 24-week prematurely born neonate unquestionably does? One 600-gram baby is dismembered and ripped from the mother’s uterus, while another 600-gram baby is valiantly cared for with the latest technology. What is the difference between these two babies? There is only one difference (other than location): one is desired, and the other is not. It is a chilling thought to realize that our society has narrowed the criteria of who has a right to life to one thing only—whether a person is wanted.

Is it a question of dependency? Dependency does not end with birth. A newborn infant is dependent. A diabetic or renal failure patient is dependent. A comatose patient is dependent. We certainly don’t want to travel down the slippery slope of saying these types of dependent people do not have a right to continue life! Our society prides itself on how we care for the most vulnerable in our midst. That is at the heart of the social justice movement. Why have we removed our protection from the most vulnerable group of humans?¹¹

NOTES

- 1 “Declaration of Independence: A Transcription,” National Archives, accessed November 14, 2018, <https://www.archives.gov/founding-docs/declaration-transcript>.
- 2 “Life,” Wikipedia, accessed November 14, 2018, <https://en.wikipedia.org/wiki/Life>.
- 3 Arthur C. Guyton, *The Textbook of Medical Physiology* (Philadelphia: WB Saunders Co., 1986), 984.
- 4 F. Gary Cunningham, *Williams Obstetrics* (Norwalk: Appleton & Lange, 1993), 16.
- 5 Keith L. Moore, *The Developing Human: Clinically Oriented Embryology* (Philadelphia: WB Saunders Co., 1998), 350.
- 6 Ibid.
- 7 Ibid.
- 8 Matthew A. Rysavy, et al., “Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants,” *The New England Journal of Medicine* 372 (2015): 1801-1811, accessed March 1, 2018, <http://www.nejm.org/doi/full/10.1056/NEJMoa1410689>.
- 9 Meera Senthilingam, “‘Plastic bag’ womb could help keep premature babies alive,” CNN, April, 26, 2017, accessed November 26, 2018, <https://www.cnn.com/2017/04/26/health/artificial-womb-premature-babies-lambs/index.html>.
- 10 See Augustine’s *The City of God*.
- 11 Francis J. Beckwith, *Defending Life: A Moral and Legal Case Against Abortion Choice* (Cambridge University Press, 2007).

insure domestic Tranquility, provide
and our Posterity, do ordain and est

MYTH 02

“ABORTION IS A CONSTITUTIONAL RIGHT.”



MYTH #2: “ABORTION IS A CONSTITUTIONAL RIGHT.”

The Supreme Court of 1973 was ideologically disposed to find a way to legalize abortion when they agreed to hear the cases of *Roe v. Wade*, and its companion case, *Doe v. Bolton*.¹² They knew where they wanted to end up (legal abortion), but they had to find a way to justify this action.¹³ They needed to make a convincing argument that the Constitution allowed the destruction of human life that would occur with legal abortion.¹⁴

As mentioned previously, the Declaration of Independence states, “We hold these truths to be self-evident, that all men are **created equal**, that they are endowed by their Creator with certain unalienable Rights, that among these are **Life, Liberty and the pursuit of Happiness**.”¹⁵ Notice our Forefathers wrote “created,” not “born.” In addition, the 14th Amendment states “...nor shall any state deprive a person of life, liberty or property, without **due process of the law**; nor deny any person within its jurisdiction the **equal protection of the laws**.”¹⁶ Based on these two statements, it is hard to see how ending an unborn human’s life can be considered “constitutional.”

Thus, the Justices were obligated to do two things. They had to make an argument for why unborn life did not deserve to be treated as a life covered by these statements, and they had to find other constitutional statements that gave a woman the power to end this life.¹⁷ Prior Supreme Court decisions had established a right to *contraceptive use* by married couples in *Griswold v. Connecticut*, and later by single people in *Eisenstadt v. Bard*, based on the “**right of privacy**,” a phrase that when previously documented in the Constitution was related to the right to own private property.¹⁸ It was then extrapolated that abortion, being a method of birth control (although it is not a method of contraception because it occurs after conception has occurred), should be covered by a woman’s right to privacy, or ownership of the fetus (even though, of course, the surgical procedure does not occur in the privacy of her own home).¹⁹

The Court professed ignorance about when life begins and advanced an argument based on “**personhood**” instead. Justice Blackmun stated, “We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at a consensus, the judiciary, at this point in the development of man’s knowledge, is not in a position to speculate.”²⁰ This was feigned ignorance. As we have discussed, an unborn human is clearly alive by the time the pregnancy is recognized (5-7 days after fertilization), and some scientists still debate whether life begins at fertilization or implantation. By claiming that this small window of time between fertilization and implantation constituted a non-consensus and therefore allowing the procedure of abortion without restriction until birth, the Court actually took a side on the question of when life begins, and gave it the most extreme definition possible. Inexplicably, the Court twisted the statement about liberty by applying it to the woman, while denying it to the unborn human. They stated that “liberty” means a “right to privacy,” which is broad enough to encompass the decision to terminate an unborn child’s life.²¹

The argument for abortion based on “personhood” rather than “life” is a weak one. The thought, apparently, was that a fetal human being who had supposedly not yet achieved personhood was of lesser value than one who had achieved personhood, and his life could be ended if the needs of an actual person required it. Obviously, this argument is extremely dubious because few can agree on just what “personhood” entails. One common definition of a person is “a being that has certain capacities or attributes such as reason, morality, consciousness or self-consciousness...”²²

On a historical note, many of the arguments made against personhood have been used before regarding certain ethnic groups, such as blacks and Native Americans. In the 1857 *Dred Scott v. Sandford* decision, the Supreme Court ruled that slaves are not legal people.²³ Abraham Lincoln once remarked that any argument used to disqualify blacks as human beings works equally well to disqualify whites. “Does color give the right to enslave? There will always be someone with lighter skin color. Intellect? There will always be a superior intellect. Interest? It may be in someone else’s best interest to enslave you.”²⁴ The same is true for the personhood of the fetus. For almost any criteria, there will be some unborn people who meet that criteria, and some born people who don’t (except for location, by definition).

It is also interesting to note that there are some groups who would like to extend personhood to species other than homo sapiens. The Nonhuman Rights Project has filed many lawsuits to declare legal personhood for chimps, elephants, dolphins, and whales.²⁶ Many people have criticized the slaughter of dolphins in Japan by likening them to persons. Likewise, the founder of People for the Ethical Treatment of Animals has famously declared, “A rat is a pig is a dog is a boy,” indicating that all these animals are equivalent beings.²⁷ It seems that the term “personhood” has lost all meaning if it can be applied to smart animals, but not to fetal humans.

There are even some who feel that personhood does not begin until the baby draws his first breath at **birth**, and that this is the definition of personhood used by the Supreme Court in 1973. Although *Roe v. Wade* allowed the states to prohibit abortion at viability, if desired, the Supreme Court ruling itself did not prohibit abortion at any time during which the fetus resides within the uterus.²⁸

There are even some who don't ascribe personhood until **self-awareness** is reached. This is a viewpoint obviously fraught with difficulty. This may not occur until late in the life of a child, perhaps never in one who is seriously disabled, and it is not a persistent state even in a normal adult. We usually don't have self-awareness when we are sleeping, and we could lose it if we become brain-damaged or develop dementia. Some have taken this argument further, and justified killing a baby after birth if a disability is discovered that was not known before birth.^{29,30} The Netherlands, no stranger to the active killing of living human beings through euthanasia, initiated the Groningen Protocol in 2002, whereby physicians could actively terminate the lives of infants with hopeless prognoses.³¹ Infanticide is just the next step in the process if personhood is based on self-awareness.

The obvious problem with assigning personhood at a **specific threshold** in pregnancy is that it is an **arbitrary** distinction. What makes one day significantly different from the day before? It's safe to say that most people feel intuitively that a fetus is a person before birth, but how do we decide when this occurs in the continuum of fetal development? Since *Roe v. Wade* stated that personhood does not extend prenatally, this allows abortions to be committed legally up until immediately before birth (if not prohibited by the state) if an abortionist can be found who is willing to commit the procedure.

In 2016, there were 40 facilities in the U.S. that will perform an elective abortion after 24 weeks gestation. Five of these (Southwestern Women's Options in Albuquerque, N.M.; Pro-Choice Medical Center in Beverly Hills, Calif.; Boulder Abortion Clinic in Boulder, Colo.; Germantown Reproductive Health Services in Germantown, Md.; and Women's Med Center in Kettering, Ohio) will conduct elective abortions throughout all nine months of pregnancy.³²

THE OBVIOUS PROBLEM WITH ASSIGNING PERSONHOOD AT A SPECIFIC THRESHOLD IN PREGNANCY IS THAT IT IS AN ARBITRARY DISTINCTION.

NOTES

- 12 *Roe v. Wade* 410 U.S. 179 (1973); *Doe v. Bolton* 410 U.S. 179 (1973).
- 13 Jack Balkin, ed., *What Roe v. Wade Should Have Said: The Nation's Top Legal Experts Rewrite America's Most Controversial Decision* (NYU Press, 2007).
- 14 Clarke D. Forsythe, *Abuse of Discretion: The Inside Story of Roe v. Wade* (New York: Wilsted & Taylor, 2013).
- 15 National Archives.
- 16 Ibid.
- 17 Drew Humphries, "The Movement to Legalize Abortion: A Historical Account," in David F. Greenberg, ed., *Corrections and Punishments* (Beverly Hills, CA: Sage Publications, 1977).

- 18 *Griswold v. Connecticut* 381 U.S. 479 (1965); *Eisenstadt v. Baird* 405 U.S. 438 (1972).
- 19 Marian Faux, *Roe v. Wade: The Untold Story of the Landmark Supreme Court Decision That Made Abortion Legal* (Cooper Square Press, 1988).
- 20 *Roe v. Wade* 410 U.S. 113 (1973).
- 21 Marian Faux.
- 22 “Person,” Wikipedia, accessed November 27, 2018, <https://en.wikipedia.org/wiki/Person>.
- 23 Ethan Greenberg, *Dred Scott and the Dangers of a Political Court* (Lexington Books, 2009).
- 24 Ibid.
- 25 “Litigation,” Nonhuman Rights Project, accessed November 27, 2018, <https://www.non-humanrights.org/litigation/>.
- 26 “Stop the Taiji Slaughter,” International Marine Mammal Project, accessed November 27, 2018, <http://savedolphins.eii.org/campaigns/sjd/>.
- 27 Ingrid Newkirk, “A Rat Is a Pig Is a Dog Is a Boy,” People for the Ethical Treatment of Animals, August 28, 2012, accessed November 27, 2018, <https://www.peta.org/blog/rat-pig-dog-boy/>.
- 28 “ROE v. WADE,” FindLaw, accessed November 27, 2018, <http://caselaw.findlaw.com/us-supreme-court/410/113.html>.
- 29 Alberto Giubilini and Francesca Minerva, “After-birth abortion: why should the baby live?” *Journal of Medical Ethics* (2012), accessed November 27, 2018, <http://jme.bmj.com/content/early/2012/03/01/medethics-2011-100411>.
- 30 Helga Kuhse and Peter Singer, et al., *Should the Baby Live? The Problem of Handicapped Infants* (Oxford University Press, 1985), 143.
- 31 Eduard Verhagen and Pieter J.J. Sauer, “The Groningen Protocol—Euthanasia in Severely Ill Newborns” *The New England Journal of Medicine* 352 (2005): 959-962, accessed November 27, 2018, <http://www.nejm.org/doi/full/10.1056/NEJMp058026>.
- 32 “Number of Late-term Abortion Facilities in the USA May Surprise You,” Operation Rescue, March 11, 2016, accessed March 3, 2018, <https://www.operationrescue.org/archives/number-of-late-term-abortion-facilities-in-the-usa-may-surprise-you/>.

A hand is shown holding a document. The word "PROVERBS" is visible in the background, suggesting a religious or biblical context. The overall image has a purple tint.

MYTH 03

“ABORTION IS A RELIGIOUS ISSUE.”



MYTH #3: “ABORTION IS A RELIGIOUS ISSUE.”

The argument is often raised that abortion is a religious issue, and thus, legislating it is prohibited by the Establishment Clause of the First Amendment, which states “Congress shall make no law respecting an **establishment of religion**, or prohibiting the free exercise thereof, or abridging the freedom of speech,” etc.³³ They argue for “separation of church and state,” implying that if it were not for religious motivation, people would not be opposed to abortion. The question then becomes whether abortion can be considered an issue of morality common to all men, rather than just those of Judeo-Christian beliefs. Is a fetus a human life? We have discussed the clear evidence that the fetus is, indeed, a human life. Is it moral to destroy a human life for extenuating circumstances? If so, how compelling should those circumstances be? It is helpful to be aware that there are many **secular pro-life** organizations: “Secular Pro-Life,” “Pro-Life Humanists,” “Godless Pro-Lifers,” “Feminists for Life,” and “New Wave Feminists,” among others.

Conversely, there are some religious organizations that are strong advocates for abortion choice. The Religious Coalition for Reproductive Choice, which counts among its members Jews, Universalists, Methodists, Presbyterians, Episcopalians, Catholics, Muslims, Hindus, and Buddhists, advocates for reproductive choice as a “**equality and justice**” issue.

Although the Bible and Torah/Talmud do not mention the word “abortion” specifically, many Christians and Jews are morally opposed to abortion based on the widely expressed scriptural notion that man is “**made in the image of God**” (Genesis 1:27), and this view is supported by various verses expressing tenderness from God toward the unborn human. “Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations” (Jeremiah 1:5). “For you created my inmost being; you knit me together in my

THERE ARE RELIGIOUS AND SECULAR PEOPLE WHO FALL ON BOTH SIDES OF THE ABORTION ARGUMENT, SO IT IS FAIR TO SAY THAT IT IS NOT STRICTLY A RELIGIOUS ISSUE.

mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be" (Psalm 139:13-16).

We can see that there are religious and secular people who fall on both sides of the abortion argument, so it is fair to say that it is not strictly a religious issue, and therefore there is no constitutional prohibition to abortion's legislation as outlined in the Establishment Clause.

NOTES

- 33 "The Bill of Rights: A Transcription," National Archives, accessed March 3, 2018, <https://www.archives.gov/founding-docs/bill-of-rights-transcript>.
- 34 Secularprolife.org; Prolifehumanists.org; Godlessprolifers.org; Feministsforlife.org; New-wavefeminists.com
- 35 "The Moral Case," Religious Coalition for Reproductive Choice, accessed April 24, 2018, <http://rcrc.org/the-moral-case/>.



MYTH 04

“MOST ABORTIONS ARE DONE FOR
COMPELLING REASONS.”



MYTH #4: “MOST ABORTIONS ARE DONE FOR COMPELLING REASONS.”

Of the many abortions committed in the U.S. each year, only 1-3 percent are for the “hard cases” of **rape, incest, fetal anomalies, and danger to the mother’s life**. That means 97 percent are for **financial or emotional strain**, or other undefined reasons. Let’s look in more detail about how this is broken down. Three quarters of women who obtain an abortion say they cannot afford a child or that having a baby would interfere with school, work, or the ability to care for dependents; 86 percent are unmarried;⁶ 59 percent have at least one child; 24 percent are currently in school; 13 percent of women having abortions identify as evangelical Christians, 24 percent as Catholics, and 17 percent as Protestants.³⁷

ONLY 1-3 PERCENT ARE FOR THE “HARD CASES” OF RAPE, INCEST, FETAL ANOMALIES, AND DANGER TO THE MOTHER’S LIFE. THAT MEANS 97 PERCENT ARE FOR FINANCIAL OR EMOTIONAL STRAIN.

Our country saw the numbers of abortions increase ten-fold when it was legalized, so it is clear that most women would not pursue an abortion if it were not legally permissible and readily available.³⁸

It is estimated that 25-30 percent of American women have had an abortion. About half of women who obtain abortions were not using any contraception. But this means half of them were using a method of contraception which failed to prevent pregnancy. In the first year of contraceptive use, 16 percent of teens become pregnant. Despite our best efforts, contraceptives often fail—43 percent of abortions are repeats.³⁹ Despite reassurances to the contrary, there are many women who do use abortion for birth control. Some women are pressured by their families, male partners, and friends to have abortions even if they are not sure this is what they want to do.⁴⁰

Stop for a minute to really think about what these numbers represent. Lack of resources and family support seems to encourage many women to choose abortion. The majority of these women are already mothers, and presumably love their children, and yet are in circumstances where they are not willing to give birth to another child. Teens are often encouraged to embrace their sexuality and are told that as long as they practice responsible contraception and “safe sex,” there is no risk. Yet half of women who conceive undesired pregnancies were using contraception.⁴¹ Though Christian adults are often opposed to abortion, many of their daughters are having abortions. What a tragedy. Abortion affects nearly everyone!



It is often assumed that **late-term abortions** are usually obtained for compelling reasons such as “life of the mother” and “severe fetal abnormalities,” but that is an incorrect assumption. Most are obtained for the very **same elective reasons** that earlier abortions are obtained. Post-viable abortions account for only a small percentage (1.3 percent) of total abortions in America. Yet, that still means there are about 15,000-18,000 potentially viable babies aborted yearly after the 20th week of pregnancy.⁴² **Most of those aborted are healthy babies being carried by healthy women.** Currently, many babies survive when born prematurely as early as 22 weeks gestation. This is only a little over halfway through a normal pregnancy duration. Yet, we continue to allow their elective killing. Recently, the U.S. Senate failed to pass the Pain Capable Unborn Child Protection Act.⁴³

Although it is possible not to know about a pregnancy, my experience as an obstetrician has revealed that most women know or suspect that they are pregnant, but they may be reluctant to admit it to their parents or unsupportive partners. Women are often forced or **coerced** into a late abortion when the pregnancy becomes obvious, even though this may not have been their “choice.”⁴⁴ One study found that as many as 58 percent of women felt that they had their abortions in order to “make others happy,” with over 28 percent saying they had the abortion because “they feared their partner would leave them” if they did not.⁴⁵



A large study confirmed the elective nature of most late abortions: 10.3 percent of U.S. abortions are committed after the first trimester with the following breakdown: 6.2 percent between 13-15 weeks, 4 percent at or after 16 weeks (includes 1.3 percent after viability). Reasons given for the abortion were: “not knowing about the pregnancy,” “trouble deciding about the abortion,” and “disagreeing about the abortion with the man involved.”⁴⁶ Another study found 50 percent of women having second trimester abortions delayed the procedure due to **indecision**, and 33 percent due to the **difficulty of the decision.**⁴⁷ With all this indecision, it is likely that another change of mind could occur for the woman after going through with the abortion, and the choice

could be regretted. These studies did not report the number of “**hard cases**,” because apparently there were so few. The state of Florida keeps statistics on the reasons for all abortions in the state, and they found incest accounted for only 0.001 percent of all abortions, rape 0.085 percent, health of mother 0.5 percent, life of mother 0.065 percent, and serious fetal anomalies 0.66 percent.⁴⁸

Interestingly, although we are often told that late abortions occur because a woman has trouble finding funding,⁴⁹ one study showed that these abortions were more frequently funded with health insurance (and that they cost about four times the amount a first trimester abortion costs).⁵⁰ A similar study in England and Wales found 11 percent of abortions occurred after the first trimester (a similar number to the U.S. despite available funding through socialized medicine). The reasons were also similar: 41 percent indecision, 30 percent procrastination, 23 percent relationship changed.⁵¹

One of the most frequent myths about late-term abortion is that it may be necessary to save a woman’s life. Don’t get me wrong. It is clearly the standard of care for any physician to intervene in a pregnancy that presents a risk to the mother’s life, as long as no direct action is taken to terminate the life of the unborn child.⁵² However, these life-threatening situations occur far less commonly than one may assume. Some examples are ectopic pregnancy, infection due to extremely premature rupture of membranes, severe hypertension, and certain cardiac conditions. The law has never limited intervention in these circumstances, even in countries in which all elective abortion is illegal. In reality, there are really only a few **rare preexisting maternal cardiac conditions** that have a high mortality rate such as Marfan’s syndrome with aortic root involvement, complicated coarctation of the aorta, and peripartum cardiomyopathy with residual dysfunction. Even **cancers** can usually be treated by delaying treatment or using chemotherapies that are less toxic to a fetus. Surgical intervention outside of the uterus can also allow for treatment of cancers in pregnancy.⁵³

It should also be noted that an ectopic pregnancy will inevitably become a miscarriage, as there is no chance the fetus can reach viability in a location such as a fallopian tube, so intervention for this condition always occurs early in pregnancy, and no physician considers this an abortion. Interventions later in pregnancy are more correctly termed “premature parturition.” In these cases, the purpose of delivery is not to kill the fetus, as in elective abortion, but to save the life of the mother, and the life of the fetus, or to save the life of at least one of them. This can be done in such a way, induction or C-section, that the baby can be saved if possible.



With modern surgical techniques, a C-section delivery is usually very safe, even in an extremely sick woman. (One out of three pregnancies in our country are delivered this way.) By comparison, a dilation and evacuation abortion usually

necessitates between one and three days of cervical ripening in order for the surgeon to enter the uterus. If a woman were truly sick enough to need emergent delivery, this much of a delay would only worsen her condition. In addition, a delivery by induced labor or C-section, even if the baby dies during the course of the delivery, allows the woman to mourn, hold, photograph, and bury her baby, if desired. In the event of a fetal abnormality, an autopsy can be performed to assist with counseling for future pregnancies. A dilation and evacuation (D&E) dismemberment abortion, of course, does not allow for any of that. While few OB/GYNs other than high volume late-term abortionists have the clinical skills to commit a late-term D&E, due to its complexity and high incidence of complications, all OB/GYNs can perform inductions or C-sections, thus allowing the woman's own physician to care for her in her distress.⁵⁴

Even late-term abortionists have acknowledged the rarity of late-term abortion to save a woman's life. Dr. Rose Middleman, former medical director of the Pittsburgh Planned Parenthood, stated in 1972, "It's extremely rare, if nonexistent, for a physician to have a medical reason to abort a woman in the 7th or 8th month."⁵⁵ Likewise, abortionist Dr. Don Sloan stated, "If a woman with a serious illness... gets pregnant, the abortion procedure may be as dangerous for her as going through the pregnancy... The idea of abortion to save the mother's life is something that people cling to because it sounds noble and pure—but medically speaking, it probably doesn't exist."⁵⁶

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MYTH 05

“A FETUS DOES NOT FEEL PAIN IN AN ABORTION.”



MYTH #5: “A FETUS DOES NOT FEEL PAIN IN AN ABORTION.”

There is compelling evidence that fetuses in the late second trimester and third trimester do feel pain when they are aborted. The International Association for the Study of Pain defines **pain** as an “**unpleasant sensory and emotional experience associated with actual or potential tissue damage.**”⁵⁷ During a dilation and evacuation (D&E) abortion, there is immense tissue damage as a result of the dismemberment of the unborn human being.⁵⁸ A D&E abortion is the most common method of abortion (95 percent) once the fetus has become fully formed, when the tissue cannot be completely removed solely with suction (starting in the beginning of the second trimester, around 14 weeks).

Generally, a hygroscopic (water absorbing) or prostaglandin (hormonal) cervical dilating agent is placed for one to three days prior to the abortion. When the cervix is sufficiently dilated, the abortionist introduces a suction catheter to remove the amniotic fluid and softer tissue such as the placenta. The size of the fetus and his calcified bones necessitate his extraction manually. This can be done in one of two ways. His legs can be grasped and pulled through the cervix. Usually his body can be delivered this way, but his skull will be too large to deliver through the partially dilated cervix. The abortionist will then introduce an instrument such as scissors into the base of the skull creating an opening. The brain can then be suctioned out, and the skull can be crushed with clamps and extracted. This is called an **intact D&E**, or in layman’s terms, a “**partial birth abortion.**” An alternative method is to progressively dismember the fetus by pulling off his legs and arms and sections of his torso, prior to crushing and removing his skull. This is a **non-intact D&E**, or “**dismemberment abortion.**”⁵⁹

Many state legislatures, including my home state of Texas, have passed legislation limiting this procedure because it is felt to be inhumane, causing an extremely painful death to the fetus, who is an immature living member of the human species. Sadly, the Texas legislation was overturned by a judge who feels that any type of obstacle (**undue burden**) in the path of a woman seeking an abortion is unconstitutional.⁶⁰ Hopefully, the U.S. Supreme Court will someday consider this case, because a strong argument can be made that this legislation is indeed supported by the

Constitution's respect for life, as we discussed earlier.

Opponents of such legislation argue that fetal pain does not occur at the gestational ages between 14 weeks (when the fetal bones are calcified and cannot be removed by suction alone, necessitating a D&E procedure) and the third trimester. However, there is undeniable evidence that the sensory pathways that allow the fetal body to detect and respond to physical pain are functional at these gestational ages.

These opponents argue that this does not qualify as pain because the fetus cannot experience an **emotional response** to the pain. They believe this because they have not found histologic evidence that the neural tracts connecting the thalamus to the cerebrum are fully formed this early (they believe the tracts are not completed until 26-30 weeks), and they assume these tracts are necessary to have an emotional experience in response to pain. This argument is based upon an **extreme interpretation** of what constitutes pain.

They support their position with an oft quoted study which states: "Pain is an emotional and psychological experience that **requires conscious recognition** of noxious stimulus." This **study lacks credibility** because author Susan Lee previously practiced as a National Abortion Rights Action League attorney, and author Eleanor Drey, M.D. was the medical director of an abortion clinic at the University of California, San Francisco. Thus, they had a clear bias. The intent of the study is readily apparent from the first paragraph, where the authors discuss legislative limitations on mid-trimester abortions and discount any concern for the fetus, as they attempt to systematically dismantle all of the observed fetal physiologic responses and attempt to explain how that does not actually represent pain as we know it.

Others have taken this extreme definition a step further, asserting that it does not count as pain unless the fetus has the ability to look back on the experience and feel traumatized. Since he is destined for death, he cannot do this. The logical extension of such a thought process would extend to offering physician assisted suicide, but not pain control or palliative treatment, to terminally ill people, because they also are destined for death.

The first requirement for fetal pain perception is the presence of **cutaneous sensory receptors** (nociceptors), which begin to develop in the peri-oral area at seven weeks, spread to the palms and soles by 11 weeks, to trunk and proximal limbs by 15 weeks, and are present throughout the fetus's entire body by 20 weeks.⁶³ As these sensory neurons develop, the unborn child begins to react to touch.⁶⁴ Early in the process, the pain system is relatively primitive and consists of a **spinal reflex** from a peripheral sensory neuron which detects the noxious stimuli, transmitted to a dorsal horn neuron in the spinal cord, which is then transmitted to a ventral horn motor neuron, which initiates a motor response transmitted to the muscles that causes the fetus to withdraw **from the tissue damage**.⁶⁵

The part of the central nervous system leading from the peripheral nerves to the brain starts developing in the dorsal horn of the spinal cord at 13 weeks.⁶⁶ Connection is made to the brain's **thalamus (midbrain)** between 14-20 weeks.⁶⁷ Early in the second trimester, the fetus reacts to stimuli that would be recognized as painful if applied to an adult human, in much the same

ways as an adult, for example, by **recoiling**.⁶⁸ Fetuses can be seen reacting to intra-hepatic vein needling with **vigorous body and breathing movements, increased heart rate, and increased blood flow to the brain** (these responses do not occur during placental cord insertion needling, where there are no pain receptors).⁶⁹ Increases in levels of **circulating stress hormones and endogenous opioids** (which are independent from maternal levels) can also be measured.⁷⁰ Although the neurons of the cerebral cortex begin development at 8 weeks, and are complete by 20 weeks, it appears that neural connections between the thalamus and the **cerebral cortex** are made starting at 17 weeks, and are fully functional by 26-30 weeks.⁷¹ Electroencephalographic bursts (measuring cerebral activity) are noted in the cerebrum starting at 20 weeks, and have a mature pattern by 30 weeks.⁷²

It is well established in fetal and neonatal anesthesia literature that subjection to a painful stimulus can be associated with **long-term harmful neurodevelopment effects**, such as altered pain sensitivity and possibly emotional, behavioral, and learning disabilities later in life.⁷³ Thus, it is the standard of care to provide **anesthesia for intrauterine surgery** at these gestational ages, and **analgesia for prematurely born neonates** undergoing potentially painful procedures, even if they occur at gestational ages earlier than full thalamocortical functioning is anticipated. In fact, the mortality rate from fetal surgery was noted to drop from 25 percent to 10 percent after routine fetal anesthesia was initiated.⁷⁵ It should be noted that extremely preterm neonates born at the edge of viability (currently around 22 weeks) can be noted to have **cries and facial expressions** that we recognize as resulting from pain (even though they are far younger than we expect for complete thalamocortical connectivity).⁷⁶

Contrary to the assertion that a **fully functioning cerebral cortex** is needed to emotionally process pain, some literature indicates that **only a functioning thalamus** is needed to cause **emotional processing of pain**.⁷⁷ It has been observed that children with hydranencephaly (absence of almost all of the cerebral cortex) exhibit all the responses to painful stimuli we expect of normal children. In fact, sometimes if the diagnosis has not been made antenatally, it may be several months before the condition is diagnosed, because initially the baby exhibits the characteristics we expect of a baby with normal cerebral function. They seem awake and alert, show responsiveness to their surroundings, express pleasure by smiling and laughing and aversion by fussing and crying. They respond differently to the faces of those familiar to them, compared to strangers.⁷⁸ Clearly there is much that science does not understand about how the brain processes emotions.

Neurosurgical clinical data also causes us to question the assumption that the cerebral cortex is primarily responsible for pain perception, because it has been shown that ablation or stimulation of the primary somatosensory cortex (in the cerebrum) does not alter pain perception in adults, whereas **thalamic ablation or stimulation does**.⁷⁹ Interestingly, a 4-D ultrasound study of twin fetuses between 14 and 18 weeks gestation showed movements that appeared to be **intentionally directed** toward the co-twin, showing that social interaction may begin far earlier than previously thought.⁸⁰ We should also consider the possibility that pain perception in the fetus may not use the same pathways as in the human adult, just as it may not in other species, such as the octopus.⁸¹ Many fetal structures are different from those in the adult, and may function in a different way. One example is the fetal mesonephros, which functions to filter blood before the

fetal kidneys develop. Some researchers theorize that at 18-22 weeks, the fetus may experience a **more severe sensation** of pain than older neonates because the **pain modulation system** (which sends inhibitory signals to decrease the body's response to pain) has not yet developed.⁸²

Some advance the theory that “the fetus never experiences a state of true wakefulness in utero, and is kept, by the presence of its chemical environment, in a **continuous sleep-like unconsciousness or sedation**” due to elevated levels of neuroinhibitors.⁸³ This hypothesis is wishful thinking and remains untested. It also fails to explain the “vigorous body and breathing movements” that require paralytics in fetal surgery. They are clearly not a part of the natural sleep state. It is also common sense to understand that having your arm pulled off while you sleep would surely wake you up!

There are many instances in our society in which we take extra precautions to prevent pain even though we do not know whether the recipient is capable of fully experiencing pain. When organs are harvested from a person who has experienced brain death, we administer anesthesia. Prior to undergoing a painful procedure, a person in a persistent vegetative state is given anesthesia. When a convicted murderer is given the death penalty, there is a long list of safeguards to make sure that this individual dies as quickly and painlessly as possible. We have many laws that monitor how animals raised to provide meat should be treated when they are butchered, and many more laws to tell us how we should interact with pets so that they do not experience pain. A conference on pain in laboratory animals noted that “it is imperative to acknowledge that unless it is established to the contrary, we should assume that those procedures that produce pain in us might also produce pain in animals,” and proposes preemptive analgesia in those situations.⁸⁴

Maureen Condit, a neurobiology researcher, has explained that pain and consciousness are complex, and cortical involvement should not be the only consideration. She summarizes the controversy succinctly: “This is not so much a medical ambiguity, as it is an opportunity for us to **consider the kind of society we want to be**. And I think there is sufficient uncertainty to warrant **giving the fetus the benefit of the doubt**.”⁸⁵

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MYTH 06

“ABORTION IS SAFER THAN CHILDBIRTH.”



MYTH #6: “ABORTION IS SAFER THAN CHILDBIRTH.”

The assumption that “abortion is safer than childbirth” was one of the primary arguments that drove the legalization of abortion, and it continues to drive the effort to overturn all legislative safety restrictions on the procedure, both within our country and internationally. Prior to *Roe v. Wade*, abortion advocates frequently cited the number of **5,000-10,000 women** killed per year by illegal abortions. Dr. Bernard Nathanson, one of the founders of the National Association for the Repeal of Abortion Laws, has stated, “How many deaths were we talking about when abortion was illegal? ... when we spoke about (the mass statistics) it was always 5,000-10,000 deaths a year. I confess that I knew the figures were totally false, and I suppose the others did too... but in the morality of our revolution it was a useful figure.”⁸⁶ The American Medical Association documented that in 1950 there were **263** deaths related to illegal abortion, and by 1970 this number had dropped to **119**.⁸⁷ Likewise, the Guttmacher Institute (an abortion research organization started by Planned Parenthood) has published a graph showing the drop in abortion related deaths from **200** in 1965 to **110** in 1967.⁸⁸

BEFORE ABORTION WAS LEGALIZED THERE WERE AN ESTIMATED
98,000 ABORTION A YEAR. AFTER LEGALIZATION, THERE HAVE
BEEN ABOUT 1 TO 1.5 MILLION ABORTIONS PER YEAR.

A septic abortion is a horrible thing, but it did not happen nearly as often as we assume. We have good reason to believe the reported numbers of deaths were accurate, because these deaths resulted from broken laws, and those who enforced the laws were vigilant to detect these deaths. Abortion had been becoming increasingly safer, even before it was legalized, due to advances in medicine, such as **antibiotic use, improved surgical techniques, and anesthesia**.⁸⁹

Contrary to the common assumption of a hack job by a medically illiterate abortionist, 90 percent of “illegal” abortions were committed by physicians, usually by surgical dilation and curettage. Most of the rest were done by nurses, midwives, or those with some medical training. The term “**back alley abortion**” that pro-abortion activists often use as a scare tactic actually refers to the door the women were advised to use to enter the medical clinic, not where the procedure was committed. Although abortion activists claimed that there were over a million abortions yearly prior to legalization, a better estimate is **98,000** a year.⁹⁰ Since legalization, our country has consistently reported about 1 to 1.5 million abortions per year (10-15 times more common than before legalization), so in fact, deaths of women from botched abortions have likely increased, if they were reported accurately. The majority of women in abortion clinics have consistently reported that they would not have sought the procedure if it were illegal.⁹¹

How could an abortion cause a woman to die? Complications that can occur from any abortion procedure include **vaginal or intra-abdominal hemorrhage** (sometimes requiring transfusion), **infection** (endometritis which may lead to septicemia, sometimes requiring hospitalization for IV antibiotics, surgery or ICU support), **incomplete removal of the remains of the aborted baby, damage to the cervix, uterus, or other pelvic or abdominal organs** (sometimes requiring surgery, including hysterectomy or bowel resection to repair), **anesthetic reactions or overdoses, amniotic fluid, septic, or thrombotic embolisms, cardiac or cardiovascular events**, any of which could lead to **death**.⁹² Studies suggest that the immediate physical complication rate of induced abortion may be as high as 11 percent.⁹³ The safety of abortion is determined less by whether it is legal, and more by other factors such as **available technology, gestational age** in which it is committed, and the **skill of the practitioner**.

The frequency of complications increases as the pregnancy advances. The likelihood of complications in **mid trimester abortions** increases due to “inherently greater technical complexity of later abortions related to the anatomical and physiologic changes that occur as the pregnancy advances. The increased amount of fetal and placental tissue requires a greater degree of cervical dilation, the increased blood flow predisposes to hemorrhage, and the relaxed myometrium is more subject to mechanical perforation.”⁹⁴ A late-term dilation and evacuation abortion requires multiple blind passages of the surgeon’s instruments into the uterus, which could easily result in damage to a woman, even in experienced hands.

When most observers consider safety related to abortion, they are thinking of **physical complications** such as these, but they should also consider **psychologic complications**, which can also lead to a woman’s death. One comprehensive study analyzed 22 studies which considered mental health consequences of abortion. There was an 81 percent overall increased risk of mental health problems after abortion. This broke down into 34 percent increased anxiety, 37 percent increased depression, 110 percent increased alcohol abuse, 230 percent increased marijuana abuse, and 155 percent increased suicidal behavior.⁹⁵ A task force in Texas found that of the top causes of maternal deaths in the state, **drug overdose** was second, and **homicide** and **suicide** were also listed among the top seven causes.⁹⁶

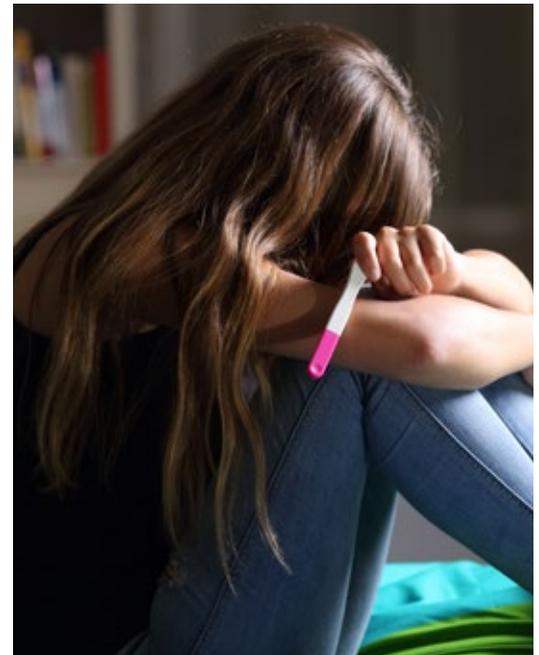
A 2012 study published in a premiere OB/GYN journal supposedly proved that abortion was **14 times safer** than childbirth, which was widely reported. The authors reported that the **death**

rate from abortion is 0.6/100,000 legal abortions, whereas the **death rate from childbirth is 8.8/100,000 live births**.⁹⁷ This study is flawed because it uses four disparate numbers to make its calculations, only one of which can be determined accurately.

The first observation we should make is that the denominators are different, which should immediately invalidate any comparisons. **Abortion deaths** are counted in terms of the **number of legal abortions**, whereas **maternal deaths** are counted in terms of the **number of live births**. Live births are the only one of the four numbers that can be counted accurately, because the government mandates a birth certificate for each child born alive. Yet, this number (live births) does not include a large number of pregnancy events, because all the losses by miscarriage, ectopic pregnancy, abortion, and stillbirth are not included, falsely elevating the numerator because the denominator is lower than it should be. Only 60 percent of maternal deaths occur in conjunction with a live birth.⁹⁸

Our country has recently become aware that we do a very poor job of accurately counting maternal deaths.⁹⁹ For a long time, there was not a standardized way to indicate on a woman's death certificate if she was, or had recently been pregnant, so many deaths related to childbirth were missed. Some studies indicate as many as **50 percent are missed** in that way.¹⁰⁰

When we look at abortion related deaths, we find that both the numerator and denominator are suspect. The estimated number of abortions is **voluntarily** reported to the Center for Disease Control (CDC) by **47** state health departments, but California (which is estimated to commit one quarter to one third of the country's abortions), New Hampshire, and Maryland do not report any data.¹⁰¹ The Guttmacher Institute, the research branch of Planned Parenthood, also keeps track of the numbers of abortions, and their numbers are consistently different (and higher) than the numbers reported by the states.¹⁰² Only half of the states require abortionists to report their complications (and it is debatable whether this is reliably complied with), and no states require non-abortion doctors, coroners, or emergency rooms to report abortion related deaths for investigation. These deaths are counted by the CDC only if they happen to come to their attention through death certificates, anecdotal reports, reports to state health agencies, quality committees, or Morbidity & Mortality committees.



For many reasons, the information about a preceding abortion may not make it onto a **death certificate**. The abortion may have initiated a **cascade of events** resulting in death, but only the most proximate events may be listed on the death certificate. The physician who completes the death certificate may be **unaware** of the abortion (which could happen if a sick woman presents to the emergency room, but leads the staff to believe that it was a miscarriage and not an abortion that led to her complication. If she is too sick to give a history, the family may be unaware of,

or may be embarrassed about the abortion). Lastly, an **ideologic commitment** to legal abortion may lead a physician to leave this information off of the death certificate. A single investigative reporter was able to document 30 percent more abortion related deaths nationwide than the CDC had listed, merely by correlating public documentation of malpractice cases with autopsy reports. Since most women with abortion complications do not initiate a malpractice lawsuit, this number probably represents only the tip of the iceberg.¹⁰³

There are other confounding factors to consider when analyzing abortion or maternal deaths. There is some inconsistency in what **time interval** should be considered: some systems record up to six weeks after pregnancy and some report up to one year. Should all deaths be looked at, or only those related to a **physiologic effect or complication** of the pregnancy or procedure? Some researchers only count deaths related to a **physical complication** such as hemorrhage, infection, or anesthetic complications. But what about **psychologic effects** that are exacerbated by the way the pregnancy was resolved? Grief and depression are common after pregnancy losses and abortion. Should a **suicide** be counted as a maternal death?



It is also intuitive but important to note that early abortions are less dangerous for the mother than later abortions—as the mother’s womb grows, the dangers increase. Although one study found an overall death rate of 0.7/100,000 legal abortions, this number rose to **6.7/100,000 for late-term procedures**.¹⁰⁴ Another study found that the risk of death increased by 38 percent for each additional week beyond eight weeks. Compared to early abortions, the relative risk of death was 14.7 times higher at 13-15 weeks (rate 1.7/100,000 abortions), 29.5 times higher at 16-20 weeks (rate 3.4/100,000), and 76.6 times higher beyond 21 weeks (rate **8.9/100,000**).¹⁰⁵

The **CDC Abortion Surveillance** team has been tasked with protecting the public from dangerous procedures by **tracking abortion-related complications**, but they have been derelict in their duty due to their ideologic commitment to keeping abortion readily available. An investigation in the mid 1990’s found that of 68 upper level employees in this branch, over half (34) were somehow **involved with the abortion industry**, including then chairman, Dr. David Grimes, who wrote the misleading safety study referenced earlier.¹⁰⁶ This team also authored another study which misused statistical analysis to assert that they were successfully identifying at least 90 percent of deaths associated with abortion.¹⁰⁷ Dr. Julie Louise Gerberding, director of CDC, has written “Maternal mortality rates and abortion mortality rates are conceptually different and are used by the CDC for different public health purposes.”¹⁰⁸ It appears that members of her team must be unaware of her comments, as they have insisted upon comparing the two numbers.

An attempt to answer the question of whether abortion is safer than childbirth through a **meta-analysis** (reviewing all available studies) revealed a curious lack of interest by most investigators in the question. Of 989 studies that looked at deaths and pregnancy outcomes, only **11** provided results which allowed comparison between the death rates associated with all possible pregnancy outcomes. Nonetheless, these researchers found that within 180 days, the risk of death is **over twice as high following abortion** compared to that following delivery, and remains elevated for at least 10 years.¹⁰⁹

It is clear with the **incomplete records** available in the U.S., the **political nature** of abortion, and the **ideological commitment** of many academic researchers to legal abortion, that the question of comparative safety of abortion to childbirth is unlikely to be answered in our country. A more complete, and less biased way to look at this question is to perform a **records-linked study** in a country with a more neutral view on legalized abortion, single payer health care so that records on all procedures are readily available, and more complete death certificate documentation. This has been done in Finland. All death certificates on reproductive aged women from 1987-1994 were reviewed, and deaths on non-pregnant, recently delivered, and post-abortive women were compared. The researchers found the opposite of what Dr. Grimes and his CDC colleagues found. A woman who had an abortion was **3.5 times** more likely to die within a year compared to a woman who carried to term. She was **7 times** as likely to commit suicide, **twice** as likely to die of an accident, and **4 times** as likely to be murdered!¹¹⁰

Two follow-up studies from this same data revealed that **94 percent of abortion related deaths, and 73 percent of maternal deaths were not identified from death certificates** alone, showing the clear inadequacy of the CDC's data drawn from death certificates.¹¹¹ The risk of death in a given year for a woman who had an abortion was **83/100,000** Finnish women, non-pregnant **57/100,000**, miscarriage **52/100,000**, and for those who carried a pregnancy to term **28/100,000**.¹¹² The researchers concluded that these findings may be attributed to two causes: giving birth may have a **protective effect** for a woman, and having an abortion may have a **deleterious emotional effect**, leading her to **greater risk-taking activities**.



In the interest of space, we will not delve into the potential association of long term risks related to abortion, but there is compelling evidence that abortion may increase a woman's risk of delivering early in a subsequent pregnancy, causing her future children to be at risk of death from **prematurity** (the number one killer of neonates). When a young woman chooses to abort her first pregnancy, she loses the known **protective effect** of that pregnancy against **breast cancer**

later in life. There are also compelling studies that the abortion itself may leave her breast tissue **more susceptible** to cancers. Though the studies have been mixed, the question has clearly not been answered, yet most medical societies have insisted on no link, and tried to suppress the question. For the reader who is interested in studying the extensive discussion on these issues, please refer to the website of the **American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG.org)**.

Dr. David Reardon has summarized the above discussion well: “We must conclude that ‘abortion is safer than childbirth’ can no longer be characterized as an established fact. It is at best an **unsubstantiated opinion**, most likely a **hope**, and at worst, an **ideologic mantra**. At this time, it is almost impossible to accurately compare deaths related to abortion and deaths related to childbirth in the U.S. due to incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimates, political correctness, inaccurate and/or incomplete death certificates, incompatibility with maternal mortality statistics, and failing to consider other psychologic causes of death, including suicide. When we look abroad, we see a different conclusion, that women are far more likely to die in the year following an abortion than they are following childbirth. This assumption should no longer be the reason for keeping all abortions legal, especially at more advanced gestational ages, when the procedure becomes much more dangerous.”¹¹³

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MYTH 07

“ABORTION IS AN IMPORTANT PART OF
WOMEN’S HEALTH CARE.”



MYTH #7: “ABORTION IS AN IMPORTANT PART OF WOMEN’S HEALTH CARE.”

Pregnancy is a **normal physiologic function**, not a disease state. Interrupting this normal process is not health care. It is a **surgical solution to a societal problem**. The oft quoted statement, “Abortion is between a woman and her doctor” incorrectly assumes that an abortion requires a medical judgment, and will be performed by a woman’s own OB/GYN. A survey of the members of the American College of Obstetrics and Gynecology found that while 97 percent of its members had patients requesting abortions from them, only 14 percent would actually commit the abortion.¹¹⁴ The reality is that while many OB/GYNs profess to be “pro-choice,” very few want to dirty their hands by actually committing an abortion. Most OB/GYNs love caring for unborn babies, and they are uncomfortable with the cognitive dissonance that occurs when they are asked to kill a healthy unborn baby.

THE VAST MAJORITY OF ABORTIONISTS ARE EMPLOYED BY ABORTION CLINICS, NOT HEALTH CARE CLINICS. MOST ABORTIONISTS ARE MERELY TECHNICIANS WHO ONLY PERFORM ONE PROCEDURE FOR MONEY; THEY DO NOT PERFORM ANY OTHER HEALTH CARE SERVICE.

The vast majority of abortionists are employed by abortion clinics, and for many, this is the only medical procedure they do. They are merely technicians performing a procedure for money. In busy clinics, it is not uncommon for an employee to counsel a woman and obtain her consent for the procedure. The abortionist may never even talk with the woman. Sometimes the speculum has already been placed by an employee, so he may never even see the woman’s face. Surely, in this situation, the doctor is not helping a woman to consider all her options. She has made the decision, and he is merely the tool to carry out that decision.¹¹⁵

Since Planned Parenthood commits one third of the abortions in our country, it is instructive to look at their **2016-2017 annual report** to discover what they say about the actual health care services that they perform.¹¹⁶ They report that they committed **321,384 abortions** in the most recent year. (In 2014-2015, the last year that complete national abortion statistics were available from Guttmacher Institute, they committed 323,999 out of the 926,200 reported abortions in our country, which equals **35 percent**.) In 2016-2017, they provided **prenatal care** for **7,762** women, **miscarriage services** for **1,182**, and **adoption referrals** for **3,889**. Statistically, if a pregnant woman walks through Planned Parenthood's door, there is a **96 percent** chance that the pregnancy service she will receive is an abortion. Only 3 percent will receive prenatal care, and less than 1 percent of women will choose to place their babies for adoption, to be raised by a loving family if the woman is unable to do so. We know that 10-15 percent of recognized pregnancies end in miscarriage,¹¹⁷ so one also wonders why they do so little miscarriage management (1 percent)?

While their abortion numbers have consistently gone up, the number of other health services they provide has gone down. They perform far less preventative health services than one might assume. In the most recent year, they performed **235,355 well woman exams**, **336,614 breast exams**, and **281,063 pap tests**. They call these services "cancer screening and prevention," but it should be noted that a breast exam on an asymptomatic reproductive aged woman is extremely unlikely to detect a breast cancer, because it is extraordinarily rare in that situation. None of their facilities perform mammograms, which is the usual diagnostic test for breast cancer. They report 75,040 women "whose cancer was detected early or whose abnormalities were identified." It is likely this consisted almost entirely of early cervical dysplasia, which, although it can progress to cervical cancer, is much more likely to remain stable or regress.

They state that they reduce the numbers of abortions by providing contraception, but when one looks critically at the contraceptive services they provide, one sees that **730,329 (27 percent) of the 2,701,866 contraceptive services** they provide are **emergency contraception (EC)**. "Morning after pills" like Plan B, the most commonly used form of emergency contraception, don't work very well! Their only mechanism of action is to **delay ovulation**. If a woman has unprotected intercourse, and is due to ovulate tomorrow, EC will reduce the risk of pregnancy by delaying ovulation for a few days. But if she happened to ovulate yesterday, EC does almost nothing, and the risk of pregnancy is about 10 percent. If they are distributing ulipristal as an emergency contraception instead, then they may be causing early abortions, because this medication is related to misoprostol (RU486), the abortion pill. Allowing the public to be misinformed on the mechanism of action of EC is likely to increase pregnancy rates (by encouraging couples to engage in intercourse even though they have no protection available).

It is often reported by an uncritical media that only 3 percent of their services are abortion. If a woman presents for an abortion, she is also going to have several other discrete services performed: pregnancy test, sonogram, STD testing, and possible pap, as well as provision of birth control afterward. Thus, abortion is only 17-20 percent of the services provided to this woman, but an abortion is why she came. It is easy to see how counting every individual service, when most women have multiple services provided each visit, can dilute out the numbers and make it look like abortion is only a small part of what they do. The reality is that **321,384 abortions**

is greater than 281,063 pap tests. It is easy to see the primary purpose for this organization's existence.

Planned Parenthood reports \$1.36 billion in expenses from July 2016 to June 2017, of which \$822 million was spent on medical services and \$47.9 million on sexuality education. Meanwhile, \$198.2 million was spent on “**public policy, engaging communities, promoting health equity, movement building, deploying 21st century technology, and strengthening and securing the organization.**” That sounds to me like activity designed to shore up the organization's political power. Meanwhile, they received **\$543.7 million from government health services reimbursements and grants (taxpayer's money)** and \$523.7 million from private contributions and bequests.

These numbers make it clear that Planned Parenthood lobbies and supports politicians to advance its interests. That is clearly seen in the annual report as it discusses their opinions on many political issues. Many organizations do likewise through political action committees. But this annual report seems to indicate that the money that keeps this organization afloat is immersed into one pool. They are fighting mightily to keep tax payer dollars coming to their organization (37 percent of their revenue), but only 60 percent of expenses go toward medical services. It appears that they spent almost \$200 million to make sure the money keeps flowing to them.

THE HEALTH CARE SYSTEM DOES NOT NEED PLANNED PARENTHOOD. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) OUTNUMBER PLANNED PARENTHOOD CLINICS 20 TO 1.

What happens if women do not have access to a Planned Parenthood? Although we are often told that women rely on them for their health care, there are many alternatives to this organization that provide the same services, and more. **Federally Qualified Health Centers (FQHCs)** also receive state and federal money to provide indigent care, and they provide every service that Planned Parenthood does, except abortion. In addition, they employ practitioners who specialize in other health problems. A woman is more than a uterus, and she often has other health issues that can be addressed in a more comprehensive way by an FQHC. While the number of Planned Parenthood clinics in our country has dropped to 620 as of August 2017, there are 13,540 FQHCs. They outnumber Planned Parenthood clinics **20 to 1**.

There are several services FQHCs provide that Planned Parenthood does not: **mammograms and immunizations; screening for diabetes, cholesterol, cardiovascular disease, and thyroid function; eye, ear, and dental screenings, as well as preventative dental services, well child services, medical nutrition services, and bone density measurements; social work, mental health and substance abuse services, and some emergency medical services.** Clearly, they care not just for the woman, but for her whole family. If the half billion dollars that Planned Parenthood gets were instead given to FQHCs, these organizations could continue to grow and serve more clients.¹¹⁸

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MYTH 08

“MOST AMERICANS SUPPORT ABORTION ON DEMAND.”



MYTH #8: “MOST AMERICANS SUPPORT ABORTION ON DEMAND.”

In the lingo of the current dysfunctional political climate, it is considered a “war on women” to impose any restrictions that might limit access to abortions. It is implied that all those who support any limitation on abortion would like to see *Roe v. Wade* overturned and for abortion to become illegal in every instance. It seems those who advocate for legal abortion must resist mightily any legislation that attempts to regulate the industry. But the reality is that **most Americans do not inhabit these extremes**. The majority of Americans are willing to allow abortions in certain clearly defined circumstances, but almost all prefer some limits on the procedure of abortion.

ONLY 29 PERCENT OF AMERICANS BELIEVE THAT ABORTION SHOULD BE LEGAL IN ANY CIRCUMSTANCE, WHICH IS WHAT CURRENT LAW ALLOWS.

It is interesting to track Gallup survey results on abortion since its legalization. Consistently, most Americans favor **allowing abortion in some situations, but with restrictions** (54 percent in 1975, **50 percent** now). A smaller proportion feel that it should be legal in any circumstance (as allowed by *Roe v. Wade*—22 percent in 1975, **29 percent** now), and an even smaller group would like for it to **be illegal in all** circumstances (21 percent 1975, **18 percent** now). Undoubtedly, if *Roe v. Wade* were overturned, and the question of abortion was returned to the states to legislate, we would still have legal abortion available, but in more limited situations. Interestingly, more Americans today consider abortion to be **morally wrong** (49 percent) than **morally acceptable** (43 percent).¹¹⁹

ACCORDING TO THE LAST 40 YEARS OF POLLING, THE MAJORITY OF AMERICANS CONSISTENTLY SUPPORT RESTRICTIONS ON ABORTION, INCLUDING A 24-HOUR WAITING PERIOD, INFORMED CONSENT, ALTERNATIVE COUNSELING, PROHIBITING PARTIAL BIRTH ABORTIONS, AND MORE.

In addition, the majority of Americans have consistently supported the following restrictions: a **24-hour waiting period, parental consent, spousal notification, informed consent, alternative counseling, prior ultrasound, and prohibition of “partial birth abortions.”** While most favor allowing abortion to save the life and physical or mental health of the mother, in the cases of severe physical or mental abnormalities in the child, or in the cases of rape and incest, only **36 percent** felt it should be allowed for **financial reasons**.¹²⁰

Americans become even more squeamish about abortion as the pregnancy progresses past the first trimester. The last time Gallup asked the question (2012), **64 percent** wanted the procedure **to be illegal in the second trimester**, and **80 percent in the third trimester**.¹²¹ In 2017, 67 percent of those polled were in favor of some restrictions on the procedure.¹²² Similarly in a 2017 Pew poll, 73 percent favored some restrictions on late-term abortions.¹²³ Although abortion is commonly classified as a woman’s issue, one Marist poll found that **82 percent** of women “would restrict abortion—at most—to the first three months of pregnancy.”¹²⁴ With the widespread availability of ultrasound pictures in physician’s offices and on YouTube, most Americans have seen what I see daily in my work as an obstetrician: a fetus beyond the first trimester is easily identified as a young human being.¹²⁵

Finally, it’s important to point out that the lack of significant abortion restrictions in the U.S. is not mirrored by the rest of the world. Of 198 countries, only 59 (29 percent) allow abortion on demand (no reason needed). Only seven allow abortion past **20 weeks (3 percent): China, North Korea, Vietnam, Canada, the Netherlands, Singapore, and the U.S.** In fact, we are second only to China in total number of abortions in the world (and they are forcibly aborting many of their children!). Only six other countries allow abortion between 12-20 weeks. The rest (45) allow abortion only at 12 weeks or below. Think about that: only 6 percent of the countries in the world allow abortion after the first trimester.¹²⁶ We consider ourselves the **champion of human rights** throughout the world. How did we become part of this **nefarious group**?



NOTES

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MYTH 09

“GOVERNMENT HAS NO RIGHT TO BE INVOLVED IN THE LEGISLATION OF ABORTION.”



MYTH #9: “GOVERNMENT HAS NO RIGHT TO BE INVOLVED IN THE LEGISLATION OF ABORTION.”

In order to determine whether government should be able to legislate the procedure of abortion, we must first ask the question: what is the **function of government**? One common source asserts that the first aim of government is to secure the right to life, which includes the safety of fellow citizens, allows for the exercise of liberty, and provides the conditions upon which men may pursue happiness.¹²⁷ How the citizens pursue happiness is an end that is entirely private, and beyond the competence of government.

Given our previous discussion, there are several obvious ways in which government regulation of abortion can determine these ends. The government has the responsibility to **protect the life of its citizens, including those not yet born**. Our country already has laws that reflect this, most prominently in the *Unborn Victims of Violence Act*, which recognizes an unborn child as a legal victim if they are injured or killed.¹²⁸ We have also noted how the procedure of abortion is physically and psychologically dangerous. At an absolute minimum, the government has the **responsibility to ensure that this elective procedure is performed in a way that reduces the risks to the mother. But it must be recognized that a truly “safe” abortion is impossible, of course, because it involves the killing of a human being.**

At the very least, governments can require that the providers are competent, the facilities are clean and prepared to handle emergencies, and the women are well counseled. The government should ensure that women considering an abortion are **aware of the risks**. The government should also insure that the woman is made aware of the benefits of all the other options they have when they find themselves facing an unintended pregnancy. Those who think that legislation is unnecessary because these things routinely occur need look no further than the trial of Dr. Kermit Gosnell.¹²⁹ He was a notoriously incompetent abortionist, but others like him continue to operate. Operation Rescue details this horrifying reality by cataloguing the gruesome deaths of many American women since legal abortion became widespread.¹³⁰

Many are familiar with the statement, “You can’t legislate morality.” This is only partially true. We frequently legislate activities that are related to morality when the **actions are likely to harm another human**. Murder, rape, and assault restrictions; drug, prostitution, and gambling prohibitions; even traffic regulations; all restrain the “free will” actions of some people in order to benefit others who may be adversely affected by those actions.

As mentioned, how a woman elects to **pursue happiness** is beyond the scope of government regulation, but what is not beyond the government’s scope is the duty to protect the lives of its most vulnerable citizens—unborn children—by enacting constitutional laws.

NOTES

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A woman with long hair is seen from behind, looking out a window. The scene is dimly lit, and a heavy purple overlay covers the entire image. The woman's hair is dark and falls down her back. The window shows a blurred outdoor scene with some greenery and a building. The overall mood is contemplative and somber.

MYTH 10

“ABORTION ON DEMAND HAS MADE
WOMEN’S LIVES BETTER.”



MYTH #10: “ABORTION ON DEMAND HAS MADE WOMEN’S LIVES BETTER.”

If women are not better off when they choose abortion, then why do we recommend, encourage, and sometimes coerce women into choosing this option?

In the past 45 years, the lives of 60 million unborn humans have been forcibly ended in our country. This number should give anyone pause, no matter their views on abortion. It has been said, “One death is a tragedy. A million is a statistic.” Imagine how each abortion has impacted the woman who found herself in a situation where she felt that ending the life of her unborn child was her best, or only, option.

We frequently hear that a woman must be able to control her own body, including terminating the life of the fetus residing there, in order to control her own destiny. One abortion rights activist stated, “Abortion is necessary to free women from historically routine conscription into maternity.”¹³¹ Certainly, thinking about “**motherhood as slavery**” is a pessimistic view of a woman’s unique ability to bear and nurture children, but is it true? Has the ability to terminate an undesired child led to improvements in the lives of women over the past 45 years?

By many parameters of success, of course, women’s lives have improved over the last four decades. Many women have received advanced degrees and are very successful in their chosen careers. Women hold many positions of power in our government, they are presidents of many universities, and executives of many companies. **Yet, there is no direct correlation between any of these gains and legalized abortion.** Virtually all progress in legal, social, and employment rights has come about through federal or state legislation and judicial interpretation unrelated to legalized abortion. This progress includes legal protections regarding job discrimination, pregnancy discrimination, equal pay, educational equity, sexual harassment, maternity coverage, maternity leave, medical leave, domestic violence, and sexual assault.¹³²

Despite these positive changes, we see that many of the **societal issues** that legalized abortion was supposed to solve have actually become more common. How might this happen? Let's examine how the unrestricted sexuality that abortion enables may harm a woman. Although sex outside of marriage is nothing new, it has definitely become more common since the “sexual revolution” of the 1960's, which coincided with the legalization of contraception and abortion. These changes reduced a woman's ability to withhold premarital sexual favors from men. Whereas once, the fear of an out of wedlock pregnancy was enough to provide a strong motivation for a couple to abstain from intercourse, now that excuse is no longer valid.

The easy access to contraception and abortion has led to a dramatic increase in **promiscuous sexual activity** with related **unintended pregnancies** and **sexually transmitted infections**. Sex while dating casually, or for recreation, has become the norm. Despite the reassurances about “safe sex,” contraception frequently fails, and half of unintended pregnancies are conceived while a couple is using some method of contraception. Likewise, sexually transmitted infections (STIs) are extremely common. The CDC estimates that one in four sexually active young women has an STI, such as chlamydia or human papillomavirus.¹³³

The vast majority of women (80-95 percent¹³⁴) still desire to marry and have children.¹³⁵ Sadly, if a woman has contracted an STI such as chlamydia (of which over one million cases were reported in 2016¹³⁶) during her years of non-monogamous sexual activity, she may have trouble conceiving a desired child later, due to tubal damage. Years spent obtaining an education and establishing a career often lead to a delay in forming a serious relationship. This may place a woman in a bind when her fertility begins to wane in her mid to late 30's. At that point there may not be a serious candidate for marriage and fatherhood in her life, so she may choose to have a child alone, or she may remain unintentionally childless.

Or, a woman may become accidentally pregnant during a casual relationship, and her boyfriend may see the ready availability of abortion as a quick fix. In the past, an accidental pregnancy often led to a couple reevaluating a superficial relationship, and more often than not, they committed to seeing the pregnancy through and raising the relationship to the next level. But with the ready accessibility of abortion, this is no longer necessary. Six hundred dollars later, the problem has been “taken care of,” and the commitment is often not made. Sadly, studies show that this action often marks the end of the relationship. A woman may succumb to pressure to end a pregnancy “until a better time.” But the guilt and grief that often accompany that decision are likely to tear the relationship apart.¹³⁷



THE RHETORIC OF “HER BODY, HER CHOICE...” IS OFTEN INTERPRETED BY MEN AS “HER PROBLEM, NOT MINE...”

If a woman chooses to continue an unintended pregnancy, her boyfriend may feel he has no responsibility because she had another option but chose not to use it. The rhetoric of “her body, her choice...” is often interpreted as “her problem, not mine...” The insistence that men have no right to express opinions about the subject of abortion has likely led to many men feeling distant and unsympathetic to the plight of a pregnant woman, and also may lead them to believe they have no responsibility as a father. What was once a beautiful bonding experience for a couple has become a lonely, solitary task for many women. Society has placed the responsibility of childbearing solely on the shoulders of the mother. Men have been removed from the decision of whether to bring a child into the world, and an increase in fatherless children is the result. The dark side of women’s “bodily autonomy” is isolation and loneliness for far too many women and their children.^{138 139}

One more fact to acknowledge is that sex outside of a relationship, and abortion itself, are both actions that are contrary to a woman’s biology. The female body is beautifully designed to create and nurture a human life, performing a vital function without which the human species would be unable to continue. A woman’s body is also hormonally predisposed to bond with the one with whom she has sexual intercourse. Pheromones and estrogen attract a couple to each other. Oxytocin and prolactin are released during the act of intercourse, resulting in the formation of an intense bond with her partner. Dopamine causes a pleasurable emotion that makes the couple want to repeat the sexual act over and over. This influences the couple to stay together and care for any children that result from their union. Denying this biology, and encouraging the participants to enjoy the act for entertainment outside of a relationship, causes harm in many ways.¹⁴⁰

If there was hope that available abortion would reduce **divorce rates** by avoiding “shotgun weddings” of couples ill-suited to **marriage**, then we see that abortion did not deliver as promised. The divorce rate doubled shortly after abortion was legalized, from 2.5/1000 people in 1970, to 5/1000 in 1980.¹⁴¹

The divorce rate is finally starting to improve (it is now around 3/1000), but for a depressing reason.¹⁴² Many young people are choosing **not to marry** instead. Marriage rates have dropped from 12/1000 in 1970, to 7/1000 in 2010. Meanwhile, **cohabitation** has increased from 500,000 to 8 million. Couples who choose to raise their children without the bond of marriage are more likely to separate, and if they do eventually marry, their divorce rates are 33 percent higher.¹⁴³

Though abortion might be expected to lower the number of **illegitimate births**, we have actually seen the opposite. The number of births to unmarried women has increased from 10.7 percent in 1970, to 28 percent in 1990, to 40 percent in 2014.¹⁴⁴ We know that a child raised by a single parent suffers both short and long-term economic and psychologic disadvantages.¹⁴⁵ Families

headed by **single mothers** have five times the poverty rate than that of married couples. The percentage of children now living with a single parent has risen in every demographic category. The rate for black children has risen from 35 percent in 1970 to 54 percent in 2014, Hispanic children from 18 to 29 percent, white children from 10 to 19 percent, and Asian children from 10 to 13 percent.¹⁴⁶ Thus, the number of children living in **poverty** has increased from 15.1 percent in 1970 to 21 percent in 2014.¹⁴⁷

Overall, we have seen an increase in the number of **unintended pregnancies** since abortion was legalized, and this has been particularly striking in the teen population. The number of **teen pregnancies** more than doubled from 4.9 percent in 1972 to 9.92 percent in 1990.¹⁴⁸ Abortion increased from 2 percent of teenagers in 1972 to 4.4 percent in 1990, while the number of **teen births** increased from 2.3 percent to 4.2 percent. Thankfully, we have seen a downward trend since then, although the U.S. still has some of the highest teen pregnancy rates in the developed world.¹⁴⁹

Unfortunately, we've also seen more women **relying on abortion as a form of birth control**. The **repeat abortion** rate has tripled from 15 percent to 43 percent, and half of women who present for an abortion report they were not using any birth control when they became pregnant.¹⁵⁰

We have also seen **domestic violence** against women rise.¹⁵¹ It is estimated that three women are murdered every day in our country by their current or former partners, and that one out of four women will be the victim of domestic violence in her lifetime.¹⁵²

Avoiding the birth of unwanted children was supposed to decrease **child abuse**. Yet, the number of reported cases of child abuse has increased tremendously, from 167,000 in 1973 to more than 3 million today.¹⁵³ Guilt, poor self-esteem, and lack of social support are common attributes in women who have had abortions and are also commonly associated with child abuse.¹⁵⁴

The children who experience domestic violence may become violent themselves. The rate of **juvenile violent crime arrests** has doubled, from 215.9 arrests per 100,000 people in 1970 to 430.6 arrests per 100,000 people in 1990.¹⁵⁵



Infanticide should have become nonexistent, since women could now rid themselves of unwanted infants prior to birth. Yet, rates of infanticide have increased from 4.3/100,000 in 1970 to 7.2/100,000 in 2013.¹⁵⁶ The last 45 years have resulted in lower childhood death rates for almost every cause, except one. **Homicide** was the only leading cause of childhood death that increased in that period, and our country ranks seventh in the world in child homicide.¹⁵⁷ Is it possible that our decreased respect and protection for a child in the womb has led to devaluing the lives of our born children as well?

There are many men who benefit from easy access to abortion. An abortion is the obvious way to avoid detection of an illicit sexual encounter, whether it be an **extramarital affair**, the consequences of a **power or age imbalance**, **incest**, or **sex trafficking**. A woman or a minor who receives an abortion in this situation, without any other social service intervention, has been done a great disservice. The assumption that young teenagers can and should be sexually active can prevent the discovery of incest and abuse. Abortion allows sex crimes to be covered up more easily, which can lead to the perpetrator escaping the consequences of their crime.

Ethicist Daniel Callahan summarized the response of men to readily accessible abortion succinctly: “If legal abortion has given women more choice, it has also given men more choices as well. They now have a potent new weapon in the old business of **manipulating and abandoning women**.”¹⁵⁸

It appears many abortions are not freely “chosen.” Often the decision to terminate is influenced by **partner abandonment**, **family pressure**, or **outright coercion**. In a recent survey of post-abortive women, 58 percent said that they had their abortions in order to “make others happy,” with over 28 percent saying they had the abortion because “they feared their partner would leave them” if they did not. Perhaps most heartbreaking is that 66 percent of women “said they knew in their hearts that they were making a mistake when they underwent the abortion.”¹⁵⁹

Sadly, the **murder of pregnant women** has become increasingly common. We can get insight into this when we consider the possible reaction of a narcissistic, violent man to an unintended pregnancy. If a woman doesn’t want to have a baby, she has the choice of an abortion. If a man doesn’t want a baby, he can’t do anything about it. He is “stuck” with the child, child support, and the woman, possibly for the rest of his life. He may come to the conclusion that if she goes away, the problem goes away. Homicide is the leading cause of death in pregnant women.¹⁶⁰

**MINORITY GROUPS ARE
DISPROPORTIONATELY
AFFECTED BY ABORTION.**

These consequences of abortion **disproportionately affect minority groups**. There is much discourse in our country today about the reasons that many young black people are suffering. It is beyond the scope of this discussion to comment on the many possible reasons for this, but let’s look at some relevant demographic facts. In 1960, only 22 percent of black children were raised in single parent families. After the expansion of welfare programs, it rose to 37 percent in 1970. Today, more than 70 percent of black children are raised by only one parent, usually the mother. Although 37 percent of black families headed by a single woman live in poverty, only 8 percent headed by a married couple do.¹⁶¹ One significant factor that has occurred in the time period in which we have seen the dissolution of the black family is the widespread legalization and availability of abortion.

Black women are **overrepresented in women that have abortions**. Although they represent only 12 percent of the U.S. population, they obtain 37 percent of the abortions in our country.¹⁶² Half of all pregnancies black women conceive are aborted. Black women are also more likely to have a late abortion. The risk to a black woman continues beyond the current pregnancy. Black women are more likely to have premature babies, develop breast cancer, and experience mortality in pregnancy, all of which have been linked to a history of abortion.¹⁶³

The same groups that noisily object to government regulation of abortion are usually insistent that the government sponsor social programs to enhance the well-being of the groups previously discussed: minorities, those in poverty, and broken families. Would it be possible to consider that the great experiment of abortion on demand in our country has worsened the conditions for these unfortunate Americans and support walking back this policy for the good of women and our country?

To close, here are some eloquent thoughts by two women who have bravely taken a deep look into the issue of abortion. Frederic Mathewes-Green, a pro-life feminist has stated: “For the question remains, do women want abortion? Not like she wants a Porsche or an ice cream cone. Like an animal caught in a trap, trying to gnaw off its own leg, a woman who seeks abortion is trying to escape a desperate situation by an act of violence and self-loss. Abortion is not a sign that women are free, but a sign that they are desperate.”¹⁶⁴

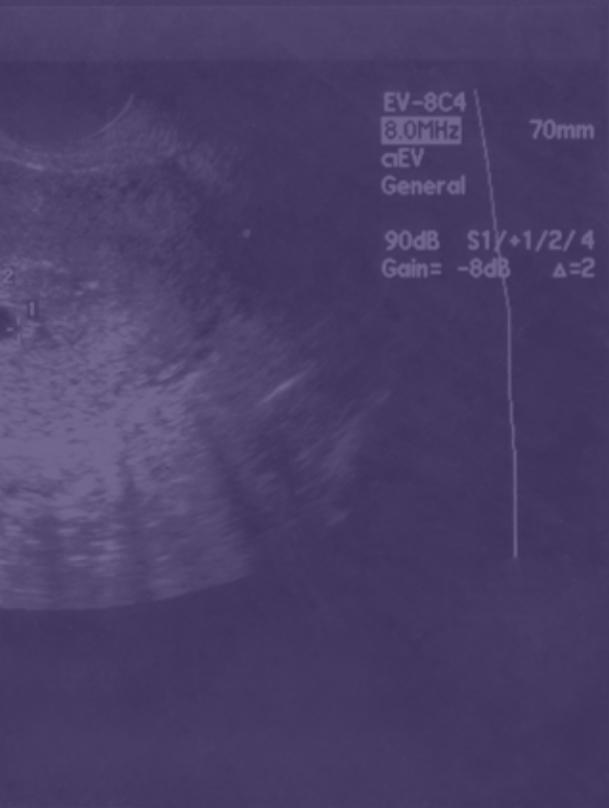
Likewise, pro-choice advocate Naomi Wolf has been willing to look at some of the complexities that legal abortion has created. Here is an outline of some of her more compelling statements (but consider committing the time to read her full essay). She takes pro-choice feminists to task for “refusing to look at abortion within a moral framework ... We stand in jeopardy of losing what can only be called our souls ... We risk becoming precisely what our critics charge us with being: callous, selfish and casually destructive men and women who share a cheapened view of human life ... Some feminists developed a rhetoric that defined the unwanted fetus as at best valueless: at worst an adversary, a ‘mass of dependent protoplasm’. Yet that has left us with a bitter legacy. For when we defend abortion rights by emptying the act of moral gravity, we find ourselves cultivating a hardness of heart ... If we avidly cultivate love for the ones we bring to term, and ‘get over’ our love for the ones we don’t, do we not risk developing a hydroponic view of babies—and turn them into a product we can cultivate for our convenience? ... How can we charge that it is vile and repulsive for pro-lifers to brandish vile and repulsive images, if the images are real? To insist that the truth is in poor taste is the very height of hypocrisy ...”¹⁶⁵

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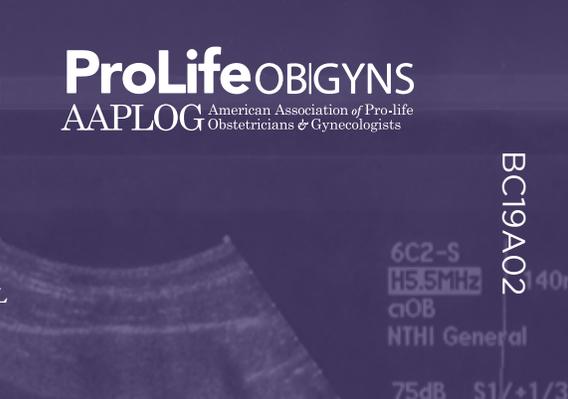
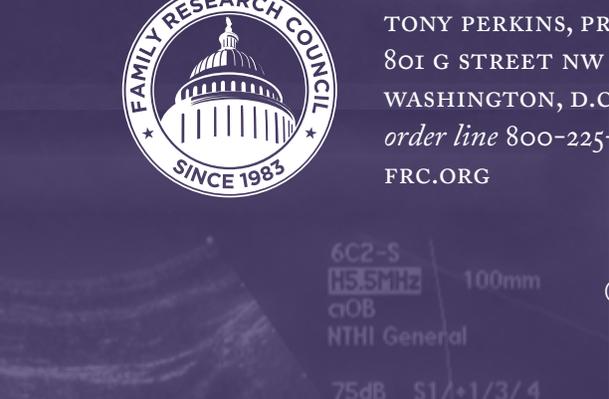
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