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Abortion Is Not Health Care

by Mary Szoch, M.Ed. and Ingrid Skop, M.D.

Key Points

Abortion uses medical procedures to end human life rather than sustain it.

Abortion targets historically disadvantaged groups: women, minorities, and those with disabilities.

Abortion activists have ignored medical developments over the past 50 years, arguing that qualified surgeons, regulated facilities, sonographic documentation, laboratory evaluation, and consideration of fetal pain capability are all unnecessary actions.

Summary

As government officials debate the issue of funding abortion, the question, "Is abortion health care?" is consistently at the forefront of the discussion. However, "health care" itself is rarely, if ever, defined—thus, making it difficult to determine if abortion fits the definition of health care. While the American Medical Association (AMA) does not define "health care," the AMA does define the type of health care for which physicians should advocate. This paper examines whether abortion fits these seven criteria defining the type of health care for which physicians should advocate. After exploring the historical events surrounding the *Roe v. Wade* Supreme Court decision, political and judicial action since then, the scientific data on abortion, and the medical advances since the 1970s, it is clear that abortion does not fit a single component of the criteria defining the type of health care for which physicians should advocate.

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What Is Health Care?

Is abortion "health care"? Is it something for which medical professionals should advocate?

How you answer that question likely depends on your definition of "health care." The dictionary defines health care as "the field concerned with the maintenance or restoration of the health of the body or mind."[1] Proponents of abortion argue that abortion fits this definition; opponents argue that it does not. According to the American Medical Association, both individually and professionally, physicians should advocate for health care that:

1. Is transparent,
2. Strives to include input from all stakeholders, including the public, throughout the process,
3. Protects the most vulnerable patients and populations, with special attention to historically disadvantaged groups,
4. Considers best available scientific data about the efficacy and safety of health care services,
5. Seeks to improve health outcomes to the greatest extent possible, in keeping with principles of wise stewardship,
6. Monitors for variations in care that cannot be explained on medical grounds to ensure that the defined threshold of basic care does not have a discriminatory impact, and
7. Provides for ongoing review and adjustment in consideration of innovation in medical science and practice to ensure continued, broad public support for the defined threshold of basic care.[2]

What constitutes "maintenance or restoration of the health of the body or mind" is somewhat subjective. However, these seven criteria provide an objective means of assessing whether abortion fits the definition of health care for which physicians should advocate.

I. Is There Transparency Surrounding Abortion?

When it comes to abortion's health risks and related medical statistics, transparency is close to nonexistent.

Claims Made by the Pro-Abortion Movement

According to the largest abortion business in the United States, Planned Parenthood:[3]

> In-clinic abortion is a very safe, simple, and common procedure. Serious problems are really rare, but like all medical procedures, there can be some risks.[4]

Planned Parenthood goes on to assure patients:

> Serious complications are really rare, but can happen. These include:
>
> - the abortion doesn't work and the pregnancy doesn't end
> - some of the pregnancy tissue is left in your uterus
> - blood clots in your uterus
> - very heavy bleeding
> - infection
> - injury to your cervix, uterus or other organs
> - allergic reaction to medication
>
> These problems are really rare, and they're usually easy to treat. … Unless there's a rare and serious complication that's not treated, there's no risk to your future pregnancies or to your overall health. Having an abortion doesn't increase your risk for breast cancer or affect your fertility. It doesn't cause problems for future pregnancies like birth defects, premature birth or low birth weight, ectopic pregnancy, miscarriage, or infant death.[5]

Perhaps most importantly, Planned Parenthood claims that abortion will "take a pregnancy out of your uterus."[6] However, the U.S. Department of Health and Human Services defines pregnancy as "the period in which a fetus develops inside a woman's womb or uterus."[7] It is nonsensical to say a period of time can be removed from a uterus; Planned Parenthood is using the word "pregnancy" as a euphemism for an unborn child.

Since Planned Parenthood stands to profit from a woman's decision to have an abortion, its statements meant to allay women's fears about acquiring one are hardly trustworthy. Other groups making positive claims about abortion include NARAL Pro-Choice America, which states:

> Medication abortion care is a safe, effective, and FDA-approved option for ending an early pregnancy. The FDA's in-person dispensing restriction disproportionately harms people of color and those with low incomes.[8]

And:

> The right to choose abortion is essential to ensuring a woman can decide for herself if, when and with whom to start or grow a family. We'll never stop fighting to protect and expand this fundamental human right.[9]

The American Civil Liberties Union (ACLU) states, "Abortion is already extremely safe—99 percent safe, according to the Centers for Disease Control [CDC]."[10] Notably, the ACLU does not cite the theoretical CDC study declaring abortion "99 percent safe."

Some of the claims pro-abortion organizations make are easily refuted. For example, it is medically and scientifically impossible for a pregnancy (*i.e.*, a period of time) to be taken out of a uterus. Other claims, such as whether abortion is safe, are more difficult to challenge because accurate data on

abortion in the United States is non-existent.

A Lack of Abortion Data

The total number of legal abortions in the United States—and their resulting complications and deaths of women—is unknown.[11] All we have are estimates, and those estimates are based on numbers voluntarily reported to the CDC by state health departments. Notably, the state with the largest number of abortions, California, does not report any data to the CDC.[12] The Guttmacher Institute (GI) also tracks abortion numbers, and they consistently report higher totals than the states do. For example, in the most recent year calculated, the states reported 619,591 abortions,[13] whereas GI reported 862,320.[14] Furthermore, only 28 states require abortion businesses to report their complications, but there is rarely an enforced penalty for noncompliance.

In addition to this stunning lack of data regarding abortion complications, states exhibit a lack of curiosity about who is having abortions, why these women are having abortions, and when. In the United States, only:

- 16 states require businesses to give some information about the woman's reason for seeking an abortion.
- 10 states ask if the abortion was sought due to a threat to the mother's health.
- Eight states ask if the abortion was sought due to rape or incest.
- Six states require abortion businesses to report whether the baby was viable.
- Six states require abortion businesses to report the stage in pregnancy the abortion took place.[15]
- Nine states ask if the abortion resulted in a live birth.[16]

In the absence of accurate, reliable reporting, it is essentially impossible to determine if abortion is safe

for women in the United States. Any assertion to the contrary is based largely on subjective opinions, with little objective verification from external sources.

Medical professionals must ensure that real health care is transparent. They should call for reporting requirements, improved studies, and objective estimates of complications and deaths resulting from both legal and illegal abortion. Additionally, they should call for abortion businesses to provide accurate information to women. Until there is real data and an accurate transmission of information to women, it is impossible to claim abortion is a transparent practice.

II. Does Abortion Policy or Law Strive to Include Input from All Stakeholders, including the Public, throughout the Process?

Abortion policy does not include feedback from all stakeholders, which includes the general public, the medical community, state legislators, and survivors of abortion.

How Abortion Became Legal

It is important to note that *Roe v. Wade* and *Planned Parenthood v. Casey* were U.S. Supreme Court decisions, not laws made by elected representatives of the American people. In both cases, nine members of the Court overruled state legislation and decided the fate of abortion law that would govern all Americans.

In 1973, the Court ruled in *Roe v. Wade*, and its companion case, *Doe v. Bolton*, that the U.S. Constitution protects abortion. In its decision, the Court created a trimester framework for determining the legality of an abortion. During the first trimester, states could not restrict abortion at all. During the second trimester, states could restrict abortion to protect a woman's health. During the third trimester, states could completely outlaw abortion—except when necessary to preserve the life or health of the mother. This health exception has been loosely interpreted to allow any mental health

claim as sufficient reason for an exception to a state's third trimester restrictions. As a result of *Roe*, individual states may pass laws restricting abortion in the second or third trimester, but the default nationally is that abortion is legal through all nine months of pregnancy.[17]

The 1992 *Planned Parenthood v. Casey* decision did away with *Roe*'s trimester framework and instead created a new rule that a state cannot impose an "undue burden" on a woman's attempt to obtain an abortion pre-viability. As in Texas' *Whole Woman's Health v. Hellerstedt* case, this rule has been loosely interpreted to negate states' efforts to impose any safety restrictions. Pro-abortion advocates have argued that safety restrictions impose an "undue burden" on women because some abortion facilities cannot afford the safety upgrades necessary to stay open.

A Lack of Feedback from the Medical Community

If abortion were health care, one would expect that the medical community would have been a major proponent of its legalization. However, this was not the case.

In the years leading up to the *Roe* decision, the American Medical Association was not largely involved in promoting abortion. In fact, the national AMA was not involved in leading the abortion expansion charge at all. The American Law Institute worked to pass 10 statutes between 1967 and 1969 that expanded state abortion laws to include exceptions for physical and mental health, as well as rape, statutory rape, incest, and fetal anomaly. AMA affiliates only played a role in passing this legislation in five states.[18] Abortion expansion was not a top priority for the AMA.

There was great concern within the medical community that the repeal of abortion laws would diminish the role of the doctor. In a debate at the AMA regarding an expansion of abortion policy, AMA House of Delegates member Edward Kilroy prophetically argued, "It [legal abortion] makes the patient truly the physician: she makes the diagnosis and establishes the therapy."[19] Even pro-abortionist Dr. Alan Guttmacher had concerns that doctors would be reduced to acting as "a rubber stamp."[20]

In 1970, the AMA expanded its policy on abortion, stating that abortion should be between a woman and her doctor. However, this policy also stipulated that a doctor should not provide abortions in "mere acquiescence to the patient's demand."[21] The AMA did not intend for abortion on demand to become the law of the land, for abortion to be declared a woman's right, or for the role of physician and patient to be confused.

In 1971, abortion rights attorneys asked the AMA to submit an amicus brief as part of the *Roe v. Wade* case. The AMA declined, evidence of the medical community's lack of support for the expansion of abortion.[22] The central tenets of *Roe,* which legalized abortion through all nine months of pregnancy for virtually any reason, were out of touch with the views of the medical community in the 1970s.

Pro-abortion advocates continue to distance abortion from the typical practices of medicine. Only 19 states require abortions after 20 weeks to be done at hospitals, and no states require abortions before 20 weeks be done at hospitals. In 12 states, abortions can be done by someone other than a licensed physician. Perhaps most shockingly, only one state requires that abortions be carried out by an OB/GYN.[23]

Recently, medical professional associations such as the American College of Obstetricians and Gynecologists have become advocates for abortion, but their leadership does so without any input from their membership. They have never directly surveyed their membership about their opinions on abortion advocacy. Meanwhile, surveys of practicing OB/GYNs demonstrate that only 7-14 percent say they would carry out an abortion when requested by their patient.[24]

As will be expanded upon later, Congress and state legislatures have passed many laws attempting to provide a minimal standard of care for abortion. Most have been invalidated in the courts under the mistaken assumption that they will place an "undue burden" on women seeking abortions. As Dr. Kilroy foresaw, the patient has replaced the physician. The lack of standards of care means a woman cannot be guaranteed that an abortion business will carry out her abortion with good quality. This leaves her at far higher risk of injury from an incompetent abortionist than a woman who seeks routine prenatal care.

Failure to Respond to Feedback from Americans and States

The Supreme Court's ruling in *Roe* was completely out of touch with state law. In fact, when the Court ruled that the Constitution protected the right to abortion, it overturned nearly every state's laws regarding abortion. Through the mid-1960s, 44 states had outlawed abortion with exceptions only for the life of the mother. In the early 1970s, when *Roe* was decided, only four states had legalized abortion in all cases before viability. Fourteen states allowed abortion in some circumstances, and 33 states continued to ban abortion in most cases.[25]

In 1975, Gallup performed its earliest public opinion polling on abortion. At this time, just two years after the passage of *Roe*, 79 percent of Americans disagreed with *Roe*'s findings. In 2020, 47 years after *Roe*'s passage, 71 percent of Americans disagreed with *Roe*'s findings.[26] According to a 2021 Marist poll, 76 percent of Americans, including a majority who identify as pro-choice, want significant restrictions on abortion.[27]

The American people's power to elect representatives who will create abortion laws reflective of their views was usurped by nine presidentially appointed—not democratically elected—justices of the Supreme Court.

Each year, states are passing laws that challenge the Supreme Court's jurisprudence. Since 2017, states have passed over 250 abortion-related laws in 45 states, with 88.7 percent of those laws restricting abortion.[28] In 2019, Alabama's governor signed into law a bill that almost completely bans abortion from the moment of conception. In 2021, in *Little Rock Family Planning Services v. Rutledge*, the Eighth Circuit panel asked the Supreme Court to reconsider *Casey*'s viability standard.[29]

Input from Louisiana Is Rejected—A Recent Case Study

In 2019, the Supreme Court ruled in favor of abortion businesses in *June Medical Services v. Russo*. In doing so, it struck down a Louisiana law requiring abortionists to maintain admitting privileges at a local hospital.

The Louisiana law struck down by the Supreme Court was introduced by Louisiana State Senator Katrina Jackson, a Democrat. The law, which received bipartisan support in the state legislature, was passed with the intent of improving the treatment received by women having abortions. In the state of Louisiana, every physician at an outpatient surgical facility must have admitting privileges at a local hospital—except for those operating at abortion facilities.

After recognizing this loophole and noting numerous instances of abortion businesses violating the Louisiana Department of Health regulations—including failure to verify the medical history of patients, monitor how long or how much nitrous oxide was given to patients, perform or document a physical exam of each patient, store and safeguard medication properly, have qualified personnel administer anesthesia, sterilize equipment properly, and ensure that single-use IV fluid was only used once—State Senator Katrina Jackson filed the *Unsafe Abortion Protection Act* to apply the same safety standards to abortion facilities that all other outpatient surgical facilities follow.[30]

Notably, the plaintiffs in the Supreme Court challenge of the *Unsafe Abortion Protection Act* were not women who felt their "rights" were being infringed upon by the law. In fact, the plaintiffs could not find a single woman who wanted to testify that this law violated her rights.[31] Instead, the plaintiffs were abortionists who stood to profit from committing abortions without following the standards that medical professionals at surgical facilities throughout Louisiana are required to follow. In 2020, the Court struck down this bipartisan law, which protected women but inconvenienced abortion businesses. The people of Louisiana provided input, but their voice was, once again, silenced by the Supreme Court.

Failure to Accept Feedback from "Key Stakeholders"

Abortion is the only procedure legalized nationwide that kills a living human being and is still called "health care" by its proponents. An essential component of "key stakeholder feedback" ought to be feedback from the intended victims of abortion who managed to survive. One such abortion survivor is Melissa Ohden.

In 1977, four years after the Supreme Court legalized abortion in *Roe v. Wade*, Melissa's 19-year-old mother underwent an abortion using a toxic saline solution. This solution was meant to scald Melissa, who was in her mother's womb, to death. She soaked in the solution for five days. On the fifth day, Melissa was meant to be delivered as a "successful abortion." The abortion failed, and Melissa was born alive. She was adopted into a loving home.[32] Today, Melissa shares her story around the country. She started the Abortion Survivors Network in 2012 and has connected with 356 abortion survivors to date.

In June 2019, Melissa testified before the U.S. House Judiciary Subcommittee on the Constitution, Civil Rights, and Civil Liberties. Melissa stated:

> [L]argely ignored in the abortion narrative that is woven so skillfully throughout our culture, behind even the words in the title of this hearing, "reproductive rights," are stories buried beneath the narrative of abortion that has been sewn since *Roe v. Wade*.
>
> Is there space for stories like mine, women who are alive today after surviving failed abortion procedures; for stories like my biological mother's, women who have been coerced or forced into an abortion? Do we ever create space for the stories of women who regret their abortions?
>
> The most important stories, though, are likely the ones that you'll never hear. The stories of the little girls who will never live outside of the womb. In all of the discussion about women's rights, some lose sight of the fact that without the right to life, there are no other rights. This is the greatest human rights issue we are facing as a country.[33]

As an abortion survivor, Melissa's "key stakeholder" feedback is clear. Abortion is not health care.

Abortion and abortion policies strive not to include input from all stakeholders, including the public, throughout the process. Driven by the pro-abortion movement, the U.S. government has ignored input from the American people, from the duly elected government officials, from women who have been directly impacted by abortion, and even from the victims of abortions themselves. Until the people's voice is recognized, it is impossible to argue that abortion policy and law take feedback from the public and key stakeholders into account.

III. Do Abortion and Abortion Policies Protect the Most Vulnerable Patients and Populations, with Special Attention to Historically Disadvantaged Groups?

As evidenced by Melissa Ohden's testimony, abortion does not protect the most vulnerable patients, the unborn. Additionally, evidence shows that abortion and abortion policies *target* historically disadvantaged groups, such as people with physical and intellectual disabilities, black populations, and women.

Abortion Targets People with Disabilities

Margaret Sanger, the founder of Planned Parenthood, embraced eugenic theory and believed birth control to be the "greatest and most truly eugenic method" and "nothing more or less than the facilitation of the process of weeding out the unfit."[34] In her own words, Sanger's mission was "to apply a stern and rigid policy of sterilization and segregation to that grade of population whose progeny is already tainted, or whose inheritance is such that objectionable traits may be transmitted to offspring."[35] Sanger, the founder of what would become the largest abortion business in the country, began her organization targeting people with disabilities.[36]

If she were alive today, Sanger would likely consider her mission largely successful. Of the 42 states that restrict abortions, five have exceptions "in case of fetal abnormality." As such, they offer abortions in the case of fetal abnormality up to the point of birth.

Although there are numerous types of disabilities, or "fetal abnormalities," prenatal testing has made it possible for doctors to diagnose some in the womb. One of these is Down syndrome. The results of prenatal genetic testing have been catastrophic for people with Down syndrome.

In Denmark, 95 percent of babies prenatally diagnosed with Down syndrome are aborted.[37] In 2019, only 18 babies with Down syndrome were born in the entire country. In the United States, 67 percent of babies prenatally diagnosed with Down syndrome are aborted.[38] In France, 77 percent are aborted. In Iceland, just one or two babies with Down syndrome are born each year due to prenatal testing making the targeting of such babies possible.[39]

Various U.S. states have tried to pass bans on aborting an unborn child solely because of a prenatal diagnosis of Down syndrome.[40] [41] [42] [43] Planned Parenthood has opposed this type of legislation stating, "These severe restrictions on abortion access do nothing to address disability rights or discrimination. They only stigmatize abortion and shame the people who seek that care."[44] The pro-abortion ACLU is also opposed to this type of legislation, arguing, "Proponents of these bans claim that their goal is to protect the rights of people with disabilities. Such attempts to co-opt the mantle of disability rights to ban abortion are not only hypocritical but also deeply offensive."[45]

It is challenging to see the logic behind the belief that banning the killing of a specific group of people because they have an identifying trait, such as Down syndrome, is offensive—or does nothing to address disability rights. The right to life is an essential component of all other rights. Abortion clearly targets people with Down syndrome, and the abortion industry is unwilling to work to stop this. The elimination of people with Down syndrome appears consistent with Margaret Sanger's original mission.

The Targeting of Black People

People with Down syndrome are not the only group being targeted by the abortion industry. Planned Parenthood founder Margaret Sanger not only spoke at a Ku Klux Klan rally, but she also said, "We don't want the word to go out that we want to exterminate the Negro population."[46] Planned Parenthood of Greater New York (PPGNY) has recently taken steps to disavow its founder's eugenic philosophy, announcing in July 2020 its intention to remove Sanger's name from its building in Manhattan.[47] Yet despite PPGNY's efforts to acknowledge Planned Parenthood's "historical reproductive harm within communities of color" and treat this harm as being a thing of the past, there is considerable evidence that abortion disproportionally slows racial minority birthrates and victimizes vulnerable populations.

Abortion disproportionately impacts the black community. In fact, abortion impacts black Americans more than any other group. Although black Americans constitute only 14 percent of the population,[48] they obtain 33.6 percent of the abortions.[49] Black women have obtained approximately 18,700,000 of the 65 million abortions in the U.S. since abortion was widely legalized in 1973.[50] Poignantly, that is almost the entire U.S. black population (18,872,000) at the time of the civil rights movement in the 1960s.[51] Today, there are 44 million black people in the U.S.[52] Our country would have nearly 50 percent more black citizens if abortion had not ended the lives of so many black children prior to birth.

Abortion has led to a decrease in the black population and has had many adverse consequences for women and children. Given the roots of the pro-abortion movement, just as with targeting of people with Down syndrome, this targeting appears intentional.

Impact on Women

While proponents of abortion often refer to it as "health care," no other form of accepted "health care" has had such a negative impact on the people it purports to serve.

Due to legal or ideological motivations, death certificate deficiencies, search engine failure to obtain abortion-specific codes, and the failure of many abortionists to maintain hospital admitting privileges or care for their complications, it is likely that most U.S. abortion-related serious complications and maternal deaths are not reported to the CDC for investigation. This lack of transparency makes it difficult to state abortion complication statistics with certainty. Even so, the negative impact of abortion on a woman's physical health cannot be overstated.

Physical Impact of Abortion on Women

Despite the lack of mandated or accurate reporting on abortion, it is evident that there are multiple ways an abortion may cause harm to a woman's physical health, both in the immediate future and in the long-term.

Induced abortion interrupts a normal bodily process. Some risk factors are unique to that intervention, such as the need to force open the strong muscular cervix, which is designed to remain closed until natural childbirth. Various types of abortions carry with them different risks.

During a surgical abortion, a misdirected cervical dilator or instrumental perforation of the uterus may cause hemorrhage or damage to adjacent organs, leading to a catastrophic series of events. A dilation and evacuation (D&E) abortion procedure is particularly dangerous, as the late-term unborn child must be extracted in a piecemeal fashion, necessitating many blind passages with sharp instruments.[53] Compared to early abortions, maternal mortality is 15 times higher early in the second trimester and 76 times higher after viability.[54] Because of the potential for complications during this procedure, the American Board of Medical Specialties recommends an additional two-year fellowship training, but few abortionists have completed this training.[55]

Chemical abortions, which will be expanded upon later, are often assumed to be safer than surgical abortions. However, the risk of complications is *four times greater*.[56] In at least one in 20 chemical abortions, women require surgical completion due to hemorrhage, failed abortion, or retained fetal

body parts.[57] Mifepristone and misoprostol, the two pills in the chemical abortion regimen, are known to suppress the immune system, raising the risk of infection. As a result, many of the deaths reported after chemical abortions occurred due to infection from a common soil organism, Clostridium sordellii.[58]

Mental Health Effects of Abortion

Regardless of the abortion method, many women have adverse mental health outcomes. These can also lead to a woman's death. Of course, mental health risks can be difficult to decipher. Poor social support and difficult life circumstances can factor into a woman's decision to have an abortion, and these can affect her mental health as well.[59] Many interpret the "relief" a woman feels with the resolution of the pregnancy crisis to mean that there could be no mental harm from the procedure.[60] [61] Yet, increasingly, the evidence shows that the feeling of relief declines over time, and the feeling of negative emotions related to the abortion increases.[62] [63] [64]

A meta-analysis of 22 studies found a moderate to highly increased risk (81 percent overall) of mental health problems after abortion. Specifically, it found a 34 percent increased risk of anxiety, 37 percent increase in depression, 110 percent increase in alcohol abuse, 230 percent increase in marijuana abuse, and 155 percent increase in suicidal behavior.[65] [66]

Additionally, there are subsets of women well documented by the American Psychological Association to have higher risks of mental health complications after abortion: those who have later abortions, previous abortions, prior mental health history, low self-esteem, pressure from others to terminate, attachment to the pregnancy, ambivalence about the decision, poor social support, and numerous other factors.[67]

Abortion and Breast Cancer

The interruption of a normal pregnancy might place a young woman at increased risk for breast cancer later in life. In early pregnancy, dramatically increased estrogen levels promote the development of undifferentiated, immature type one and type two lobules in the breast, which have an increased potential to develop into cancer. Delivery at term and breastfeeding the infant will complete the breast development into mature type three lobules, which are more resistant to cancer. If pregnancy is interrupted prior to 32 weeks gestation, this maturation does not occur, leaving breasts in a state more prone to breast cancer development.[68] [69]

The studies examining an "abortion-breast cancer" link are particularly controversial because many are plagued by methodological flaws. Still, it is an indisputable fact that a term pregnancy early in life has a protective effect against breast cancer later in life.[70] [71] As the lifetime risk of breast cancer in American women climbs steadily upward, from one in 10 American women in 1970 to one in eight currently, more studies are needed to determine if there is a causal connection between abortion and breast cancer.[72]

Abortion and Premature Delivery

There are several potential mechanisms by which an induced abortion may increase the risk of subsequent premature deliveries. Forced dilation of an unripe cervix may result in cervical trauma and later cervical incompetence. Instrumental trauma of the uterus may result in faulty adherence of the placenta in subsequent pregnancies, resulting in chronic abruption or placenta previa/acreta/increta (invasion of the placenta into the cervix, uterine wall, or other adjacent organs). In addition, the procedure may alter the cervical and vaginal bacterial flora, resulting in intra-amniotic infection in subsequent pregnancies,[73] or the abortion decision itself may cause premature stress-induced activation of the hypothalamic-pituitary-adrenal axis.[74]

There are many statistically significant studies showing a connection between abortion and preterm birth.[75] [76] Prematurity is the number two cause of infant deaths and the cause of substantial lifelong morbidity for many children.[77] One meta-analysis found a 25 percent increased risk of premature birth in a subsequent pregnancy after one abortion, 32 percent after more than one, and 51 percent after more than two abortions.[78] Likewise, another meta-analysis found a 35 percent increased risk of delivery of a very low birth weight infant after one abortion and 72 percent after two or more abortions.[79] Despite the widespread knowledge of an abortion-preterm birth link in the academic literature,[80] women are often not warned by physicians that an elective abortion could increase the risk of the next child being born premature.[81]

Instead of protecting them, abortion and abortion policies harm historically disadvantaged groups such as people with disabilities, black Americans, and women. Although laws and policies could be made protecting people with disabilities and black Americans from abortion, there is no possible way to ensure that abortion does not harm women.

IV. Does Abortion Policy Consider the Best Available Scientific Data about the Efficacy and Safety of Health Care Services?

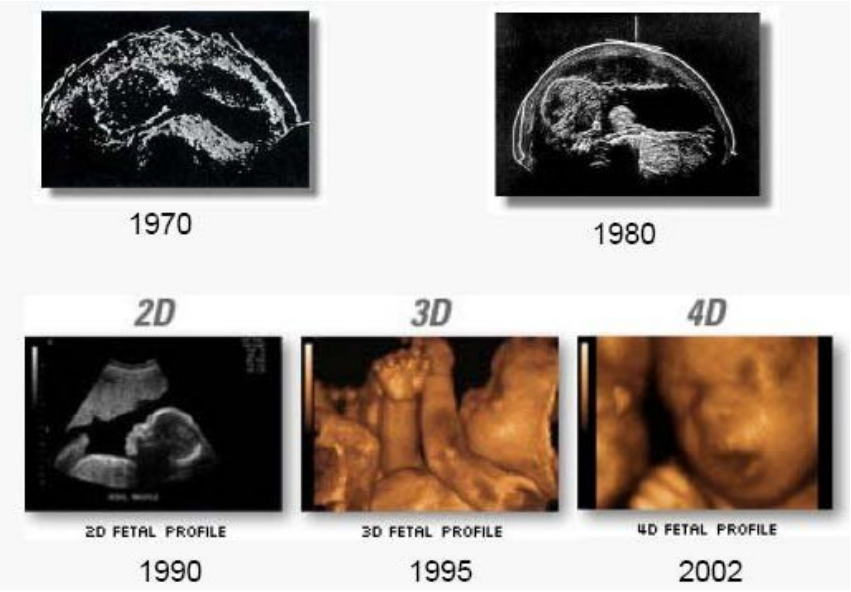
No. Abortion policy remains rooted in the 1970s and fails to consider medical advances with regard to both the unborn child and the mother.

Updates in Ultrasound

Although ultrasound has been in use since the 1950s, the technology has progressed significantly since then. Fetal cardiac action was first detected via ultrasound in 1972, prior to the passage of *Roe*.[82] However, between 1980 and 1990, ultrasound technology has progressed significantly, including developments in the use of gel on the woman's abdomen to allow better ultrasonic signal, the transvaginal scanner, the first real-time vaginal scanner; the first real-time color imaging that allows

tracking of blood flow, major improvement in the quality of images offered, and the use of the 3D/4D ultrasound machines.[83] [84]

In 1984, Kazunon Baba began using 3D imaging in Japan, but it was not until the mid-1990s that 3D/4D ultrasound began playing a major role in obstetrical and gynecological imaging.[85] In 1985, KretzTechnic created the first real-time mechanical vaginal sector scanner.[86] With the advent of transvaginal scanning came the accurate recognition of fetal cardiac pulsations as early as six weeks.[87] This allowed doctors to identify healthy early pregnancies as well as earlier diagnosis of miscarriages.



[88]


[89]

2013

These pictures demonstrate the advancements in ultrasound technology. The ultrasound on the top left is from 1970, three years before the *Roe* decision. The final image is a 4D ultrasound from 2013 showing the "humanity" of the unborn child. "It is believed that a 3D moving sequence (*i.e.*, 4D ultrasound) demonstrating the 'humanity' of the fetus can encourage maternal-fetal bonding."[90]

In the 1970s, even determining the sex of the child through ultrasound was a challenge. However, charts detailing the length of bones and organs and the ratios between them were developed using ultrasound around 1982. Also in the 1980s, through the use of the transvaginal probe, David Nyberg and Roy Filly from San Francisco and Bruno Cacciatore from Finland were able to diagnose ectopic pregnancy with over a 90 percent success rate. By the 1990s, transvaginal scans to assess pelvic pain and bleeding were common practice in virtually every hospital emergency room.[91] In 1983, the ultrasound was used to diagnose preeclampsia at 24 weeks gestation.[92] Today, predictive markers for preeclampsia can be identified using Doppler ultrasound in the first trimester of pregnancy.[93]

Since the *Roe* decision in 1973, ultrasound technology has advanced markedly, giving scientists further evidence of the humanity of the child in the womb. Since the late 1990s, an ultrasound examination is standard practice for each and every pregnancy.[94]

A Refusal to View the Science

The scientific data obtained from advances in ultrasound technology have allowed doctors to diagnose health issues a pregnant mother will face, including ectopic pregnancy and preeclampsia, during the first trimester of pregnancy. Today, ultrasounds provide a woman with the best scientific data on what is occurring in her womb. Still, NARAL Pro-Choice America argues, "For most women seeking abortion care, an ultrasound is not medically necessary" and NARAL, as well as other pro-abortion organizations, oppose the legislation requiring ultrasounds prior to abortion. In an era where, according to the AMA, the physician is obliged to present medical facts accurately to the patient and withholding medical information from patients without their knowledge is ethically unacceptable, pro-abortion organizations work to ensure that neither women, nor their doctors, have the most up to date scientific

data. In doing so, they are endangering the lives of women seeking abortions.[95]

Change in Viability

At the time of the *Roe* decision, viability was around 28 weeks. Today, the youngest baby to survive was born at 21 weeks, four days gestation.[96] In 1973, a baby's survival largely depended on whether there was medical equipment available that fit the newborn's size. Babies 1,200 grams or more survived in the 1970s.[97] Needles, breathing machines, and feeding instruments were far too large to accommodate a human being tinier than this.[98] Today, size is no longer a problem. In 2019, a baby girl weighing just 245 grams at birth was discharged from the hospital.[99] Given these scientific advancements and extreme abortion laws, in some states, babies can be aborted for at least 18 weeks after they could be delivered alive and placed for adoption.

Advances in Pain Care

Until 1987, doctors operated on newborn babies without anesthesia because the medical community did not recognize newborn babies as capable of feeling pain.[100] Today, the medical community has advanced so far that they agree that by 20 weeks in the womb, and perhaps as early as 12 weeks, an unborn child feels pain.[101] In recognition of this, when an unborn child undergoes surgery in the womb, the anesthesiologist gives that unborn child separate anesthesia because the anesthesia given to the mother is NOT sufficient for pain relief in the unborn child.[102] Despite this fact, Planned Parenthood opposes legislation to limit abortion after an unborn child feels pain, arguing that an unborn child does not feel pain before 26 weeks.[103]

Since 1973, those in the pro-abortion movement have failed to adequately examine the scientific advances and data that have clarified that abortion is a torturous procedure that takes the life of an organism that is clearly human. The pro-abortion movement has failed to stay current with scientific advances and data, and in doing so, is endangering the lives of the women they aim to serve.

V. Does Abortion or Abortion Policy Seek to Improve Health Outcomes to the Greatest Extent Possible, in Keeping with Principles of Wise Stewardship?

No. Abortion does not improve health outcomes for women or their children.

As already discussed, abortion can cause significant damage to a woman's physical and mental health, including complications that lead to death, future premature births, sterilization, suicide, and drug use. However, proponents of abortion argue that lack of access to abortion leads to higher maternal mortality rates.[104] In the United States, due to the lack of transparency surrounding abortion, it is impossible to obtain U.S. statistics that affirm or deny this claim. Still, information obtained in the United States and other countries indicates that this claim is inaccurate.

How is Maternal Mortality Defined?

Deaths of women that occur in proximity to childbirth are separated into three categories based on their timing and causation. "Maternal death" is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration of the pregnancy or location of embryo implantation, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. "Pregnancy-related death" is the death of a woman while she is pregnant or within 42 days of pregnancy termination, irrespective of the cause of the death. Additionally, a "late maternal death" is the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of the pregnancy.[105]

While a physical complication caused or exacerbated by changes in a woman's physiology during pregnancy is the most evident event to consider, one would be remiss in failing to consider events associated with a woman's mental health. Joyous events (such as the birth of a child) have been associated with improved health and well-being. Likewise, the stress and guilt that can accompany a

pregnancy loss may adversely impact a woman's health.[106] In addition, motherhood may have a protective emotional effect, whereas an abortion may have a deleterious emotional effect, leading to greater risk-taking activities.[107] It is evident that a suicide on the anniversary of a coerced abortion or stillbirth should be linked to that pregnancy outcome, but none of these definitions will make that connection.

How to Best Determine Whether Abortion Contributes to Maternal Mortality

The best type of study to answer whether abortion contributes to an increase in maternal mortality would link records for all deaths in reproductive-aged women with all medical records of all pregnancies so that no deaths were missed.[108] The only study done this way in the U.S. examined the records of California Medicaid recipients. Those women who had an induced abortion or delivery of a baby were followed for eight years. Compared with those who delivered a baby, those who aborted had a significantly higher age-adjusted risk of death from all causes (162 percent higher), from suicide (254 percent higher), as well as from natural causes (144 percent higher).[109]

Similar studies in Finland found that following an abortion, a woman was two to three times as likely to die within a year,[110] six times as likely to commit suicide,[111] [112] four times as likely to die from an accident, and 14 times as likely to be murdered[113] compared with a woman who carried to term.[114] Ninety-four percent of abortion-related deaths and 73 percent of maternal deaths were not identified on death certificates, demonstrating the clear inadequacy of death certificate data alone.[115] The risk of death in a given year for a woman who was not pregnant was 57 in 100,000 women, but after an abortion, the risk was 83 in 100,000, after miscarriage 52 in 100,000, and for those who carried a pregnancy to term, 28 in 100,000.[116]

Danish studies also confirmed these findings. A woman who had a first trimester abortion had an 84

percent higher risk of dying within 180 days and a 39 percent higher risk of dying within 10 years, compared with one who carried to term. After a late-term abortion, she had a 341 percent higher risk of dying within a year and a 131 percent higher risk of dying within 10 years.[117] [118]

Is Abortion Necessary to Save a Mother's Life?

The pro-abortion movement argues that there are cases where abortion is necessary to save the mother's life. If this were true, it would clearly improve health outcomes for the mother to the greatest extent possible; however, this argument is based on a dated knowledge of medicine.

There are times when ending a pregnancy is recommended to save a mother's life; however, carrying out an abortion is only one way of ending a pregnancy—and a dangerous way at that. The most common situation in which pregnancy termination is required to save a woman's life is an ectopic pregnancy, when the unborn child is implanted in an extra-uterine location. An unborn child located outside the uterus can never reach viability. As previously discussed, thanks to the improvements in ultrasound, ectopic pregnancies can be identified earlier and earlier in pregnancy. Sadly, this pregnancy results in an inevitable miscarriage, and there is no controversy in removing this embryo in order to protect the mother. Such a procedure would not be considered an abortion.

Other rare scenarios in which delivery is required include severe preeclampsia early in pregnancy or uterine infection from extremely premature rupture of membranes. Even cancers do not often necessitate delivery because they can usually be treated with chemotherapy or surgery that does not disrupt the unborn child.[119]

It is clearly a moral imperative, regardless of the law, for a physician to intervenein a pregnancy that poses a threat to the life of the mother. Abortion, by definition, is the intentional ending of the life of an unborn child. Premature parturition, otherwise known as premature birth, is the treatment of

choice in these situations. The purpose of the delivery is not to kill the unborn child but to save the lives of the mother and the child, or to save the life of at least one of them.[120] Therefore, it is not abortion.

A woman's own obstetrician can perform these deliveries by induced vaginal delivery or C-section, and the neonatal intensive care unit team can evaluate if the unborn child's life can also be saved. If the unborn child is too premature to live, perinatal hospice providers can ensure that the child remains comfortable and can be held and loved by the parents until passing away.[121] If a woman is truly at risk from her pregnancy, she should be cared for in a high acuity hospital, not transferred to an abortionist's clinic with potentially inadequate emergency equipment. Abortion is not the solution to a high-risk pregnancy.

Abortionists themselves will attest to this. In 1992, Dr. Don Sloane 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 a mother's life is something that people cling to because it sounds noble and pure, but medically speaking, it probably doesn't exist."[122] Since 1992, medical care has advanced significantly, so this statement is even more accurate today.

If those in the pro-abortion movement want to improve health outcomes to the greatest extent possible, then instead of focusing on promoting abortion—which increases the likelihood of maternal death and is never necessary to save a woman's life—the movement should focus on changing the circumstances surrounding women seeking abortions so that those women can carry their child to term.

VI. Do Health Professionals Monitor Abortion and Abortion Policies for Variations in Care that Cannot Be Explained on Medical Grounds to Ensure that the Defined Threshold of Basic Care Does Not Have a Discriminatory Impact?

Abortion certainly has a discriminatory impact on people with Down syndrome and black Americans.

Due to abortions following prenatal diagnosis, the United States has seen a 30 percent reduction in the population of people with Down syndrome.[123] Globally, this number is much higher. The availability of abortion based solely on the criteria of a child having Down syndrome has had the discriminatory effect of beginning to eliminate this population of people from the world.

Abortion has also had a discriminatory effect on black Americans. As stated previously, black Americans constitute only 14 percent of the population,[124] yet they obtain 33.6 percent of the abortions.[125] Black women have obtained approximately 18,700,000 of the 65 million abortions that have occurred in the United States since abortion was widely legalized in 1973.[126]

Discrimination in Prenatal Care May Be Exacerbated by Abortion

Much attention has been given to the increased mortality rates in black women surrounding pregnancy and childbirth. There are many explanations for this, but few are aware that the 3.3-fold increased rate of maternal mortality in black women compared to white women mirrors the 3.6-fold increased rate of abortion.[127] Limiting the discussion to racism ignores other factors exacerbated by abortion that contribute to maternal mortality.[128]

Risk factors for pregnancy complications such as obesity, hypertension, and diabetes occur more commonly in black than white women.[129] There may be genetic reasons for this, but poverty is also associated with these high-risk conditions. Pregnancies complicated by these co-morbidities are more

likely to lead to C-section delivery, which has a far higher mortality rate. Although black and white women experience similar preeclampsia rates, the rate of death for black women from preeclampsia is three times that of white women. This could be explained by inequities in access to prenatal care.[130] [131]

Black women do not have the same level of access to prenatal care as white women. In Philadelphia, a case study found that when 13 of the area's 19 obstetrics units closed from 1997 to 2012, the remaining hospitals could not handle the numbers. Pregnant black women were getting their prenatal care in their own neighborhoods but were required to deliver elsewhere, and ultimately the maternal deaths among black women increased.[132]

Philadelphia only had six obstetrics units, but the city has at least eight abortion businesses.[133] In Washington, D.C., the nation's capital, the maternal mortality rate for black women is 71 deaths per 100,000 live births compared to 63.8 nationally.[134] The District has some of the least restrictive abortion laws in the country—placing no restrictions on abortions and only places restrictions on abortion funding.[135]

Notably, the District's overwhelmingly majority black neighborhoods, Wards 7 and 8,[136] [137] are served by one hospital, United Medical Center, which closed its obstetrics unit in 2017 and is set to close completely in 2023.[138] [139] The District has promised to open St. Elizabeths East hospital in Ward 8, and this hospital will have an obstetrical care and level II neonatal intensive care unit.[140] However, it is not slated to open until 2024, at least seven years after the closure of the obstetrics unit at United Medical Center.

During this same time period, the District city council passed the Strengthening Reproductive Health Protections Amendment Act, which did not strengthen reproductive health care. Instead, it removed all remaining protections—including baseline health and facility safety requirements for sanitary conditions, administration of medicine, and reporting of suspected abuse of children or human trafficking.

Black women more commonly have later abortions (13 percent) than white women (9 percent).[141] The

risk of death from abortion increases by 38 percent every week after eight weeks gestation.[142] Thus, deaths directly related to physical complications of later abortions are increased in black women.

In addition to the immediate physical risks of abortion, there are long-term complications that increase a woman's risk of death in a subsequent pregnancy. Forcibly opening a cervix, which is designed to remain closed until natural childbirth, may result in cervical trauma and cervical incompetence in future pregnancies, often leading to preterm birth. Black women are documented to have higher preterm birth rates, leading to much suffering for their children from the complications of prematurity. Obstetric interventions for the management of preterm birth can lead to mortality from infections or medication toxicity.[143]

Because of the high instances of abortion among the black population, black women need access to better maternal health care, not worse.

Cities like Philadelphia and Washington, D.C. point to the fact that while abortion itself is having a discriminatory impact on black women, the pro-abortion movement, led by Planned Parenthood—which pours millions of dollars into promoting abortion instead of actual health care for women, while decreasing actual services that promote women's health[144]—is also having a discriminatory impact on black women.

Instead of focusing on opening new abortion facilities, which hurt women physically and emotionally, states should provide real prenatal services, especially for black women who do not have access to adequate health care to raise their children. Instead of opening more abortion businesses and passing more legislation that allows those businesses to commit unsanitary abortions without fear of any consequences, cities should work to open more OB/GYN units and promote actual health care for women.

VII. Is There Ongoing Review and Adjustment of Abortion or Abortion Policy in Consideration of Innovation in Medical Science and Practice to Ensure Continued, Broad Public Support for the Defined Threshold of Basic Care?[145]

Over 60 pieces of abortion-restricting legislation were introduced at the state level in 2021 alone, demonstrating a clear lack of public support for abortion through nine months of pregnancy. However, the abortion movement has not changed its mission to be more in line with public support and medical innovation.[146] Instead, as demonstrated previously, the pro-abortion movement relies on outdated medicine to justify carrying out abortions.

The Ongoing Adjustment of Abortion

Abortion practices have changed since the passage of *Roe* in 1973, but they have not changed to make abortion safer for women.

Mifepristone (Mifeprex®; also known as RU-486) was approved by the FDA in 2000 to chemically induce an abortion. Since that time, chemical abortions via the two-pill regimen of mifepristone and misoprostol (Cytotec®) have become increasingly common. Mifepristone blocks progesterone receptors to cut off hormonal support for the unborn child, which results in disruption of the implantation site. This is usually followed in 24 hours with misoprostol, which induces contractions to expel the unborn child.[147]

This regimen was originally approved for use in pregnancies up to 49 days gestational age, and the regulations were initially very strict. Prescribers of the abortion pill were required to be physicians who became registered only after specific training in mifepristone's use. They needed to be able to accurately determine the gestational age and location of the pregnancy (usually through an ultrasound) because ruptured ectopic (extra-uterine) pregnancies are a common cause of maternal deaths, and the failure rate of the abortion is far higher at more advanced gestational ages. The prescriber had to have the

ability to intervene surgically if the abortion was unsuccessful, or if complications resulted, or he needed to have an agreement with another doctor and facility to provide this care. A 14-day follow-up visit was required.[148]

The initial experience demonstrated that complications were common. The average woman bled for eight to 16 days, but eight percent bled for more than a month and 4.5 to 7.9 percent required surgical intervention for hemorrhage, incomplete abortion, or ongoing pregnancy. If an ongoing pregnancy led to a child's birth, teratogenic effects such as limb, facial, cranial, and other abnormalities related to misoprostol were sometimes seen. The FDA required a "black box warning," which stated that use of the medical abortion regimen was contraindicated if there was no access to emergency services. Eighty-five percent of women had at least one, and often all, of the following adverse effects: cramping, vaginal bleeding, hemorrhage, nausea, weakness, fever, chills, vomiting, headache, diarrhea, and dizziness. In the first few years of use, over 2,200 adverse events were reported to the FDA, including 14 deaths.[149]

Nonetheless, in 2016, the FDA further loosened the restrictions. It is no longer required to complete a follow-up visit or report a complication unless it leads to a woman's death. Chemical abortions may be provided up to 70 days gestational age,[150] even though the higher gestational ages (64-70 days) had only been studied on about 300 women, and at those gestational ages, only 92.7 percent of the women expelled the unborn child completely, with 3.1 percent requiring additional surgery.[151]

Unfortunately, on April 13, 2021, under pressure from the Biden administration, the FDA opted to ignore the Risk Evaluation and Mitigation Strategy (REMS), which supervises the use of the chemical abortion regimen, for the remainder of the COVID-19 pandemic.[152] This decision will allow medical abortion pills to be prescribed by telemedicine, ordered over the internet, delivered by mail, and ultimately, provided over the counter. For the duration of the pandemic, the FDA will no longer require in-person counseling, examination, or ultrasound or laboratory evaluation before abortion pill provision. This will lead to more coercion, failures due to underestimated gestational age, ruptured ectopic pregnancies due to failure to diagnose, and isoimmunization leading to severe fetal anemia in future pregnancies when immunoprophylaxis is indicated, but blood type has not been determined prior to the abortion.[153]

The use of misoprostol alone to induce an abortion in the first trimester has even greater failure rates but is sometimes recommended because it is easier to obtain. Misoprostol is more readily available because it is also used to treat peptic ulcer disease, does not require the training and registration that mifepristone does, and is available without a prescription in neighboring countries. Although some researchers report that misoprostol use alone is safe and effective,[154] a recent meta-analysis of first trimester use demonstrated that 20 percent of women required a surgical uterine evacuation, and nearly seven percent had ongoing viable pregnancies.[155]

When medical abortions are carried out after the first trimester, the risk of complications is extraordinarily high.[156] A failed abortion occurs in up to 39 percent of cases when misoprostol is used alone in the second trimester or later, with most of these complications related to incomplete evacuation of the unborn child, hemorrhage, and infection.[157] [158] Although elective medical abortions at these late gestational ages are uncommon in the United States, they are more frequently carried out worldwide.[159] [160] [161]

The abortion movement's efforts to consider "innovative science" have only made abortion less safe for women. The movement has not responded to the public's demands for change; however, the movement has found new ways to make describing abortion as "health care" even less accurate.

Conclusion

Proponents of abortion argue that abortion is health care. Opponents of abortion, members of the pro-life movement, argue that abortion is not health care. The question of whether abortion is health care or not hinges upon how an individual defines health care. While it is not clear what the pro-abortion movement means by "health care," it is clear that abortion does not fit the American Medical Association's definition of the type of health care professional should advocate for.

Abortion is not transparent, as there is no accurate data on abortion in the United States. Abortion and abortion policies do not strive to include input from key stakeholders—including doctors, the general

public, and most importantly, the survivors who were victims of abortion themselves. Abortion does not protect the most vulnerable, with special attention to historically disadvantaged groups, as this practice targets people with disabilities, black Americans, and women. Abortion does not consider the best available scientific data, as abortion advocates fail to note the changes in viability, ultrasound technology, and pain care. Abortion does not seek to improve health outcomes to the greatest extent possible, as there is no accurate data on the connection between abortion and maternal mortality, and there is no recognition of the health risks faced by a woman who has an abortion. Abortion does not monitor for variations in care that cannot be explained on medical grounds to ensure that it does not have a discriminatory impact, as there is no examination of black American's access to abortion businesses versus their access to maternal health care. There is not ongoing review and adjustment of abortion in consideration of innovative medical science to provide basic care, as the only changes in abortion procedures actually make abortion more dangerous.

In short, pro-abortion activists may argue that abortion is health care, but abortion is certainly NOT the type of health care for which any health care professionals should advocate. Rather, abortion is the intentional ending of an unborn child's life that uses medical procedures to kill rather than heal.

Mary Szoch, M.Ed. is Director of the Center for Human Dignity at Family Research Council.

Ingrid Skop, M.D., F.A.C.O.G. has been a practicing obstetrician-gynecologist for 24 years. Dr. Skop is a Fellow of the American College of Obstetrics and Gynecology, a former Board Member of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), and a Charlotte Lozier Institute Associate Scholar.

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