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Abortion in America

by Dr. Camilla Hersh and Barbara L. Lyons

Why do women have abortions? Who is the typical woman obtaining an abortion? How many abortions are performed in the United States each year and at what stage of pregnancy? Is abortion being used as a means of birth control? What are the attitudes of Americans toward the reasons for which abortions are performed? These are some of the important questions which arise in the public policy debate on abortion.

Although abortion on demand has been legal for 20 years, most Americans still do not realize the extent to which abortions are performed, and are not aware that abortion is legal for the full nine months of pregnancy.

Most Americans want to believe that an abortion decision is the act of a desperate woman in an extreme circumstance who, subsequently realizing her mistake, alters her behavior so that she will not abort again. However, that vision of abortion in America could not be further from the truth. In fact, the extreme circumstances in which Americans believe that most abortions occur – those situations where the woman is a victim of rape or incest, when the mother's life or health are gravely jeopardized, or when the child has a potential disability – comprise, at most, only 7% of the 1.6 million abortions which are performed each year.

This issue of *Life Cycle* will focus on reasons for abortion in America in two parts.

The first part will deal with the 93% of abortions which are performed as a matter of convenience to the mother. The reader will learn:

- why women have abortions.
- who is the typical woman obtaining an abortion.
- the number of abortions.
- the stages of pregnancy at which women obtain abortions.
- statistics on the rising number of repeat abortions.
- public attitudes on reasons why women have abortions.

The second part will deal with the so-called hard-case pregnancies which comprise, at most, 7% of abortions. It will also discuss medical conditions which, in the past, may have required abortion to save the life of the mother, but for which abortion is today no longer necessary due to the advances in medical care and technology. We will look at statistics as well as the personal stories of ordinary people who found themselves in extraordinary circumstances.

It is our hope that the reader will be given new insights into the true nature of abortion in America, not only reasons and numbers, but also the need for both life-respecting public attitudes and increased support systems for women facing problems associated with pregnancy. As depicted in our dramatic personal stories, even a hard-case pregnancy can result in decisions which not only preserve life but enhance the very meaning of life.

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Table 1

Why Women Have Abortions

Reason for abortion	*	**
Woman is concerned about how having baby would change her life	16%	284 women
Woman can't afford baby now	21%	372 women
Woman has problems with relationship/ wants to avoid single parenthood	12%	213 women
Woman is unready for responsibility	21%	372 women
Woman doesn't want others to know she has had sex or is pregnant	1%	18 women
Woman is not mature enough, or is too young to have child	11%	195 women
Woman has all the children she wanted, or has all grown children	8%	142 women
Husband or partner wants woman to have abortion	1%	18 women
Fetus has possible health problem	3%	53 women
Woman has health problem	3%	53 women
Woman's parents want her to have abortion	–1/2%	–9 women
Woman was victim of rape or incest	1%	18 women
Other	3%	53 women

* Percent of 1,773 responses. Percentages in the original add up to 101% due to rounding (per Communication Dept. of *Family Planning Perspectives*.)
** Raw number of 1,773 respondents who chose each answer.

Why do women have abortions?

According to a 1988 article published in a journal by advocates of abortion, approximately 93% of abortions are obtained for social reasons. Authors Aida Torres and Jacqueline Sarroch Forrest conducted a survey of 1900 women with 1,773 responding. They then compiled a table, taken from the responses of the women surveyed, of the most important reason each woman had obtained an abortion.[1] When the percentages are added together, 93% of abortions were obtained for social reasons which do *not* include abortions for hard-case pregnancies. Their own analysis showed that so-called hard cases were, at most, 7%. These include abortions for:

- rape or incest (1%),
- pregnancies which jeopardized health (3%),
- pregnancies in which the child had a potential disability (3%).

Abortions in these circumstances are the focus of the second part of this *Life Cycle*.

[1] Torres, Aida and Jacqueline Sarroch Forrest, *Family Planning Perspectives*, Volume 20, Number 4, July/August 1988, p.170.*

** Please note that data comes from a publication of the Alan Guttmacher Institute, the research arm of Planned Parenthood, an abortion advocate group. Data presented in this and other tables may be biased in favor of abortion.*

TABLE 2

Characteristics of all women obtaining abortions in 1988

CHARACTERISTIC	PERCENT OF WOMEN BY CHARACTERISTIC	NUMBER OF WOMEN BY CHARACTERISTIC
AGE OF WOMEN		
<15 years of age	0.9%	13,650 women
15-17 years of age	10.0%	158,330 women
18-19 years of age	14.7%	234,390 women
20-24 years of age	32.7%	519,600 women
25-29 years of age	21.8%	347,250 women
30-34 years of age	12.4%	197,210 women
35-39 years of age	6.0%	95,870 women
>40 years of age	1.5%	24,450 women
RACE OF WOMEN		
White	64.5%	1,025,670 women
Non-White	35.5%	565,080 women
MARITAL STATUS OF WOMEN		
Married	17.4%	276,690 women
Unmarried	82.6%	1,314,060 women
TOTAL NUMBER OF ABORTIONS		1,590,750 women

Who is the woman obtaining an abortion?

The majority of abortions in the United States are obtained by young women (58.3%), white women (64.5%), and unmarried women (82.6%).[1] Women aged 18-19 have the highest abortion rate of any age group (63.5 abortions per 1,000 women).

Approximately 28.6% of pregnancies end in abortion each year.[2]

Table 2 outlines abortion in percentages and number of women by age, race, and marital status. The most recent statistics available are from 1988, and numbers have been copied precisely from a publication put out by advocates of abortion.*

[1] Henshaw, Stanley and Jennifer Van Vort eds., *Abortion Factbook*, 1992 Edition, "Readings, Trends, and State and Local Data to 1988," pp.173-177.
[2] Ibid., Ibid.

** An attempt was made to contact the authors for clarification of the discrepancy between percentages and actual numbers in Table 2. Numbers do not match percentages. Authors offered no assistance with clarification.*

TABLE 3

Number of repeat abortions in 1988[1]

NUMBER OF PREVIOUS ABORTIONS	% OF TOTAL ABORTIONS ANNUALLY	NUMBER OF WOMEN OBTAINING ABORTIONS (as applied to 1.6 million abortions/year)
First abortion	57.0%	(907,520 women)
1 previous abortion	27.0%	(429,260 women)
2 previous abortions	10.2%	(162,960 women)
3 or more previous abortions	5.7%	(91,010 women)
Total	100.0%	(1,590,750 women)

[1] Henshaw, Stanley and Jennifer Van Vort, eds., *Abortion Factbook*, 1992 Edition, "Readings, Trends, and State and Local Data to 1988," p.179

Is abortion used as a means of birth control?

Each year, a significant number of women obtain a second, third, or even a higher number of abortions. These are called repeat abortions. Because at least 43% of abortions performed each year are repeat abortions, the most obvious conclusion is that abortion has become a routine means of "birth control" in America.[1] Since the most recent repeat abortion numbers available go back to 1988, projection of the numbers from the rates up to 1988 would indicate that repeat abortions are probably closer to 50% in 1993.

Table 3 indicates the number of abortions a woman has previously obtained, (for example, 0-3 abortions or more), what percent of total abortions each category represents, and the number of women obtaining an abortion in each category.

[1] Henshaw, Stanley and Jennifer Van Vort, eds., *Abortion Factbook*, 1992 Edition, "Readings, Trends, and State and Local Data to 1988," pp.11-12.

ow many abortions are performed the United States each year nd at what stage of pregnancy?

Currently, abortion is legal in the United States throughout the full nine months of egnancy (see box on back cover for explanation of the 1973 Supreme Court decions which legalized abortion in all 50 states). There are approximately 1.6 million portions performed annually in the United States, an average of 4,400 each day. able 4 represents the number of abortions performed in the U.S. each year at varius times throughout pregnancy.

Though abortion statistics are not broken down between 21 and 40 weeks gestaion, the number of third trimester abortions (27 to 40 weeks gestation) was estimated at 4,000 in 1984 by former Surgeon General C. Everett Koop. In a 1993 news article, late-term abortionist Martin Haskell stated that "probably Koop's numbers are most correct.[1]"

1. Martin Haskell, *American Medical News*, "Shock-Tactic Ads Target Late-Term Abortion Procedure," July 5, 1993.

TABLE 4

Number of U.S. abortions annually at stages of pregnancy[1]

1988 Statistics 7 to 12 weeks	13 to 20 weeks	21 to 40 weeks (full term)
1,423,070	157,020	10,660

1. Henshaw, Stanley and Jennifer Van Vort, eds., *Abortion Factbook*, 1992 Edition, "Readings, Trends, and State and Local Data to 1988."

What are the attitudes of Americans toward reasons why women have abortions?

Since 1973, numerous public opinion polls have been conducted by a wide spectrum of polling firms to measure public attitudes on abortion. Depending on the questions asked, the conclusion is that a majority of Americans consider themselves to be "pro-life," but a majority of Americans are also decidedly "pro-choice." These contradictory results point out the pitfalls in obtaining objective data for opinions on abortion. Poll questions must avoid using terms such as "life" or "choice" which bias the response in one direction or the other.

Consequently, some of the most objective and significant poll data available can be gleaned by asking under what circumstances Americans believe abortion should be legal. *The Boston Globe* conducted such a national poll in 1989. According to *The Boston Globe*, "Most Americans would ban the vast majority of abortions performed in this country. While 78% would keep abortion legal in limited circumstances, according to the poll, those circumstances account for a tiny percentage of the reasons cited by women having abortions.[1]"

The Wirthlin Group conducted a similar poll in Wisconsin in 1993. The data from the two polls indicate that the American public strongly *opposes* legal abortion for the reasons for which 93% (1.5 million of the 1.6 million) of abortions are performed each year. Conversely, the American public tends to support abortion for the reasons that account for, at most, 7% of abortions performed each year (or for 100,000 of the 1.6 million abortions performed). Table 5 contains the poll results from *The Boston Globe* (5a) and The Wirthlin Group (5b).

1. Brenner, *The Boston Globe*, March 31, 1989.

Table 5a

1989 / The Boston Globe: National Poll

	Abortion Should *NOT* Be Legal	Abortion Should Be Legal	Refused to Respond/ Undecided
Woman is a minor	46%	44%	10%
Wrong time in life to have a child	62%	31%	7%
Fetus not desired sex	68%	27%	5%
Woman cannot afford child	59%	33%	8%
As a means of birth control	66%	28%	6%
Pregnancy would cause emotional strain	53%	37%	10%
Father unwilling to help raise child	63%	30%	7%

Table 5b

1993 / The Wirthlin Group: Wisconsin Poll

	Abortion Should NOT Be Legal	Abortion Should Be Legal	Refused to Reply/ Undecided
Woman cannot afford child	64%	32%	4%
Woman did not want to become pregnant/ did not want more children	61%	36%	3%
Child would jeopardize career or education	81%	16%	3%
Baby would have a mental or physical abnormality	41%	52%	7%
Baby is the wrong sex	91%	8%	1%

Discrimination against those with disabilities

By Barbara L. Lyons

Most expectant parents when asked if they want a boy or girl, respond that they don't care, as long as the child is *healthy*. Parents have been known to count their baby's fingers and toes almost immediately after birth for reassurance that the baby is okay.

With most pregnancies, a normal outcome can be expected. However, in that small number of pregnancies where something has gone awry, hopes and dreams can be shattered, and parents truly experience a sense of loss. Most often, this does not mean they love their child any less, but they grieve for their child and themselves, and experience fear and uncertainty regarding the future. What changes will they have to make in their lives? How severe is their child's disability? What does the prognosis, which is often overly grim, mean? Will their child live or die?

Increasingly, with the legalization of abortion at all stages of pregnancy, prenatal testing and diagnosis has become a tool by which parents decide whether or not to end the life of their unborn child should a disability be present. Physicians are pressured to offer such tests out of fear they will be successfully sued for the "wrongful" birth of a child with a disability.

Currently, most testing is done around 15 to 20 weeks into the pregnancy. The most common diagnostic tests are alpha-fetoprotein testing (AFP), ultrasonography, amniocentesis, or a combination of any of these tests. Although chorionic villus sampling (CVS) is conducted early in pregnancy (usually 8 to 12 weeks), some medical studies have found the miscarriage rate to be twice as high following CVS than for amniocentesis.[1] Chorionic villus sampling is also associated with the birth of babies with limb abnormalities (1-6%), especially when CVS is performed before the 8th week of pregnancy.[2]

The most common genetic abnormality is Down syndrome which affects one in 700 births. Down syndrome is most often associated with women who become pregnant at an older age and, perhaps, paternal age greater than 55 years. While for women in the 15-19 age group, the occurrence of Down syndrome is one in 2,300 births, for women over age 45 it is one in 46 births.[3]

Although not considered a severe disability, 92% of Down syndrome children detected prenatally have their lives ended by abortion.[4]

The second most common abnormality is the presence of a neural tube defect (NTD) which is "any defect of the brain and spinal cord caused by failure of the neural tube to close during growth during pregnancy...."[5] The incidence of NTD is one child in 1,000 births.[6] This means that approximately 2,500 infants with NTDs are born in the United States each year.[7]

Neural tube defects cause conditions known as spina bifida (open spine), anencephaly (lack of brain formation), and encephalocele (an abnormal closure of the spinal column). Anencephaly is a condition incompatible with life, and these infants usually die within a few hours or days. Typically, spina bifida is accompanied by hydrocephalus (fluid on the brain) in 70% to 90% of infants. "All will have bowel and bladder abnormalities, although with new techniques, bowel and bladder continence is becoming a realistic goal for most individuals with spina bifida," according to Dr. Harold Rekate, an expert on treatment for spina bifida.[8] Intellect of children with spina bifida can range from profound retardation to high intelligence, although few have profound retardation.[9]

"One of the most exciting medical findings in the last part of the 20th century is that folic acid, a simple, widely available water-soluble vitamin, can prevent spina bifida and anencephaly," proclaims a March, 1993 editorial in the *Journal of the American Medical Association*.[10] Consequently, the U. S. Public Health Service has recommended that all women of childbearing age capable of becoming pregnant should consume 0.4 mg. of folic acid every day to reduce the risk of a neural tube defect.[11]

An unknown number of children with NTDs are aborted each year.[12]

The overall rate of abortion when an abnormality is detected in the child is at least 73%, with some authorities placing the rate between 80% and 100%.[13]

Not only are there questions about killing unborn children, but new technology has raised ethical questions regarding whether or not having a baby is becoming analogous to buying a car. These new technologies include: (1) screening embryos conceived through in vitro fertilization for genetic defects, (2) screening for the sex of the child, and (3) discovery of genes which could signify significant disease or even behaviors at some later time in the individual's life.

For example, in a recent study of 200 couples by the New England Regional Genetics Group, 1% would abort on the basis of sex, 6% would abort a child likely to contract Alzheimer's in old age, and 11% would abort a child predisposed to obesity.[14] This raises the specter of a eugenics society which regards the perfection of the person as more important than the existence of the person.

Some justify this discrimination by arguing that the child is a "burden" placed on the family, that the child is "spared" a life of "suffering," or that the child is "better off dead" because his/her life is deemed not worth living. These attempts at justification speak volumes about cultural attitudes which demean those who have differences, and how far we have come in accepting elimination of those differences by whatever means available, including death.

Unquestionably, society must be concerned about the additional stress placed on a family caring for a child with a disability. We must be committed to providing services which not only assist the family but also offer opportunities for the child to reach his/her full potential. Fortunately, many of these opportunities now exist with:

- educational programs geared to the needs of the individual with disabilities.
- birth-to-three early intervention programs, whose goal is to enhance the development of the child in the earliest years when results are most beneficial.
- vocational programs to train those with disabilities.
- assistive technology, which perfects technological devices such as computers and voice boxes to assist specific disabilities.
- independent living programs to allow persons with disabilities to live in the community.
- programs to assist the person with a disability to be employed.
- codes requiring public places to provide access for people in wheelchairs.

Finally, many caring families are willing to adopt children with disabilities.

How must a person with a disability feel to know that his or her existence is deemed so meaningless, so valueless, that an unborn child with any disability can be destroyed by abortion? That attitude can, many times, be more of a burden than the disability itself.

Parents who learn that their unborn child has a disability are initially confronted with fear and uncertainty. The following personal story describes how a family coped in those circumstances.

1. Halliday et al., *The Lancet*, October 10, 1992, Volume 340, p.886.
2. Brambati et al., *Prenatal Diagnosis*, 1992, Volume 12, p.789- 799. *Journal of Assisted Reproduction and Genetics*, 1992, Volume 9, Number 4, pp. 299-302.
3. Danforth & Scott, eds., *Obstetrics and Gynecology*, Fifth edition. "Genetic Considerations," Gloria E. Sarto, Part 1, Chapter 2, Lippincott and Company, Philadelphia, 1986, p.32.
4. Vincent et al., *Southern Medical Journal*, October 1991, Volume 84, Number 10, Table 1.
5. *Mosby Medical Encyclopedia*, Plume Company, New York, 1992, p.354.
6. *Journal of the American Medical Association*, March 10, 1993, Volume 269, Number 10, p.1292.
7. Ibid, p.1233.
8. Rekate, Harold L., M.D., *Comprehensive Management of Spina Bifida*, 1991, Intro.
9. Ibid.
10. *Journal of the American Medical Association*, p.1292.
11. *Ibid*, p.1233.
12. *Ibid*.
13. *Southern Medical Journal*, p.1211.
14. Cowley, Geoffrey, *Newsweek Special Issue*, "Made to Order Babies," Winter/Spring, 1990, Volume 114, Number 4, p.98.

Hard-Case pregnancies

When there is a problem with the baby

By Diane Perrone

What does a couple do when faced with information that their unborn baby has medical problems? How does a physician-father reconcile his feelings of helplessness? How do parents cope with advice from well-intentioned friends and medical professionals to abort their little girl?

Richard and Lori Shamblin faced these questions in 1990. He was 35; she, 30. This third pregnancy was unplanned but joyously received. It was an exciting time for the pair and their children, Mary Catherine, then seven, and Dawson, then two.

With all the plans and preparations for an addition to the house as well as the family, the summer seemed to fly by. However, at 20 weeks into the pregnancy, as he performed a routine sonogram, Lori's obstetrician spoke terrifying words: "Where's Richard [the father]? We have a problem with the baby."

A physician in internal medicine in private practice in Tuscaloosa, Ala., Richard forced himself to focus on the facts as he raced to the hospital: the "problem" was rare and serious, a large encephalocele [an abnormal closure of the spinal column] at the base of the baby's brain. Although the baby's complete prognosis could not be made until after birth, the Shamblins were told to expect motor as well as mental impairment, sight loss, seizures, hydrocephalus [a build-up of fluid on the brain], and a host of other problems.

"The nightmare every expectant mother secretly fears became my reality," Lori recalled. Richard remembered that "the shock of the call was nothing compared to my shock upon seeing Lori. She's always been my 'Rock of Gibraltar.' Throughout the prolonged illnesses and deaths of her father, mother, and sister, she never faltered. She is the glue that holds our family together.

"Pale and shaking uncontrollably, Lori looked up at me when I walked in. Neither of us could express ourselves in words, but just being together allowed us to pool our strength. It's a pattern we returned to again and again during the remainder of the pregnancy, at Sarah's birth, and, in fact, throughout Sarah's brief life."

Like most doctors, Richard noted, he needed to feel in control of every situation. "But now, in my own family's time of medical crisis, there was nothing I could do."

Richard was buoyed with hope when he held his newborn daughter that mid-December day. "Her encephalocele wasn't nearly as disfiguring as I expected – some swelling on the back of her head covered by her long black hair." Lori, too, focused on hope. "When I greeted her, her heart rate surged on the monitor. Unmistakably, Sarah recognized my voice and Richard's," she said. "Tests conducted after Sarah's birth indicated that the part of her brain controlling hearing was not functioning correctly; thus, they concluded she could not hear. I am certain, however, that she responded to our voices and recognized them. This realization touched me deeply and has been, to me, one of the miracles of her life.

"Sarah responded to our touch. She knew she was loved."

Sarah's condition stabilized within the week and she underwent surgery to repair the protrusion and close up her skull, but Sarah died during surgery.

Richard knew many people felt they made a mistake when they didn't abort Sarah. "They thought we were going through all this heartache for nothing. Nothing? Who can place a value on being able to hold my baby girl in my arms and tell her I love her?

"Who can measure the joy of feeding her with a bottle when we thought she might always be tube-fed? What is it worth? To me, it was worth everything," Richard exclaimed.

"Despite the pain and grief of losing Sarah, we have never for one moment regretted our decision not to abort her," Lori said. "So many wonderful things came out of the experience of carrying her for eight months and knowing and loving her for nine days. Sarah enriched our lives beyond measure and we're extremely thankful for her existence."

The Shamblins decided to make Sarah's organs available for transplant. It was a long shot; Sarah was so tiny, the probability of finding a recipient was not great. However, the call came. A critically ill baby boy in Nashville was born with a severe congenital heart defect and his only hope was a transplant. "For the first time in days," Lori remembered, "we rejoiced again because Sarah's death was not to be the end."

"Even in my continuing grief, I am at peace," Richard now states. "Sarah touched so many people, clearly demonstrating that no matter how 'handicapped' she was, her life had inestimable worth just by being who she was. We'll eventually spend eternity together, but even now I am thankful she is still alive, not only in our memories, but also in a little boy somewhere in Tennessee."

"It is our hope that Sarah's life and our experience can encourage other parents faced with difficult pregnancies," reflected Richard. "Surely this world is a better place for Sarah having lived in it."

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The trauma of rape

By Fran Driscoll

RAPE. Excluding homicide, rape is the crime most devastating to its victims. Whether it be the parent of a daughter late in coming home or the lone woman leaving work at night, the fear of sexual assault is very real, very alive. Some would define it as the ultimate act of savagery against women. But, regardless of how it is defined, rape damages the physical, mental, and social well-being of its victims. In addition to the trauma of the physical attack (assuming the victim survives), there is the very real threat of contracting AIDS, venereal disease, or other infection from the attacker. But in regard to long term damage, mental harm usually presents the greatest problem. Psychological manifestations following rape are referred to as "the rape trauma syndrome."[1]

There are three stages a woman normally goes through after the assault.[2] The first is the "shock" phase. This can last from several days to several weeks. The victim exhibits disbelief, anxiety and fear. She also tends to blame herself; guilt and self- hatred are common. Not only does she lose trust in her own judgment, she loses trust in others to respect or empathize with her. Effects of rape trauma syndrome include insomnia, nightmares, loss of appetite, irritability, and depression, usually accompanied by headache, nausea, and stomachache. These effects can be ongoing and chronic unless there is support for the victim from qualified personnel as well as family members and friends.

Phase two is the adjustment phase. It can appear several days to several weeks after the rape, depending on the coping mechanisms of the victim, as well as the amount of damage the rapist inflicted on her emotionally. The greater the humiliation (i.e. being forced to say she "loved it" or to perform degrading acts) or fear for her life, the longer it takes to get to this phase. She loses interest in seeking help and wants to talk less about her experience. The physical distress diminishes and the nightmares lessen. It is not unusual at this stage for the victim to reorganize her life. She may move, change her job, or her phone number. At about six weeks following the rape, as she is just beginning to cope, she must go in to be tested for pregnancy or the presence of a sexually-transmitted disease.[3]

Finally, the integration phase follows. At first, the victim may withdraw from contact with other people. Her depression may return, and she will have to deal with her feelings. Some women return to counseling. But others do not. "...Over 19% of rape victims and 9% of attempted rape victims had attempted suicide. This is compared with a 2.2% rate for nonvictims of any crime. In addition, 14% of rape victims reported experiencing nervous breakdowns following the assault."[4] Rape can sever relationships, permanently change a victim's outlook, or result in emotional illness.

Even worse, reported cases of forcible rape are increasing at an alarming rate. In 1990, there were 102,555 forcible rapes in the United States, an increase of 9% from 1989, and comprising 6% of the total violent crimes.[5] It is estimated that between 15% and 25% of women are victims of a completed rape at some point in their lives.[6] However, only a fraction of sexual assaults comes to the notice of police or health services.

For those women who do report their rape immediately to authorities, there is medical treatment, including efforts to avoid conception. However, a small percentage of women, approximately 1-5%, become pregnant as a result of sexual assault.[7] Conventional wisdom dictates that this "product of conception" should be disposed of for the sake of the mother. It is widely held that carrying this child to term would impose an undue burden on the mother, that abortion is a "quick and easy" solution to this problem. But this ignores the already tenuous emotional condition of the mother, as it does the possibility of subjecting her to what is known as Post-Abortion Syndrome. In an abortion, the woman's body, as well as that of her child, is violated yet again – only this time it is for the woman's "own good." Though her attacker may not be punished, her innocent child certainly will.

The following is the story of a mother and her daughter – a daughter that many would have counselled should never have been born.

1. Mills, Patrick, *Rape Intervention Resource Manual*, Charles C. Thomas, 1977.
2. Dean, Charles W. and Mary deBruyn-Kops, *The Crime and the Consequences of Rape*, Charles C. Thomas, 1982, pp. 110- 113.
3. Mills, p.162.
4. Calchoin, Karen S. and Beverly M. Atkeson, *Treatment of Rape Victims: Facilitating Psychosocial Adjustment*, Pergamon Press, 1991, pp. 1- 13.
5. U.S. Bureau of the Census, *Statistical Abstracts of the United States: 1992* (112th Edition) Washington, DC, 1992, p.16
6. Calchion, Karen S. and Beverly M. Atkeson, p.2.
7. Dupre, et al., "Sexual Assault," *Obstetrical and Gynecological Survey*, Volume 48, No.9, 1993, Williams and Wilkins, p.646.

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Hard-Case pregnancies

When the mother has been raped

By Diane Perrone

Lee Kinney was an 18-year-old secretary at a small sailboat manufacturer in the San Francisco area. One night, when she and two other secretaries were working late, a salesman named Jack invited the three over to his trailer for pizza. Lee followed him home in her car, as she was new to the area and the other two women knew where Jack lived. Scarcely had she walked in the door of his rickety trailer and sat down, when Jack wrestled her onto the couch. Amid her cries of "No!" and "Stop!" he beat her, tore her clothes from her, and raped her. He dropped to the floor when he finished, giving Lee time to escape. She drove frantically from the scene, wondering why her co-workers had not appeared. She felt ashamed, alone, and angry. Her attacker had been cruel enough to complain that she was a virgin. Was this what she had saved herself for?

Lee did not want anyone to know what had happened. She blamed herself for being naive enough to go to his trailer alone. She did not report the attack because she thought the police could not do anything (she was 18, and thought rape was only illegal if the victim was a minor). Because she wanted to forget the whole thing had happened, Lee decided to carry the secret of her humiliation to her grave.

One month later, Lee came down with a case of the "flu." She had an upset stomach most of the time, and did not feel like eating. After two weeks, she decided to go to a doctor to obtain antibiotics so she would not feel so tired. He suggested she could be pregnant. Two days later, her blood test came back positive.

Lee knew that because of her mother's personal circumstances, she would not be able to help her. She also knew she could not go through with an abortion. So, Lee's sister arranged for her to live with a blind, older relative outside Los Angeles. While she was there, she met some good friends who cared for her as though she were their own daughter. She had time to think about her future, and realized it would be best for her child to be placed for adoption.

On February 11, 1964, Lee went into labor. After 16 hours, she was put under general anesthetic, and when she awakened, her baby had been born. She asked whether the baby was a boy or girl, whether she would be able to hold her child. The nurse told her she had delivered a healthy baby girl, but it would be best if she did not see

the child. That baby girl would grow up to be Julie Makimaa.

Julie Makimaa (now living in Springfield, Ill.) learned in childhood that she was adopted, but was not told she was conceived from a rape. "Mom explained the love she felt for me was no different than any other mother felt for her child, and that my birth mother, through an act of love, placed me for adoption since she wanted the best for me. I didn't grow up with resentment, only gratitude." But over the years, Julie did have questions and some mixed feelings. Did she look like her birth mother? Sound like her? Was her birth mother also musical? She did not want her adoptive parents to feel she was rejecting them, but she wanted to know her natural mother. She also worried about hurting her adoptive parents because of this strong desire to discover her birth mother. Julie knew that not all adopted children act upon their desire to learn the identity of their birth parents.

In 1984, Julie was living in northern Michigan, married, and with a daughter of her own, when she began to search in earnest for her biological parents. A faint phone number in the margin of her adoption records led her to a woman ("Mom" Croft) who had befriended her birth mother during pregnancy. Had Julie made the call only a few weeks later, the only link to her birth mother would have been lost because Mrs. Croft had planned to move and have her phone disconnected. But Julie did reach Mrs. Croft, and she called Lee and gave her Julie's telephone number. Julie was very excited and happy when Lee called from her California home the next morning.

They discussed Julie's childhood, their interests and looks, and planned a reunion for eight weeks later in Washington D.C. Julie asked about her birth father. Lee told her his name but said, "I don't think you want to search for him." The subject was dropped. Julie thought there would be time to pursue that later.

Shortly before the planned meeting, Lee asked her husband Harold to call Julie's husband, Bob, and reveal to him the long-suppressed secret that Julie was conceived through a sexual assault. Amazingly, Bob Makimaa's heartfelt response was, "Just think...that happened more than twenty years ago...just to give me my Julie." He broke the news to Julie about the violence and pain which brought about her existence in the world.

Julie then became concerned that the reunion might bring back painful memories for Lee and was afraid it would be cancelled. But in a subsequent call to confirm reunion plans, Lee reassured her that, while the rape had been agonizing and painful, she had been through a healing process and did not consider Julie a part of that negative experience. Instead, Lee saw their relationship and reunion as the opportunity for good to come out of her past. Julie met Lee in Washington, D.C., in February 1985. They celebrated Julie's 21st birthday together.

"I had questions about myself," Julie admitted. "Am I bad because of my conception? Did I inherit evil genes? Would I have psychological problems?" Julie sorted through her feelings and eventually realized, "I am a unique person. I love and am loved because of who I am, not how I came about. I wasn't conceived in love, but it's not how you came about that's most important, it's what you do with your life once you're here."

How does Julie feel about her biological father? "Since I had always pictured him as a nice guy, I now had to deal with the fact that he hurt my mom. But I realized I couldn't be angry with him; that wouldn't benefit me or Mom."

Today, Lee and Julie want their lives and experience to stand as an example of everyone's right to live, no matter how difficult the circumstances.

And, there has been another enriching, positive effect resulting from what most people would believe to be an unbearable situation. Learning the truth of her personal circumstances has led Julie to share her story publicly, and to form a support group for children born from sexual assault and their mothers, as well as for women who aborted children after being sexually assaulted. This organization, called Fortress International, educates the public on issues of assault pregnancy and offers support to women, children, and families affected by sexual assault pregnancies. (See sidebar for information on Fortress International.)

Because she was adopted, Julie said, she might have naturally gravitated to involvement in the pro-life movement. But now that she knows the full story behind her existence, she is more convinced than ever that her beliefs against abortion are right. While not diminishing the severe trauma caused by her birth mother's rape, Julie states, "I'm not ashamed at all, because if the sexual assault hadn't happened, I wouldn't be here."

PREGNANCY BY SEXUAL ASSAULT – HELP IS AVAILABLE

Three-and-a-half years after learning that she was conceived in a sexual assault, Julie Makimaa founded Fortress International to assist women, children, and families affected by sexual assault pregnancies and to educate the public. One of its purposes is to dispel the myths and misconceptions surrounding sexual assault pregnancies which are often the only type of information a woman who has been raped may hear.

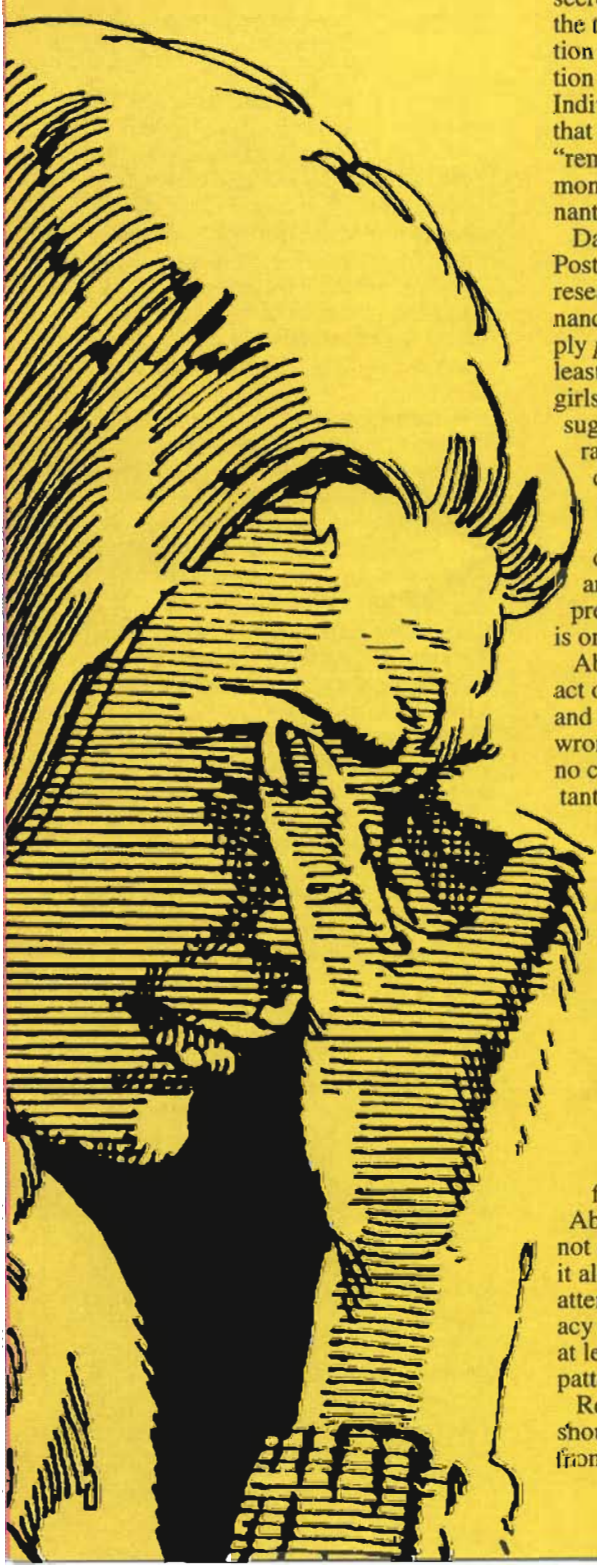
Fortress International teaches that abortion is not the compassionate avenue to heal the trauma of sexual assault that it is thought to be. Julie described what she has learned about the aftermath of such an abortion: "As time passes after the assault and the abortion, the woman begins to realize that she was traumatized by the assault but she escaped with her life. She also knows that the other victim – innocent like herself – did not escape with his/her life. The child was killed, not by a stranger, but by the decision of his/her own mother. Therefore, the woman can feel even worse, realizing that she also became the perpetrator of a crime against an innocent human life.

"It's easy to transfer the anger of being violated to the child in the womb. But there is no justice in that. Those who favor abortion have painted sexual assault pregnancy as a necessary struggle between compassion for the victim and the life of the child, as if one or the other must 'win out.' The truth that we've found is that the best thing for the woman is also the best thing for the child, namely that the child is given life. Abortion does not help a woman deal with the effects of a sexual assault; it re-victimizes her."

Fortress International welcomes contact with women, children and families who are directly involved with sexual assault pregnancies. Write: Fortress International, P.O. Box 7352, Springfield, IL 62791-7352. For other crisis pregnancy assistance, call 1-800-BETHANY, or 1-800-848-5683.

THE SHAME OF INCEST

By Catherine Souhrada



Incest – its shame is still "a deep, dark secret" even in today's society. Because of the trauma which accompanies incest, abortion is routinely suggested as the only solution for the victim who becomes pregnant. Individuals with the best intentions argue that the woman should not have to carry the "reminder" of a painful experience for nine months, or that she did not ask to be pregnant, so abortion is the obvious solution.

David Reardon, nationally recognized Post-Abortion Syndrome expert and researcher, has written about incest pregnancy and abortion: "...Abortion was simply *presumed* to be the best answer – at least best for society if not for the women, girls, or children. Through abortion, they suggested, we could cover up these embarrassing victims of our sick society; we could destroy the 'unclean' offspring of our sexual perversions. But in fact, just as with rape, there is no psychiatric evidence, nor even any theory which argues that abortion of an incestuous pregnancy is therapeutic for the victim – it is only more convenient for everyone else."[1]

Abortion conceals the perpetrator's awful act of sexual transgression (through incest), and eliminates any physical evidence of wrongdoing. The reasoning goes, if there is no child, there is no evidence. Most importantly, abortion allows the denial and silence surrounding the incest to continue within the family, and prevents outside awareness and intervention. The perpetrator remains free to continue the abuse of his victim.

Reardon calls incest the " 'conspiracy of silence....' Though the daughter desperately wants to be out of the situation, it should be remembered that she would prefer to break the incest pattern in a way that would allow her to maintain or regain the love of her parents. Pregnancy is an avenue which offers to fulfill both of these requirements. Abortion of an incestuous pregnancy, then, not only adds to the girl's guilt and trauma, it also frustrates her plans for escape and attention. Abortion perpetuates the 'conspiracy of silence' by covering up the incest, or at least its results, and continues the family pattern of denying reality."[2]

Reardon adds, "The cry that abortion should be available for pregnancy resulting from incest has little or no foundation. Statistics available show that incestuous pregnancies are infrequent. American studies involving a total of almost 2,000 cases of incest report a pregnancy rate of only 1 percent...."[3] As early as 1979, Dr. George Maloof, physician and psychiatrist in the San Francisco area, and noted author on the psychological aspects of abortion, writes in *The Psychological Aspects of Abortion*, that "considering the prevalence of teenage pregnancies in general, incest treatment programs marvel at the low incidence of pregnancy from incest."[4]

However, pregancies from incest do exist, but abortion does not solve these cases nor eliminate the trauma that case studies show incest victims experience. One such victim was Sharon Louise. She was an incest victim who was coerced into an abortion by her father, not once but twice.* Her story shouts of her pain and helplessness, and demonstrates firsthand, the further victimization of women by abortion. Here, on the facing page, is Sharon's story as she relates it.

* Since most incest victims do not become pregnant, Sharon may be atypical of incest victims. However, her story is included because her experience is representative of the emotional trauma that incest victims experience.

1. Reardon, David, *Aborted Women: Silent No More*, Loyola University Press, 1987, p. 199.
2. Ibid., p. 201.
3. Ibid., p. 202
4. Maloof, George, "The Consequences of Incest," *The Psychological Aspects of Abortion*, University Publications of America, 1979, p. 74.

***Catherine Souhrada** has been education director for six years for the Wisconsin Right to Life Education Fund. She has a bachelor's degree in social work and a master's degree in health administration. She has worked extensively in the community on public education and in nursing homes as a social worker.*

Hard-Case Pregnancies

When the Woman Has Been Victimized by Incest

by Sharon Louise

When I was a child, I had a magical visitor who came to me in the night. In the morning, I would remember him sitting at my bedside the night before. As my window was slightly open, I decided my nightly visitor was Peter Pan. I felt special to have a fairy-tale figure visit me, but was strangely uneasy about his visits. Nevertheless, it was my secret. I never told anyone. It was not until I was 37 years old that I realized that Peter Pan was my father, and the secret was incest...a despicable secret that irreversibly altered my life long before I remembered its existence.

My father began molesting me when I was two years old. It began when we would sit together on the back steps of our house. When he first began to slip his hand under me, I was startled and confused by this unusual behavior. I couldn't understand what was happening to me, or why. I knew my daddy loved me but why did he keep touching me in a way I didn't want to be touched? "This is our little secret," he would say, and I knew better than to disagree. Nobody in our household disagreed with Daddy.

Because my father could not hold a job, my mother had to work day and night to support the family. This gave my father easy access to me, and the molestation continued throughout my childhood. I was torn apart inside. I hated my father for what he was doing to me, and yet I loved him because he was my father. This added to the guilt I already felt since I, like most incest victims, believed that somehow the incest was *my* fault. If I could only be a better little girl, if I could only pray harder, he would stop. I felt totally responsible and at the same time, completely helpless to stop it.

When I was twelve, I became pregnant. I was fearful that my father would harm or even kill our baby, but I had no idea that he could destroy the child before he was even born. On the evening of November 26, 1966, my father met an abortionist and paid him a sum of money. I never knew the price of my child's life. My father sent me with the abortionist, telling me that I was to be "checked." He promised to wait outside. I was to have nightmares of that evening for the rest of my life.

There was not much time to dwell on feelings in my childhood. Life went on the same as before, with my father molesting me. I suppressed my emotions to survive.

At age 14, I became pregnant again and my father arranged for another abortion. There was a different "doctor" and a different location, but the results were the same. My baby was killed to protect my father from disclosures of the incest. Again, my heart was broken, and I assumed the blame. I felt empty, hopeless, and very, very sad.

It was obvious to me after the second abortion that my father had complete control over me. Willing abortionists freed my father so that he could continue the assaults unabated. Hired assassins killed my children, children whose mere existence exposed my father's crimes. I believe it was following the second abortion that I blocked out all memories of the incest. It was all too much for the mind of a child to handle. I do not know how long after the second abortion the abuse continued, but believe it was throughout my high school years.

When the memories of the incest returned, pain and grief became my companions. I had not only blocked out my abusive childhood, but replaced it with a fantasy happy childhood and a Daddy I believed had always loved and cared for me. It has hurt deeply to see the truth, but I know this is the only way I can be healed of the destructive effects the incest has had in my life, such as depression, guilt, and shame which have always consumed me even though I had no memories of the incest.

The hardest to bear has been the abortions. I feel such a deep sense of loss and grief. It is extremely painful for me to be around babies or pregnant women, and tears flow easily when walking near the baby section of a grocery store.

There are those who would use my story as an excuse to keep abortion legal, since both of my abortions were illegal. But legal abortion would not have helped me. It would simply have made it easier for my father to victimize me. My pain would not be any less and my babies would still be dead. Abortion, legal or illegal, is not a simple, safe procedure.

People ask how can one be so cruel and heartless to say that an incest victim must carry her baby to term when she's already been through so much pain. Such people forget that abortion does not relieve the trauma that an incest victim lives with. It does not alleviate the shame, the emotional wreckage, the self-destructive feelings, the feelings of helplessness and hopelessness. No! Legal abortion does not alleviate *any* of these problems; it merely adds one more trauma to the long list of scars that the victim must carry.

TECHNOLOGY ASSISTS WOMEN WITH HIGH RISK PREGNANCIES

By Laura Kamin

Pregnancy-induced hypertension (high blood pressure).
Diabetes.
Epilepsy.
Breast cancer or other cancers.

These words strike fear into the hearts of pregnant women with these conditions. How extensive is the cancer? What will the diabetes do to my baby? Will my health or my baby's health be jeopardized? Will I live or die? Will my baby live or die?

Abortion advocates play on emotions in these situations to press the "need" for abortion. They argue that protection of the woman's "health" takes precedence over the life of her unborn baby. She can always have other children later, they reason, and she must think of the effect this illness will have on the rest of the family.

A distinction must be made between pregnancies which could endanger the *health* of the mother, such as hypertension, diabetes, epilepsy, or cancer, and those which endanger the *life* of the mother, such as uterine cancer.

The *Handbook of Obstetrics and Gynecology* defines a high-risk pregnancy as "one that imposes a definite or probable increased hazard to the life or health of the mother or offspring. The risk may be due to maternal or fetal problems or to treatment of these problems."[1] These identified medical conditions affecting pregnancy may have mandated ending the pregnancy at one time in history. However, with current medical care, technology, and prenatal care, these conditions are manageable.

High-risk pregnancies are most commonly associated with, but not limited to:

1. *Pregnancy-induced hypertension* [high blood pressure] which complicates "about 5% to 7% of pregnancies in otherwise normal women....The major maternal hazard is that of eclampsia or gran mal seizures, resulting from profound cerebral effects of the disease."[2]
2. *Diabetes* which affects an estimated 2% to 5% of all pregnancies in the U.S.[3]
3. *Epilepsy* which complicates approximately 0.15% of pregnancies.[4]
4. *Cancer*, whose occurrence in pregnancy, according to a report in the *Archives of Internal Medicine*, is "between 0.07 and 0.1%."[5] The *Journal of the Royal Society of Medicine* study by Saunders and Baum states that breast cancer is the "second commonest malignancy seen during pregnancy (cervical being commonest) – occurring in between 10 and 39 per 100,000 pregnancies."[6]

With regard to high blood pressure during pregnancy, Scott and Worley write in their chapter on "Hypertensive Disorders of Pregnancy," that "with proper management PIH [pregnancy-induced hypertension] can often be ameliorated and eclampsia [seizures] largely, if not entirely, prevented."[7] These conditions generally only occur in the third trimester of pregnancy. As current medical knowledge and technology improve, rarely must a pregnancy be ended to save the mother's life.

Of diabetes, Benson writes that "...maternal death is rare with modern treatment..."[8] William Spellacy writes that "today, by using [the information that is available], women with diabetes mellitus can expect normal pregnancy outcomes."[9]

Danforth's *Obstetrics and Gynecology* states, regarding epilepsy, that "status epilepticus in pregnancy...is fortunately uncommon, occurring in less than 1% of epileptic pregnancies. It is not an indication for pregnancy termination..."[10] Benson writes in *Handbook of Obstetrics and Gynecology* that "therapeutic abortion is not medically indicated for epilepsy, because this disorder may or may not constitute a problem during pregnancy."[11]

Regarding treatment of cancer during pregnancy, "Significant advances have been made with current chemotherapeutic agents in increasing longevity and improving survival. Cures and long-term remissions are obtained in diseases that previously were untreatable."[12] The *Archives of Internal Medicine* report goes on to say that, while there is increased risk of spontaneous abortion and major birth defects when chemotherapy is used during the first trimester, "such a risk is not apparent beyond the first trimester."[13]

Cancer of the uterus during pregnancy poses the greatest threat to the life of the mother; removal of the uterus is usually recommended. In these cases the baby dies as an indirect result of procedures performed to save the mother's life.

Breast cancer presents special difficulties, but early diagnosis is again the key according to Drs. William Creasman and Philip Di Saia, oncologists writing in a 1993 publication, *Clinical Gynecologic Oncology*. "The best evidence indicates that pregnancy does not augment the rate of growth or distant spread of breast cancer and that abortion for women with breast cancer does not improve the prognosis. ... Therapeutic abortion has not been found to increase survival, and the presence of a fetus does not compromise proper therapy in early stages."[14] They go on to note that other reports agree that termination of pregnancy has no effect on patient survival.[15] A study in the *Journal of the Royal Society of Medicine* reports that "it appears that subsequent pregnancies after treatment for breast cancer may actually improve the patient's chance of long term survival."[16]

The following article outlines one hard-case pregnancy – an expectant mother diagnosed with breast cancer. "Termination of the pregnancy" was mentioned by the physician, but the couple never considered it.

1. Benson, Ralph C., M.D., *Handbook of Obstetrics and Gynecology*, Lange Medical Publications, Los Altos, CA; 1983, p.99.
2. Danforth, David, *Danforth's Obstetrics and Gynecology*, 6th edition, J.B. Lippincott Company, Philadelphia, PA; 1990, p.411.
3. Knuppel et al., *Hospital Medicine*, "The Pregnant Patient with Medical Disease," Vol.23, No.3, March 1987.
4. Danforth, p. 126.
5. *Archives of Internal Medicine*, March 1992, Vol.152, p.573.
6. Saunders and Baum, *Journal of the Royal Society of Medicine*, Vol.86, March 1993, p.162.
7. Danforth, p.411.
8. Benson, p.365.
9. Danforth, p.403.
10. Danforth, pp.514- 515.
11. Benson, p.360.
12. Zemlickis et al., *Archives of Internal Medicine*, March 1992, Vol.152, p.573.
13. Ibid, p.576.
14. Creasman, William T., M.D. and Philip J. DiSaia, M.D., *Clinical Gynecologic Oncology*, Mosby-Year Book, Inc., St. Louis, MO; 1993, p.567-570.
15. Ibid.
16. Saunders and Baum, *Journal of the Royal Society of Medicine*, March 1993, Vol.86, p.162.

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WHEN THE MOTHER FACES A RISK

By Mary C. Uhler

"People comment, 'He's so happy, so special. He shines!'"

That's how Joyce Maguire describes her son, Matthew, who celebrated his fifth birthday in 1992. "I think children know they're loved even before they're born. And Matthew knew he was loved."

Joyce and her husband Frank of Germantown, Md., indeed have a deep love for their son. "What emptiness we would have in our lives if Matthew weren't here," said Frank.

Because his mother was involved in a "high-risk" pregnancy, the kind some women end by aborting the child, Matthew might not even have been born.

In February 1987, Joyce became pregnant with the couple's first child. As expectant parents, they were excited and full of plans. They loved to discuss the baby's size and development. "It was a time of special joy," recalled Frank.

In July, when Joyce was five months pregnant, a small lump was discovered in her breast and a nurse suggested removal "just to be careful." The procedure took about an hour in the outpatient surgery department of a local hospital.

Soon after the surgery, Joyce called Frank at work. An anxious nurse had told her that the pathologist's report revealed there was "something wrong" – the lump was malignant. She had cancer.

Joyce and Frank endured a long, tearful night. The next morning they visited the surgeon. Joyce was given two options: a *mastectomy (removal of the breast);* or a lumpectomy (removal of the area immediately surrounding the tumor), followed by radiation treatments.

The lumpectomy would be less disfiguring but the ensuing radiation would endanger the baby. Chemotherapy, which would be imperative after either surgery, would also expose the baby to damage.

According to her doctor, Joyce's failure to treat her cancer – for fear of harming the baby – would seriously decrease her chance of survival. The surgeon then suggested they could "terminate" the pregnancy. He told the Maguires about a patient in a similar situation who saved her breast by having an abortion followed by a lumpectomy and radiation treatment.

But Joyce allowed no further discussion of abortion. "That is not a possibility," she told the doctor emphatically. She decided to have modified radical breast surgery and to postpone chemotherapy until after the baby's birth.

In looking back, Joyce said abortion was completely out of the question. "I would never have even contemplated killing my child," she said.

Her decision was not based on religious precepts. It resulted simply from her unconditional love for their baby.

Matthew was born in November of 1987. "He was incredibly healthy. He was above 95 percent in weight and height," a proud Joyce recalled.

Although members of the Maguire family were upset about Joyce's cancer, they were very supportive of her decision to have the baby. "Nobody argued against the decision," recalled Frank. "This was serious stuff, however. Everybody was scared."

Once the Maguires made their decision, the doctors also supported them. "My oncologist was wonderful," said Joyce. "He was worried about me, but he also said, 'I understand what you're doing.' " Would she do it again? "Yes," said Joyce without hesitation. Her husband agreed, "We obviously had a good result."

"For us, I always knew it was the right decision and I knew things would work out," stressed Joyce. "I don't believe in killing babies."

For other couples facing a similar crisis, Frank said he would explain what happened to him and Joyce, encourage them to have the baby, and show them pictures of Matthew. "A picture is definitely worth a thousand words," he observed.

Initially, the Maguires were cautioned about having another child. For a time, they parented foster infants awaiting adoption. After several consultations, Joyce was given the "green light" to become pregnant again.*

Their dream of another child came true when the Maguires learned they were expecting another child in 1993.

Every now and then on his way to work, Frank drives past the hospital where Matthew was born. He remembers the summer of 1987 – a summer of tears and courage, despair and joy -- when his wife seemingly risked her life to choose life for their son. For the Maguires, it was the right choice for everyone.

***Mary C. Uhler** is editor of* The Catholic Herald, *official newspaper of the Diocese of Madison, Wis. She and her husband, John, have two children and are active in church and community groups.*

* Studies released by the National Institute of Health in the early 1990s revealed that subsequent pregnancies in women who have had breast cancer and treatment have no effect upon the recurrence of cancer. *Cf.* Danforth, Jr., David. N., M.D., "How Subsequent Pregnancy Affects Outcome in Women With a Prior Breast Cancer," *Oncology*, November 1991, Vol. 5, No. 11.

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Explanation of 1973 *Roe v. Wade* and *Doe v. Bolton* decisions legalizing abortion in the U.S. for the full nine months of pregnancy

Prior to 1967, abortion was prohibited in all 50 states except when the mother's life was in danger. Between 1967 and 1973, 18 states added further exceptions, mostly to allow abortion in cases of rape or incest, or for certain limited medical reasons, or on demand (New York).

The U.S. Supreme Court rendered two decisions in 1973, *Roe v. Wade* and *Doe v. Bolton* which, taken together, have allowed legal abortion on demand at any stage of pregnancy in all 50 states. The two original decisions established legal abortion as follows:

1. In the first three months of pregnancy, no one can interfere with a woman's decision to abort her unborn child.
2. After the first three months, but before the "viability" of the unborn child, an individual state can enact laws to protect the health of the mother but cannot prohibit the abortion of the unborn child. Viability is defined to mean the ability of the child to live outside the mother, with or without life support systems.
3. After "viability" of the unborn child, an individual state can, if it chooses to do so, enact laws to protect the unborn child but abortion must be allowed if the life or "health" of the mother is at stake. The Supreme Court in *Doe v. Bolton* defined "health" as "the medical judgment that may be exercised in light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient. All these factors may relate to health."[1]

Consequently, the broad definition of "health" has made abortion legal up to the moment of birth.

1. *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973)

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