

**Response from NRLC President Carol Tobias to question
from Senator Charles Grassley regarding the relative “safety” of abortion
August 4, 2014**

QUESTION FROM SENATOR GRASSLEY: *Nancy Northup, president and CEO of the Center for Reproductive Rights, in her written testimony to the Committee, on pages 5-6, stated that Mary Spaulding Balch, state legislative director for National Right to Life, recently “openly criticized the [pro-life] movement's cynical focus on women's health because it is so clearly unconnected to the reality of how safe abortion is.” Ms. Northup asserted that Ms. Balch “conceded that data show that abortion, even after the first trimester, carries a lower risk of serious complications than vaginal births, cesarean sections, and even plastic surgery procedures such as facelifts and liposuction. And she recognized the absurdity of asserting women's health as a rationale for some of the stringent laws legislators have been leveling at abortion care . . .” These statements by Ms. Northup were all based, according to a footnote, on a single article by Sofia Resnick that appeared on the “pro-choice” advocacy website RH Reality Check on July 2, 2014. Did Ms. Northup’s testimony accurately reflect the position of your organization? Please offer any additional observations that would clarify, give context to, or otherwise illuminate the statements made by Ms. Northup or the thrust of the underlying article by Ms. Resnick.*

Response of Carol Tobias, President, National Right to Life Committee:

Is abortion safer than childbirth? Looking at the medical evidence, National Right to Life doesn’t think so. Obviously, abortion is not safer for the unborn child, reason enough to oppose the practice. Moreover, claims that the abortion procedure is seven,¹ eleven,² fourteen,³ twenty-three,⁴ or “hundreds of”⁵ times safer for the mother than childbirth, don’t hold up to scrutiny.

¹ S.A. LeBolt, David A. Grimes, Willard Cates, Jr., “Mortality from abortion and childbirth. Are the populations comparable?” *Journal of the American Medical Association*, Vol. 248, No. 2 (July 1982), pp. 1880-191.

² Susanne Pichler, “Medical and Social Health Benefits Since Abortion Was Made Legal in the U.S.” Planned Parenthood Federation of America, Fact Sheet (December 2004), available at <http://mcadams.posc.mu.edu/blog/fact-abortion-medical-social-benefits.pdf>, accessed 7/24/14.

³ E.G. Raymond, David A. Grimes, “The comparative safety of legal induced abortion and childbirth in the United States,” *Obstetrics & Gynecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

⁴ Original cite of ACOG Amicus Brief for *Doe v. Bolton*, cited by Willard Cates, Jr. David A. Grimes, L. Lynn Hogue, “Topics for Our Times: Justice Blackmun and Legal Abortion – A Besieged Legacy to Women’s Reproductive Health,” *American Journal of Public Health*, Vol. 85, No. 9 (September 1995), pp. 1204-6.

⁵ Leroy Carhart, speaking on “A Woman’s Choice, a Nation Divided,” Anderson Cooper 360 Degrees, CNN, June 5, 2009.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 2

Even ignoring the bias of the researchers responsible for publishing these estimates, many of them longtime pro-abortion activists, there are a number of problems with statistics making this claim.

Most of these claims, if they involve data of any kind, rest at some point on maternal mortality rates and abortion mortality figures from the U.S. Centers for Disease Control (CDC). Though the data represent real lost lives, use of these figures is problematic. As CDC Director Dr. Julie Gerberding acknowledged in a July 20, 2004 letter (attached): “These measures are conceptually different and used by the CDC for different public health purposes.”⁶

As the CDC letter states, “maternal mortality is computed as all maternal deaths per 100,000 live births,” while “the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions.” The Pregnancy Mortality Surveillance System used by the CDC to track maternal mortality says that “a pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”⁷

Under such circumstances, efforts to contrast maternal and abortion mortality are akin to comparing apples to oranges. Why?

1) Most dramatically, if pregnancy-related maternal deaths *include maternal deaths from abortions*, this makes pregnancy in general appear more dangerous by including those maternal abortion deaths along with those that occur during childbirth.

2) While abortion maternal mortality is compared to the total number of abortions, the pregnancy-related maternal death statistic is *not* compared to the total number of pregnancies – it is based on the number of live births, omitting miscarriages and induced abortions. The inaccurately smaller denominator inflates the value of the numerator, making the fraction -- in this case, maternal mortality -- seem higher than it actually is, e.g., $\frac{1}{2}$ is greater than $\frac{1}{3}$.

Moreover, to accurately compare mortality rates from abortion and childbirth requires that we have complete and accurate data on deaths related to each outcome. While an attempt has been made to identify and collect data on pregnancy-related deaths,⁸ efforts to get a full count of abortion-related deaths are hampered by a number of problems.

⁶ Letter of July 20, 2004 from Julie L. Gerberding, M.D., M.P.H., Director of U.S. Centers for Disease Control, to Walter M. Weber, American Center for Law & Justice.

⁷ CDC webpage for Pregnancy Mortality Surveillance System at <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html>, accessed 7/29/14.

⁸ The Centers for Disease Control and Prevention began its Pregnancy Mortality Surveillance System in 1986. See information of the government program at <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html>, accessed 7/24/14.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 3

While women giving birth are followed for a year after, women who have abortions and die may never be counted in U.S. abortion mortality statistics.⁹ If they contract a fatal bacteria or bleed to death as a result of their abortion procedure, the death will be attributed to the infection or the hemorrhage, but there may not even be any notation of the abortion, or perhaps even the pregnancy on the death certificate.¹⁰

On occasion, it may be that the omission is deliberate, in order to spare families embarrassment or the reputation of abortionist involved,¹¹ but with the advent of chemical abortions, it is entirely possible that the physician handling the fatal complication may have no knowledge of the abortion.¹²

Given the problems and limitations of U.S. maternal mortality data, any claim of abortion's relative safety against childbirth is suspect with many abortion related deaths unreported and uncounted.¹³

A much better gauge comes from countries which track each patient encounter across the entire health system, so that individual outcomes can be reported over time even where there are multiple providers.

⁹Many government and medical sources are cited in examples by David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy*, Vol. 20, No. 2 (2002), pp. 279-327.

¹⁰*Ibid*, and A.P. Mackay, R. Rochat, J.C. Smith, C.J. Berg, "The check box: determining pregnancy status to improve maternal mortality surveillance." *American Journal of Preventive Medicine*. Vol. 19, Supplement 1 (July 2000), pp. 35-9.

¹¹ David C. Reardon, Thomas W. Strahan, John M. Thorp, and Martha W. Shuping in "Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications," *The Journal of Contemporary Health Law & Policy*, Vol. 20, No. 2 (2002), pp. 279-327.

¹² One group, Women on Waves, specifically tells women that if they need to go to the hospital they do not need to say that they took misoprostol pills to induce an abortion.

Misoprostol causes a miscarriage. The symptoms of a miscarriage and an abortion with pills are EXACTLY the same and the treatment is EXACTLY the same.

You do not need to say that you took the medicines. If you took the medicines as instructed at www.womenonwaves.org, they dissolve and there is no test that can tell a doctor or nurse that you took medicines.

<http://www.womenonwaves.org/en/page/711/in-collection/702/using-medications-pills-to-end-an-unwanted-pregnancy-in-the-usa>, accessed 7/24/14.

¹³ In *Victims of Choice* (1996), private investigator Kevin Sherlock examined death certificates and other public information and matched these against state statistics and found that there were many abortion related deaths that were not reported.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 4

Studies from Finland, where there has been a nationwide and modern healthcare system and reporting in place for a number of years, provide more reliable data.

Linking data from national birth, death, abortion, and hospital discharge records in Finland from 1987 to 2000 for all deaths for females of reproductive age (15-44), Mika Gissler and colleagues from the National Research and Development Centre for Welfare and Health found data showing mortality rates at one year out for aborting women more than three times what it was for women giving birth.¹⁴

One thing the Finnish data makes plain is that pregnancy-related mortality is more than just a matter of the relative safety of a given medical procedure. And in this regard, the heavy psychological and social costs of abortion over childbirth become readily apparent.

In a second study using the same data set, Gissler and colleagues found that mortality rates for abortion were 11 times higher for homicide, more than six times higher for suicide, and even more than five times higher for unintentional injuries than they were for pregnancy or birth one year after the event. For each cause, the mortality rate was also higher for abortion than it was for non-pregnant women or those dealing with miscarriage or even ectopic pregnancy.¹⁵

State data from California are consistent with this result. A study looking at maternal deaths associated with Medicaid-eligible women having abortions or delivering babies in 1989 one year out found the aborting women nearly three times (2.88) as likely to die a violent death than those giving birth. Researchers found a good portion of this higher rate associated with suicide.¹⁶

Activist researchers defending the abortion industry may have reason to be selective in their data sets, but when outcomes are more consistently and completely tracked, it is clear that abortion is not safer than childbirth.¹⁷

¹⁴ Mika Gissler, Cynthia Berg, Marie H el ene Bouvier-Colle, Pierre Buekens, "Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000," *American Journal of Obstetrics and Gynecology*, Vol. 190, No. 2 (February 2004), pp. 422-7.

¹⁵ Mika Gissler, Cynthia Berg, Marie H el ene Bouvier-Colle, Pierre Buekens, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European Journal of Public Health*, Vol. 15, No. 5 (October 2005), pp. 459-463.

¹⁶ David C. Reardon, Priscilla Coleman, "Pregnancy-associated mortality after birth," Letter to the Editors, *American Journal of Obstetrics and Gynecology*, Vol. 191, No. 4 (October 2004), pp. 1506-7.

There is a dramatic inconsistency between abortion advocates' claims concerning the physical safety (for the mother) of abortion, coupled with their repeated assertions that health regulations proposed for abortion are unnecessary, on the one hand, and their oft-repeated argument that if legal protection against abortion is provided to unborn children in the future, a result will be maternal mortality from illegal abortion comparable to what occurred in the penicillin early years of the 20th century, on the other hand. As comprehensively demonstrated

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 5

That said, there are practical and principled reasons why National Right to Life believes that it is not wise to make the relative safety of childbirth over abortion the over-arching theme for advancing pro-life legislation. If one treats the abortion debate purely as a matter of relative safety, it makes the policy beholden to whatever the latest popular study might say, no matter how poor the data or methodology.

NRLC's state legislative director Mary Spaulding Balch, J.D., speaking at National Right to Life's convention in Louisville in June 2014, pointed out that there are studies that exist showing procedures with higher mortality rates than abortion (if the nearly 100% mortality of the unborn child is excluded).

Balch also included statistics from one hospital in India showing a higher mortality rate from cesarean sections than from vaginal deliveries, which she noted would be not be expected to lead to a statute prohibiting c-sections.¹⁸ That context has been largely missing in most coverage of those remarks.

Defenders of abortion will produce, as the need requires, inadequately backed studies, such as the latest by Raymond and Grimes.¹⁹ The mainstream news media and the medical establishment can be expected to cite claims that "abortion is X times safer than childbirth" as an undisputed fact, without reflecting the gaps in the data on which these claims are based.

The debate over relative safety should not obscure the fundamental problem with abortion, which is that it is the intentional destruction of human life.

by Cynthia McKnight in "Life Without Roe: Making Predictions About Illegal Abortions" (available at www.nrlc.org/uploads/stateleg/LifeWithoutRoe1992.pdf) "the continuing decrease in maternal deaths related to abortion—both legal and illegal—was the result, not of the legalization of abortion, but of continued medical progress.

¹⁸ The study reported a maternal death risk of 27 per 13,637 c-sections versus 19 per 30,215 vaginal deliveries. However, the cited article [G. Kamilya, S.L. Seal, J. Mukherji, S.K. Bhattacharyya, A. Hazra, "Maternal mortality and cesarean delivery: an analytical observational study," *The Journal of Obstetrics and Gynaecology Research*, Vol. 36, No. 2 (April 2010), pp. 248-53] reports a study specifically intended to fill "a dearth of data from developing countries" and covers results from one hospital in Kolkata, India from 2003 to 2006. It cannot be directly applied to the United States; indeed, the article itself cites a "literature review" from developed countries [which] concluded that there may not be an increased risk of maternal mortality with elective CD compared to VD." In any event, neither the maternal mortality rate associated with vaginal delivery nor that associated with cesarean sections reported in this one hospital in India can reliably be used in direct comparison with maternal mortality from abortion in the United States.

¹⁹ E.G. Raymond, David A. Grimes, "The comparative safety of legal induced abortion and childbirth in the United States," *Obstetrics & Gynecology*, Vol 119, No. 2, Part 1 (February 2012), pp. 215-9.

CAROL TOBIAS RESPONSE ON ABORTION "SAFETY," 6

Pro-lifers care about the life and safety of the mother, because we care about the life of each and every human being, no matter their age or stage of development. But it will not be enough to make abortion safe or safer for the mother, since it still fundamentally entails the death of the innocent child.

One expects that there will always be risk involved in both abortion and childbirth. Though the psychological ramifications for those women having abortions or giving birth will be quite divergent and are likely to entail significant consequences, it is true that within both groups most women are unlikely to encounter any immediate medical crises. There is much dispute over whether the aborting women or the childbearing women are likely to experience the most complications and negative consequences. National Right to Life firmly believes that the heavier burden will be borne by those who abort.

But even for a woman who suffers no immediate physical consequences, there is a huge difference between an outcome that leaves her with a dead baby and a live one. The lives of both the mother and the child are precious to National Right to Life, and so we will continue in our efforts to oppose abortion and to see every child welcome in life and protected in law.



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

JUL 20

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:


1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions) in the United States have been published only since the 1970s.
2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 150 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,


Julie Louise Gerberding, M.D., M.P.H.
Director