Is Late-Term Abortion Ever Necessary?
By Mary L. Davenport, M.D., FACOG

Note: The following article was first published by the American Association of Pro-Life Obstetricians and Gynecologists.

Late-term abortions have been part of the American landscape since the Supreme Court issued its landmark 1973 rulings in Roe v. Wade and Doe v. Bolton—both issued on the same day. Roe authorized abortion beyond the point of fetal viability to protect the “life or health” of the mother. Doe provided such a broad definition of “health” that it effectively required that there be abortion on demand through a pregnancy’s entirety. Thus, the Supreme Court’s abortion decisions imposed on the United States one of the most permissive abortion law regimes in the world.

Although the reproductive health pioneer Dr. Elizabeth B. Connell predicted in 1971 that contraception and early abortion would render late-term abortion obsolete, joining “the bubonic plague and poliomyelitis as practically historic conditions,” the proportion of late-term abortions has varied little in the last two decades.

Many women are referred for abortion unnecessarily.

Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, shocked the general public in 1997 when he admitted that the vast majority of partial-birth abortions were performed on healthy mothers and babies.

Abortion for Non-Medical Reasons

Contrary to the assertion of abortion rights supporters that late-term abortion is performed for serious reasons, surveys of late abortion patients confirm that the vast majority occur because of delay in diagnosis of pregnancy. They are done for similar reasons as early abortions: relationship problems, young or old maternal age, education or financial concerns.

Most of Tiller’s abortions conformed to the generally elective character of these late-term procedures. Peggy Jarman of the Pro-Choice Action League stated that about three-fourths of Tiller’s late-term patients were teenagers who denied to themselves or their families that they were pregnant until that fact could no longer be obscured.

Kansas Attorney General Phil Kline initiated a review of Tiller’s records of late-term abortions. One of the nation’s most distinguished psychiatrists, Dr. Paul R. McHugh, Johns Hopkins professor of psychiatry, was asked to determine if Tiller’s patients satisfied Kansas’ requirement that they were likely to suffer a substantial and irreversible impairment if not allowed to abort. Dr. McHugh reviewed Tiller’s patient records and determined that they were not.
Abortion for Maternal Health

Although most late-term abortions are elective, it is claimed that serious maternal health problems require abortions. Intentional abortion for maternal health, particularly after viability, is one of the great deceptions used to justify all abortion. The very fact that the baby of an ill mother is viable raises the question of why, indeed, it is necessary to perform an abortion to end the pregnancy.

With any serious maternal health problem, termination of pregnancy can be accomplished by inducing labor or performing a cesarean section, saving both mother and baby. If a mother needs radiation or chemotherapy for cancer, the mother’s treatment can be postponed until viability, or regimens can be selected that will be better tolerated by the unborn baby. In modern neonatal intensive care units 90 percent of babies at 28 weeks survive, as do a significant percentage of those at earlier gestations.

T. Murphy Goodwin, M.D., a distinguished professor of maternal-fetal medicine at the University of Southern California, has written an eloquent article describing how women are told they need abortions for their own health, when this is patently untrue.10

A major reason for unnecessary abortion referrals is ignorance, to put it bluntly, especially on the part of physicians in medical specialties inexperienced in treating women with high-risk pregnancies. According to Goodwin, there are only three very rare conditions that result in a maternal mortality greater than 20 percent in the setting of late pregnancy.11 Even in these three situations there is room for latitude in waiting for fetal viability if the mother chooses to accept that risk.

Goodwin’s essay presents several cases in which pregnant women with cardiac conditions, cancer, or severe renal and autoimmune disease had been told categorically that they “needed” an abortion for their health or to save their life. But in every case the women were given wrong diagnoses or incomplete information, and not offered any alternatives other than abortion.

One example was a 38-year-old woman, 11 weeks pregnant, with breast cancer that had spread to the lymph nodes. She was told that chemotherapy offered her the best chance for survival, that chemotherapy regimen required for her condition is apparently well-tolerated by the fetus. The experience with any given chemotherapy regimen is limited, and we were frank with the patient that there were open questions about long-term effects. When her physician was informed of the patient’s desire to undergo chemotherapy and continue the pregnancy, he suggested that we take care of her and accept the liability. The patient underwent chemotherapy (Adriamycin and Cytoxan) and delivered a baby boy who appeared entirely normal at birth.

In the prior case, the reluctance of the woman’s physician to treat her was caused by a fear of being sued for unforeseen complications in the baby. An unfortunate reality is that the legal burden for the physician is severe if all possible risks of continuing the pregnancy are not communicated to the patient.

In the U.S., multimillion dollar court judgments for “wrongful life” are allowed if the patients assert that they would have had an abortion had they known a particular problem might have ensued.

Irish Doctors: Abortion Doesn’t Save Lives

In Ireland, where there is a political battle underway to legalize abortion, more than 900 health care providers have signed the Dublin Declaration, which states that abortion is not necessary to save women’s lives.

The statement was launched in 2012 and reads:

As experienced practitioners and researchers in obstetrics and gynecology, we affirm that direct abortion—the purposeful destruction of the unborn child—is not medically necessary to save the life of a woman.

We uphold that there is a fundamental difference between abortion, and necessary medical treatments that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child.

We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.

Learn more at www.dublindeclaration.com.
It is impossible to foresee and enumerate each and every possible complication. But if abortion is recommended, even with minimal or no justification, there is no legal penalty.

Many women are thus not advised of all the possibilities for treatment and referred for abortion unnecessarily. A good source of information to counter the pro-abortion bias among physicians in these difficult situations is consultation with a pro-life maternal fetal medicine specialist.13

Abortion After Prenatal Testing

Fetal problems are the other serious rationale for considering abortion, and diagnosis of these abnormalities has multiplied with the increased use of ultrasound in pregnancy. Ultrasound studies of fetal anatomy are often done at 18-20 weeks, so abortions done as a result of these scans are late abortions. But ultrasound is imperfect and analysis of the images can result in inaccurate interpretations.

Pregnant women who have declined abortion for fetuses diagnosed by ultrasound with fatal birth defects such as Potter’s syndrome (kidney disease with no amniotic fluid) or thalassemic dwarfism (a fatal form of skeletal disease), have sometimes ended up giving birth to normal babies. Other parents have resisted recommended abortions for serious anatomical problems such as prune belly syndrome, omphalocele, congenital absence of the diaphragm, and other severe birth defects, and had their babies undergo surgical repair after birth.

C. Everett Koop, M.D., the former surgeon general and renowned pediatric surgeon, was asked during the partial-birth abortion hearings if he had treated children “born with organs outside of their bodies” (omphalocele). Dr. Koop replied, “Oh, yes indeed. I’ve done that many times. The prognosis usually is good. … the first child I ever did, with a huge omphalocele much bigger than her head, went on to develop well and become the head nurse in my intensive care unit many years later.”13

For fatal birth defects, abortion is sometimes presented as the only option. But a better alternative is perinatal hospice. This involves continuing the pregnancy until labor begins and giving birth normally, in a setting of comfort and support until natural death occurs. It is similar to what is done for families with terminally ill children and adults.

Karen Santorum, a nurse and the wife of former Senator Rick Santorum, was faced with the prospect of her own son, Gabriel, being born with a fatal birth defect. She describes how Gabriel lived only two hours, but how in those two hours “we experienced a lifetime of emotions. Love, sorrow, regret, joy — all were packed into that brief span. To have rejected that experience would have been to reject life itself.”

The sense of peace and closure felt by families experiencing neonatal death in a hospice setting contrasts markedly with the experience of families undergoing abortion for fetal anomalies. Many couples who have had abortions for birth defects suffer from adverse long-term psychological effects and prolonged grief reactions.14 Children who learn that their mothers aborted their siblings can suffer feelings of worthlessness, guilt, distrust and rage.15

Non-fatal birth defects can be more challenging. The most common prenatal diagnosis resulting in mid-trimester abortion is Down Syndrome. There has been an aggressive campaign by the American College of Obstetrics and Gynecology to use new technologies to detect Down Syndrome in younger women through measurement of fetal neck-fold thickness and first-trimester blood tests, now that prenatal diagnosis and abortion have succeeded in eliminating 90 percent of babies with Down Syndrome in women over 35.

After diagnosis of Down Syndrome, families are often not presented with an honest discussion of parenting their child with
Down Syndrome, or the possibility of their child attending school and leading a semi-independent life. There are couples who are willing to adopt children with Down syndrome or other health problems, but genetic counselors frequently do not give patients this information. Diagnosis of a child with a fetal anomaly is life-changing and a major stress, but many families rise to the occasion and are able to cope with a disabled child.

Although parents choosing abortion may allege that the disabled child is better off not existing, disabled adults would contest that assertion. When surveyed in numerous studies, no differences have been found between disabled and “able-bodied” people as to their satisfaction with life.

The Tiller murder, as well as the legislative and judicial hearings on partial-birth abortion, exposed the public to a repugnant discussion of late-term abortion techniques, which include fetal dismemberment, partial-birth abortion, and feticidal injection of digoxin or potassium chloride into the unborn baby’s heart preceding multi-day induction of labor.  

Late-term abortions result in more hemorrhage, lacerations and uterine perforations than early abortions, as well as risk of maternal death approaching that of carrying the baby to term. Subsequent pregnancies are at greater risk for loss or premature delivery due to trauma from late-term abortions. The psychological damage of aborting a late-term pregnancy, particularly one that is desired, can be profound and long lasting.

In conclusion, although serious threats to health can occur, there is always a life-affirming way to care for mother and baby, no matter how bleak the prognosis. The elimination of late-term abortion would not create a void in medical care, but would instead result in a more humane world in which vulnerable humans would be treated with the dignity and respect that they deserve.

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Citations

2. There are two organizations reporting abortion statistics in the U.S. The CDC relies on data from state governmental sources, but excludes several states that have no reporting requirements. The Guttmacher Institute’s data is collected from abortion providers. The Guttmacher data is more inclusive and accurate for the total number of abortions but lacks the analytical detail of the CDC statistics. It is generally believed that abortions are underreported.

Citations continued on page 8
Along with the medical dangers of late-term abortions (see p.1), a 2010 study of women who had abortions found that women having later abortions had increased psychological risks, were more likely to be ambivalent about having an abortion and more likely to need counseling and support.

The results came from an online survey of 374 women who answered a detailed questionnaire about the circumstances leading to their abortions, their previous mental health history, history of physical or sexual abuse and emotional state following abortion.

The small study was the first to compare the experiences of women having early abortions compared to women having later abortions (in the second or third trimester). It found that women having abortions after 13 weeks were more likely to report that:

- their partner desired the pregnancy (22.4 percent of women who had later abortions vs. 10.3 percent who had early abortions);
- that they were pressured by someone other than their partner to abort (47.8 percent vs. 30.5 percent);
- their partner didn’t know about the abortion (23.9 percent vs. 12.5 percent);
- they had left their partner before the abortion (28.3 percent vs. 15.6 percent);
- physical health concerns were a factor in having the abortion (29.8 percent vs. 14.7 percent).

Ambivalence about the abortion, unwanted abortion and poor pre-abortion counseling were also commonly reported in the late-term abortion group. Nearly 40 percent said they desired the pregnancy and only 30 percent said both they and their partner supported the abortion, while less than 14 percent said they received adequate pre-abortion counseling or information on alternatives or physical and emotional risks.

“In general, these results are indicative of more ambivalence and conflict surrounding the decision and the likelihood of less stable partner relationships among women who obtain later abortions,” the authors wrote. “Logically, women who are unsure about how to proceed with an unplanned pregnancy are more likely to put off the decision to abort, perhaps hoping their circumstances will improve and enable them to carry to term.”

The study also found high rates of post-traumatic stress disorder (PTSD) symptoms for women having both early and late abortions, with 52 percent of the early abortion group and 67 percent of the late term abortion group meeting the American Psychological Association’s criteria for post-traumatic stress disorder symptoms (PTSD).

One possible cause may be a high number of women having unwanted abortions due to the reactions of those around them, the authors said.

“Concern regarding reactions of others to having a child” was the mostly frequently cited reason for abortion for both early (69.1 percent) and late (62 percent) abortions. As a result, many women likely had abortions “despite ambivalence or actually desiring to continue the pregnancy.” Feelings of ambivalence or having an unwanted abortion are known risk factors for psychological problems after abortion.

When it came to differences between the late and early abortion groups, women having later abortions were more likely to report having disturbing dreams, reliving the abortion, having trouble sleeping and experiencing intrusion (a PTSD symptom that involves having recurring memories, flashbacks or hyperactivity when confronted with reminders of the trauma).

Study Citation

Mark your calendars for the 4th Annual Church Awareness Project/Coerced Abortion Awareness Week that will be held on April 12-19, 2015. Find out more on p. 7, and be sure to read the article below to learn how your church can reach out to those who are struggling.

You hear it everyday through TV, radio, Internet, newspapers. Forty years after legalization in the U.S., abortion remains a hot and divisive issue.

But in the wake of the over 55 million abortions having been performed in the U.S. since 1973, remain the multitudes of “silent sufferers,” for whom abortion has been a traumatic life-changing experience.

Who are these silent sufferers? They are family members, neighbors, co-workers, those sitting next to us in church.

With 43 percent of American women having had an abortion, there is a strong likelihood that half of the people you come in contact with have been affected by abortion, many exhibiting symptoms of post-abortion stress.

We hear about the effect on babies that are aborted, but little attention is paid to what happens to those that are left behind living with the decision.

Fortunately, revival is beginning. The unavoidable talk in the media is churning discussion about the consequences of abortion and spurring the silent sufferers to seek out recovery programs. Every time the word “abortion” is featured, the inner pain of the post-abortive is triggered.

But to whom do the silent sufferers turn? Some will dig deeper into their pain, refusing to consider that their past abortion has any correlation with the agony they are experiencing. The inner turmoil, never addressed, can be agonizing.

But quite often they will seek help within their church, since 79 percent of post-abortive women identify themselves as Christians, 43 percent identify as Protestant, and 27 percent identify as Catholic. Ministry leaders unequipped about the needs of the post-abortive are learning first-hand the particular agony that has festered within their congregations for many years.

Churches are now seeking resources and training to begin ministries to help the post-abortive to find God’s healing.

What can your church do to reach out to post-abortive women and men? Here are a few suggestions:

Understand the many factors that lead to an abortion: pressure from others, lack of information, and the feeling that they have no other choice. This understanding enables us to avoid condemning.

Understand that because abortion has been legal in the U.S. since 1973, our society now considers it normal and acceptable. People believe that it is their right and bears no consequences. Most importantly, realize that almost no one is addressing the severe emotional and physical effects of abortion.

Understand the cost our society has paid for legalized abortion. If we fully realized the cost, in human suffering, that abortion has caused (suicide, drug and alcohol abuse, promiscuity, abuse of women and children), we would be shaken to our core.

Understand the pain someone experiences from an abortion. Be compassionate and loving.

Understand their need for forgiveness. Many believe that abortion is a sin too big for God to forgive and often are unable to forgive themselves.

Understand and address the need to develop a specific ministry for post-abortion healing within your church.

Understand the power of love ... where they are ... as they are. Allow the post-abortive to see the love, hope and healing power of Jesus Christ. When the hurting have walked through the healing process, they then can speak out, impassioned to take their message of pain and healing to the world around them, perpetuating the truth of the harmfulness of abortion and the healing found only in Jesus.

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Debby Efurd is the co-Founder of Initiative 180 in Dallas, TX. Initiative 180 offers Peace After the Storm, a program of post-abortion healing. Learn more at http://initiative180.org.
The Elliot Institute’s Church Awareness Project is now in its fourth year, offering free resources to help churches address abortion and offer real hope and help in their communities.

An Elliot Institute survey found that many people in churches and pro-life circles want their pastors to speak out about abortion. But most respondents also told us that they seldom, if ever, hear anything about this issue from the pulpit.

The Church Awareness Project is an online program that helps pastors and faith leaders learn how to preach and teach on abortion. It also helps them learn what kind of resources and help their churches and ministries can offer to pregnant women and their loved ones and to those who are hurting after abortion (see p. 6 for more on how churches can do this).

A key component of this ministry is the Annual Coerced Abortion Awareness Week, which will take place April 12-19, 2015.

The focus on coerced and unwanted abortion is key to ending the idea that abortion should remain available because women want and need it. The Coerced Abortion Awareness Week resources show that abortion isn’t really about “choice” (in fact, most abortions are unwanted or coerced) and that it actually seriously harms the rights of women and girls.

Further, many people in our own congregations and communities are vulnerable to abortion pressure, deception and coercion. Many are left hurting, traumatized and even suicidal after abortion.

Responding with true compassion, support, and real alternatives to abortion is part of the church’s mission to help those who are hurting, and also vital to opening minds and hearts.

These ideas are laid out in The Jericho Plan: Breaking Down the Walls Which Prevent Post-Abortion Healing, a guide for pastors and faith leaders written by Elliot Institute director Dr. David Reardon. The 96-page book is available in a free pdf download to those who join the project’s email list.

There are also more than 20 other free, downloadable resources for pastors, church and ministry leaders, and lay people, including educational materials, bulletin inserts, bulletin board ads and flyers, suggested prayer intentions, fact sheets, “help and healing” guides and more. It also includes introductory letters for pastors and other church leaders to explain the project.

While these materials can be used year-round, churches are especially encouraged to devote the week after Easter—a time of new life and rebirth—to offer this important message of God’s grace and the community’s support. Two Sundays are included to give churches more chances to participate.

More than 600 people and ministries have joined so far, and we are hoping that this year will be even more successful. Learn more and sign up at www.afterabortion.org/churchawarenessproject.

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Here are just a few of the projects we’ve been busy with in the past few months:

- Periodically we get bulk orders for *The Jericho Plan*, our book for pastors on how to preach on the abortion issue in a way that opens doors to healing while also getting past all of the controversy surrounding abortion in many congregations. Most recently, we received an order for 150 copies to be distributed in South Korea. Please pray that their effort will bear great fruit.

- With election season behind us, Dr. Reardon is talking with pro-life lobbyists about why they should consider adopting our pro-woman/pro-life model screening legislation as a priority. Please encourage your state leaders to consider this legislation. Learn more at www.stopforcedabortions.com.

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**Special Contributions**

In memory of
Jack Hogan     Sharon Van Meter

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11. The conditions are Marfan’s syndrome with aortic root involvement, complicated coarctation of the aorta, and, possibly, peripartum cardiomyopathy with residual dysfunction.