

IS LATE-TERM ABORTION EVER NECESSARY?

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In the aftermath of the killing of George Tiller, the Kansas abortionist, on May 31, 2009, we have heard praises of his compassion and courage in performing late-term abortions. According to NARAL Pro-Choice Colorado, “Dr. Tiller was one of few doctors with the expertise necessary to provide safe, professional abortions under the most difficult of circumstances: when a woman who had wanted children was told late in her pregnancy that a severe fetal anomaly had developed or that continuing the pregnancy threatened her own life.”¹ Former patients gave heart-wrenching testimonies of late-term abortion being their only alternative upon discovery of fatal birth defects. In his clinic’s video given to late-term abortion patients, Tiller welcomed women who came to him to “end a pregnancy early because of some serious disease process: cancer, lymphoma, diabetes, high blood pressure, heart disease,” as well as those who were bearing children with fetal anomalies. The president of the Center for Reproductive Rights, a legal advocacy organization, claimed that the closing of Tiller’s clinic left “an immediate and immense void in the availability of abortion.”

But is late-term abortion (or any abortion) ever really necessary? Does the demise of a clinic performing late-term abortions leave a “void” that is harmful to women?

The Tiller murder and the legislative and judicial hearings on partial-birth abortion have focused public attention on late-term abortion in the U.S. Late-term abortion is not an exact medical term, but it has been used to refer to abortions in the third trimester (28-39 weeks) or even second trimester abortions (13-27 weeks). According to less-than-perfect statistics collected by the Centers for Disease Control (CDC) and the Guttmacher Institute,² 12% of U.S. abortions, approximately 144,000 procedures a year, are performed after the first trimester, that is, more than 12 weeks elapsed time after the woman’s last menstrual period. About 15,600 abortions, 1.3% of the 1.2 million abortions in 2005, occur after the 20th week.³



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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.⁴ 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. 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.⁵ 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.⁶ They are done for similar reasons as early abortions: relationship problems, young or old maternal age, education or financial concerns.⁷

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.⁸ The Kansas Attorney General Phill 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 patient records and determined that they were not.⁹

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% 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% 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 have 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 she needed to abort her pregnancy prior to treatment, and that her prognosis was worse if she remained pregnant. Goodwin states:

We discussed with her published evidence that breast cancer is not affected by pregnancy and that the 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 Cytosan) and delivered a baby boy who appeared entirely normal at birth. *That many chemotherapy regimens can be continued without apparent ill-effect in pregnancy is information readily available to any interested physician, but the patient was not informed.*

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.,

multi-million 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. 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.¹²

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 thanatophoric 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% of Down babies in women over 35. After diagnosis of Down syndrome, families are often not presented with an honest discussion of parenting their Down syndrome child, or the possibility of their Down syndrome child attending school and leading a semi-independent life. There are couples who are willing to adopt children with Down syndrome or other birth defects, 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, have exposed the public to a repugnant discussion of late-term abortion techniques, which include fetal dismemberment, partial-birth abortion, and fetocidal injection of digoxin or potassium chloride into the unborn baby’s heart preceding multi-day induction of labor.¹⁶ Late-term abortions result in more hemorrhage, lacerations and uterine perforations than early abortions,¹⁷ as well as risk of maternal death approaching that of carrying the baby to term.¹⁸ Subsequent pregnancies are at greater risk for loss or premature delivery due to trauma from late-term abortions.¹⁹ 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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NOTES

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¹ Press Release, “NARAL Pro-Choice Colorado Statement on Dr. George Tiller’s Assassination,” (Denver, CO: June 1, 2009). “NARAL” is an acronym for a pro-abortion group founded in 1968. The acronym first stood for “National Association for the Repeal of Abortion Laws,” but after *Roe v. Wade* was decided in 1973 the name was changed to National Abortion Rights Action League and later to National Abortion & Reproductive Rights Action League. In 2003, the national organization became NARAL Pro-Choice America.

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.

³ The Guttmacher statistics for 2005 are published in R.K. Jones, M.R. Zolna, S.K. Henshaw, and L.B. Finer. “Abortion in the United States: Incidence and Access to Services, 2005.” *Perspectives on Sexual and Reproductive Health* 40 (Mar 2008): 6-16. The CDC data can be found in Sonya B. Gamble, Lilo T. Strauss, Wilda Y. Parker, Douglas A. Cook, Suzanne B. Zane, and Saeed Hamdan. “Abortion Surveillance – United States, 2005,” *MMWR Surveillance Summaries* 57 (SS-13) (Atlanta, Ga: Centers for Disease Control and Prevention, Dep’t of Health and Human Services, Nov. 28, 2008): 1-36 (Tables 1, 6).

⁴ Americans United for Life. *Defending Life 2009: Proven Strategies for a Pro-Life America* (Chicago, IL: AUL Legal Guide 2009): 55. Go to: <http://dl.aul.org>

⁵ Wikipedia, Ronald J. Fitzsimmons. The Wikipedia entry contains a link to this article (.pdf): Diane M. Gianelli. “Medicine Adds to Debate on Late-term Abortion: Abortion Rights Leader Urges End to ‘Half Truths,’” 40 *American Medical News* (Washington, D.C.: American Medical Association), March 3, 1997.

⁶ Cassing Hammond, “Recent Advances in Second Trimester Abortion: An Evidenced-based Review” *American Journal of Obstetrics and Gynecology*, 200 (April 2009): 347-356.

⁷ Lawrence B. Finer, Lori F. Frowth, Lindsay A. Dauphinee, Susheela Singh, and Ann M. Moore, “Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives.” *Perspectives on Sexual and Reproductive Health*, 37 (Sept. 2005): 110-118.

⁸ Alan Bavley. “Abortions Late in Pregnancy Push Public, Doctors to Moral Dilemma.” *Kansas City Star* (Aug. 26, 1991): B1.

⁹ Bill O’Reilly. “The O’Reilly Factor,” Fox News Channel, June 13, 2007 (interview with Paul McHugh, M.D.) (< <http://www.foxnews.com/story/0,2933,281861,00.html> >). Dr. Paul R. McHugh, M.D., is the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine, and he is currently a member of the President’s Council on Bioethics.

¹⁰ T. Murphy Goodwin. “Medicalizing Abortion Decisions.” *First Things*, 61 (March 1996): 33-36.

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

¹² A directory of pro-life maternal-fetal medicine specialists can be found on-line. Go to: <www.prolifemfm.org>. These superbly qualified physicians are eager to help women who have been advised to undergo an abortion for medical reasons or fetal birth defects.

¹³ Text from Congressional Record, Senator Rick Santorum, September 24, 1996. Santorum included the following article for the record: Diane Gianelli and Christina Kent. "The View From Mount Koop," *American Medical News* (Washington, D.C.: American Medical Association), Aug. 19, 1996. Link to C-SPAN "Congressional Chronicle": <http://bit.ly/X4lXz>

¹⁴ M. C. White-van Mourik, J. M. Connor, and M. A. Ferguson-Smith. "The Psychosocial Sequelae of a Second-trimester Termination of Pregnancy for Fetal Abnormality." *Prenat Diagn.* 12 (Mar 1992): 189-204.

¹⁵ P.G. Ney. "Post-abortion Survivors Syndrome." *Can J Psychiatry* 38 (Oct 1993): 577-8.

¹⁶ Cathy Cleaver Ruse and William L. Saunders, Jr., "Partial-Birth Abortion on Trial" (Washington, D.C.: Family Research Council, 2006). Ruse and Saunders present sworn federal testimony by those who performed partial-birth abortions. The technical medical term for dismemberment abortion is "dilation and evacuation;" for partial birth abortion is "intact dilation and evacuation."

¹⁷ Daniel Grossman, Kelly Blanchard, and Paul Blumenthal. "Complications after Second Trimester Surgical and Medical Abortion." *Reproductive Health Matters Supplement* 16 (May 2008): 173-82. Abstract available at SSRN: <http://ssrn.com/abstract=1350296>

¹⁸ A study by the Centers for Disease Control showed abortion mortality rises sharply with each week of gestation. In the study period 1988-1997 the mortality rate for induced abortion after 20 weeks was 8.9 per 100,000. The maternal mortality rate for live birth in a comparable period, was 7.06. See L. A. Bartlett, C. J. Berg, H. B. Shulman, S. B. Zane, C. A. Green, S. Whitehead, H. K. Atrash. "Risk Factors for Legal Induced Abortion-related Mortality in the United States." *Obstet Gynecol.* 103 (Apr 2004): 729-37; D. A. Grimes. "Estimation of Pregnancy-related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999." *Am J Obstet Gynecol.* 194 (Jan. 2006): 92-4. Since 2000 maternal mortality for live births in the U.S. has risen to 13 in 2004 (CDC).

¹⁹ E. Papiernik, J. Zeitlin, D. Delmas, E. S. Draper, J. Gadzinowski, W. Künzel, M. Cuttini, D. Di Lallo, T. Weber, L. Kollée, A. Bekaert, and G. Bréart G; MOSAIC Research Group. "Termination of Pregnancy among Very Preterm Births and Its Impact on Very Preterm Mortality: Results from Ten European Population-based Cohorts in the MOSAIC study." *BJOG* 115 (Feb 2008): 361-8.