The Post-Abortion Review

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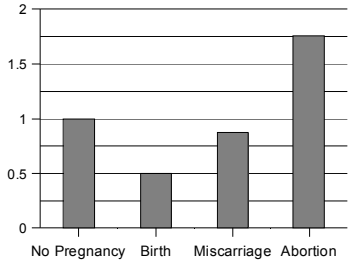
Abortion Four Times Deadlier Than Childbirth

New Studies Unmask High Maternal Death Rates From Abortion

Abortion advocates, relying on inaccurate maternal death data in the United States, routinely claim that a woman's risk of dying from childbirth is six, ten, or even twelve times higher than the risk of death from abortion.

In contrast, abortion critics have long contended that the statistics relied upon for maternal mortality calculations have been distorted and that the broader claim that "abortion is many times safer than childbirth" completely ignores high rates of other physical and psychological complications associated with abortion. Now a recent, unimpeachable study of pregnancy-associated deaths in Finland has shown that the risk of dying within a year after an abortion is several times higher than the risk of dying after miscarriage or childbirth.[1]

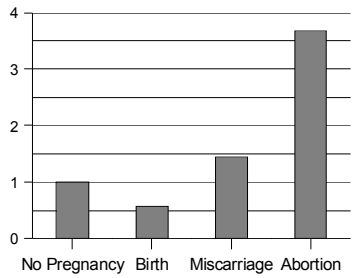
Fig. 1. Total Deaths



This well-designed record-based study is from STAKES, the statistical analysis unit of Finland's National Research and Development Center for Welfare and Health. In an effort to evaluate the accuracy of maternal death reports, STAKES researchers pulled the death certificate records for all the women of reproductive age (15-49) who died between 1987 and 1994—a total of 9,192 women. They then culled through the national health care data base to identify any pregnancy-related events for each of these women in the 12 months prior to their deaths.

Since Finland has socialized medical care, these records are very accurate and complete. In this fashion, the STAKES researchers identified 281 women who had died within a year of their last pregnancy. The unadjusted mortality rate per 100,000 cases was 27 for women who had given birth, 48 for women who had miscarriages or ectopic pregnancies, and 101 for women who had abortions.

Fig. 2. Deaths by Suicide



The researchers then calculated the age-adjusted odds ratio of death, using the death rate of women who had not been pregnant as the standard equal to one. Table 1 shows that the age-adjusted odds ratio of women dying in the year they give birth as being half that of women who are not pregnant, whereas women who have abortions are 76 percent more likely to die in the year following abortion compared to non-pregnant women. Compared to women who carry to term, women who abort are 3.5 times more likely to die within a year.

Such figures are always subject to statistical variation from year to year, country to country, study to study. For this reason, the researchers also reported what is known as "95 percent confidence intervals." This means that the available data indicates that 95 percent of all similar studies would report a finding within a specified range around the actual reported figure.

For example, the .50 odds ratio for childbirth has a confidence interval of .32 to .78. In other words, it is probable that 95 percent of the time, the odds ratio of death following childbirth will be found to be between 32 percent and 78 percent of the non-pregnant woman rate. The 95 percent confidence interval for the odds ratio of death following abortion was reported to be 1.27 to 2.42 of the annual rate for non-pregnant women.

Deaths from Suicide

Using a subset of the same data, STAKES researchers had previously reported that the risk of death from suicide within the year of an abortion was more than seven times higher than the risk of suicide within a year of childbirth.[2] Two of these suicides were also connected with infanticide. Examples of post-abortion suicide/infanticide attempts have also been documented in the United States.[3]

The same finding was reported in STAKES' more recent study. Among the 281 women who died within a year of their last pregnancy, 77 (27 percent) had committed suicide. Figure 2 shows the age-adjusted odds ratio for suicide for the three pregnancy groups compared to the "no pregnancy" control group.

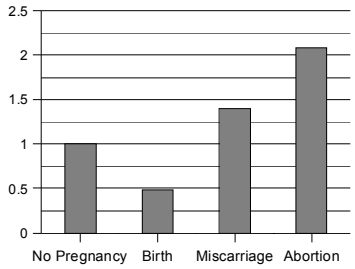
Notably, the risk of suicide following a birth was about half that of the general population of women. This finding is consistent with previous studies that have shown that an undisturbed pregnancy actually reduces the risk of suicide.[4]

Abortion, on the other hand, is clearly linked to a dramatic increase in suicide risk. This statistical finding is corroborated by interview-based studies which have consistently shown extraordinarily high levels of suicidal ideation (30-55 percent) and reports of suicide attempts (7-30 percent) among women who have had an abortion.[5] In many of these studies, the women

interviewed have explicitly described the abortion as the cause of their suicidal impulses.

The original publication of the STAKES suicide data prompted researchers at the South Glamorgan (population 408,000) Health Authority in Great Britain to examine their own data on admissions for suicide attempts both before and after pregnancy events. They found that among those who aborted, there was a shift from a roughly "normal" suicide attempt rate before the abortion to a significantly higher suicide attempt rate after the abortion. After their pregnancies, there were 8.1 suicide attempts per thousand women among those who had abortions, compared to only 1.9 suicide attempts among those who gave birth. The higher rate of suicide attempts subsequent to abortion was particularly evident among women under 30 years of age. As in the STAKES sample, birth was associated with a significantly lower risk of suicide attempts.

Fig. 3. Deaths By Accident



The South Glamorgan researchers concluded that their data did not support the view that suicide after an abortion was predicated on prior poor mental health, at least as measured by prior suicide attempts. Instead, "the increased risk of suicide after an induced abortion may therefore be a consequence of the procedure itself."[6]

Interpretation of these statistical studies is aided by numerous publications describing individual cases of completed suicide following abortion.[7] In many cases, the attempted or completed suicides have been intentionally or subconsciously timed to coincide with the anniversary date of the abortion or the expected due date of the aborted child.[8] Suicide attempts among male partners following abortion have also been reported.[9]

Teens are generally at higher risk for both suicide and abortion. In a survey of teenaged girls, researchers at the University of Minnesota found that the rate of attempted suicide in the six months prior to the study increased ten fold—from 0.4 percent for girls who had not aborted during that time period to 4 percent for teens who had aborted in the previous six months.[10] Other studies also suggest that the risk of suicide after an abortion may be higher for women with a prior history of psychological disturbances or suicidal tendencies.[11]

It is also worth noting the suicide rate among women in China is the highest in the world. Indeed, 56 percent of all female suicides occur in China, mostly among young rural women.[12] It is also the only country where more women die from suicide than men. For women under 45, the suicide rate is twice as high as that of Chinese men. Government officials are reported to be at a loss for an explanation.

Traditionally, Chinese families placed a high value on large families, especially in rural communities. But after the death of Mao Tse-Tung, who also valued large families, China instituted its brutal one child policy. This population control effort, encouraged by governments and family planning organizations from the West, has required the widespread use of abortion—including forced abortion—and infanticide, especially of female babies. Given the known link between abortion and suicide, can there be any doubt that maternally-oriented Chinese women who are coerced by their families and communities to participate in these atrocities are more likely to commit suicide?

Deaths from Risk-Taking Behavior

In this most recent study from Finland, the STAKES researchers also reported that the risk of death from accidents was over four times higher for women who had aborted in the year prior to their deaths than for women who had carried to term. Of the 281 women who died within a year of their last pregnancy, 57 (20 percent) died from injuries attributed to accidents.

Once again, giving birth had a protective effect. Women who had borne children had half the risk of suffering a fatal accident compared to the general population. On the other hand, as shown in Figure 3, women who aborted were *more than twice as likely* to die from a fatal accident than women in the general population.

This finding suggests that women with newborn children are probably more careful to avoid risks which could endanger them or their children. Conversely, women who have had an abortion are apparently more prone to taking risks that could endanger their lives.

This data is consistent with at least two other studies that have found that women who abort are more likely to be treated for accident-related injuries in the year following their abortions.

In a study of government-funded medical programs in Canada, researchers found that women who had undergone an abortion in the previous year were treated for mental disorders 41 percent more often than postpartum women, and 25 percent more often for injuries or conditions resulting from violence.[13]

Similarly, a study of Medicaid payments in Virginia found that women who had state-funded abortions had 62 percent more subsequent mental health claims (resulting in 43 percent higher costs) and 12 percent more claims for treatments related to accidents (resulting in 52 percent higher costs) compared to a case matched sample of women covered by Medicaid who had not had a state-funded abortion.[14]

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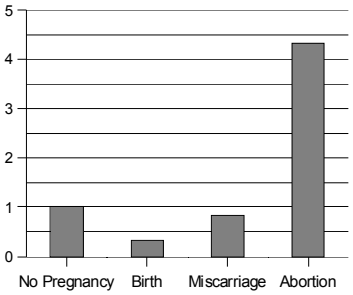
This issue has been edited by David C. Reardon, Ph.D., Director of the Elliot Institute. Assistant Editor: Amy R. Sobie. Relevant submissions will be considered for publication but cannot be returned unless accompanied by a SASE. Direct requests for permission to reprint to: Elliot Institute, PO Box 7348, Springfield, IL 62791.

It is quite likely that some of these deaths which were classified as accidental may have in fact been suicides. Reports of post-abortive women deliberately crashing their automobiles, often in a drunken state, in an attempt to kill themselves have been reported by both post-abortion counselors and in the published literature.[15]

It is also likely that many of these deaths are simply related to heightened risk-taking behavior among post-abortive women. This may occur simply because some women care less whether they live or die after an abortion. Other women may seek to "self-medicate" a sense of depression with the adrenalin rush that often comes with taking risks. In addition, heavier drinking and substance abuse are well-documented aftereffects of abortion, both of which increase a person's risk of fatal accidents.[16]

Fig. 4. Deaths by Homicide



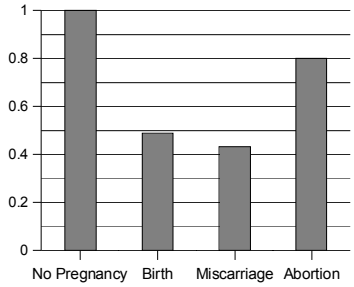
Deaths from Homicide

The STAKES study also found that 14 (5 percent) of the 281 women were killed by another person. Most of these deaths occurred among women who had undergone an abortion. As shown in Figure 4, the risk of dying from homicide for post-abortive women was more than four times greater than the risk of homicide among the general population.

This finding, especially when combined with the suicide and accident figures, once again reinforces the conclusion that women who abort are more likely to engage in risk-taking behavior.

An Elliot Institute survey of 256 post-abortive women found that nearly 60 percent stated that they began to lose their temper more easily after their abortions, with 48 percent saying they also became more violent when angered. Increased tendencies toward anger and violence after abortion were also significantly associated with substance abuse and higher suicidal tendencies.[17] In other words, women who were more prone to anger were also more prone to "giving up" on life. This is a dangerous combination which can more easily lead to fatal confrontations with others.

Fig. 5. Deaths from Natural Causes



In the STAKES study, an additional 6 deaths that were due to traumatic physical injuries were listed as "unclear violent deaths." In these cases, the researchers could not make a determination of whether the cause of death was due to accident, suicide, or homicide.

Deaths from Natural Causes

Of the 281 deaths, 127 (45 percent) were attributed to natural causes. As seen in Figure 5, the age adjusted odds ratio of dying from natural causes within a year following any outcome of pregnancy is less than the odds ratio of dying for non-pregnant women.

The obvious implication of this finding is that women who are capable of becoming pregnant are simply healthier and less likely to die of natural causes than women who cannot or do not become pregnant. In other words, women who are most likely to die from a natural physical ailment are less likely to have been pregnant in the last year of their lives.

Comparing abortion to birth, however, we once again see that the risk of death from natural causes was significantly higher (60 percent higher in this sample) for women who had an induced abortion in the prior year compared to those who carried to term or had a natural pregnancy loss.

One possible explanation would be that the women who died after an abortion were already in ill health before the abortions and sought the abortion to protect their health. But this hypothesis was rejected by the STAKES researchers when an examination of abortion registry records showed that only a single woman in this group had her abortion for reasons of maternal health.[18] The STAKES data would appear to support the view that induced abortion produces an unnatural physical and psychological stress on women that can result in a negative impact on their general health.

This theory is also supported by a 1984 study that examined the amount of health care sought by women during a year before and a year after their induced abortions. The researchers found that on average, there was an 80 percent increase in the number of doctor visits and a 180 percent increase in doctor visits for psychosocial reasons after abortion.[19]

Ten years later, another study of 1,428 patients chosen at random from their office visits to 69 general practitioners found that pregnancy loss, especially abortion, was significantly associated with a lower assessment of general health.[20] The more pregnancy losses a woman had suffered, the more negative her general health score. In addition, loss of a woman's most recent pregnancy was more strongly associated with lower health than were losses followed by successful deliveries.

While the researchers found that miscarriage was also associated with a lower health score, induced abortion was more strongly associated with a lower health assessment and more frequently identified by women as the cause of their reduced level of health. More than 20 percent of the women participating in the study expressed a moderate to strong need for professional help to resolve their loss.

From this data, Dr. Philip Ney, who led the research team, concluded that acute or pathological grief after the loss of an unborn child, whether by miscarriage or abortion, has a detrimental effect on the psychological and physical health of some women.

Ney proposed several possible reasons for this: (1) depression has been linked to suppressed immune responses, (2) psychological conflict consumes energy that would otherwise be spent in more healthy ways, and (3) prolonged or unresolved mourning may distract the woman from taking care of other health needs or confuse her interpretation of situations and events. In addition to these factors, abortion has been linked to sleeping disorders, eating

disorders, and substance abuse, all of which can have a direct negative impact on a woman's health.

Conclusions

The STAKES study of pregnancy-associated deaths is beyond reproach. It is a record-based study in a country with centralized medical records. While a small number of women who died during the period investigated may have had births or abortions outside of Finland which would not have been identified in the records, there is no reason to believe these few cases would have altered these dramatic findings.

Clearly, the odds of a woman dying within a year of having an abortion are significantly higher than for women who carry to term or have a natural miscarriage. This holds true both for deaths from natural causes and deaths from suicide, accidents, or homicide. In addition, the study underscores the difficulty in reliably defining and identifying maternal deaths. Only 22 percent of the death certificates examined had any mention of the woman's recent pregnancy.

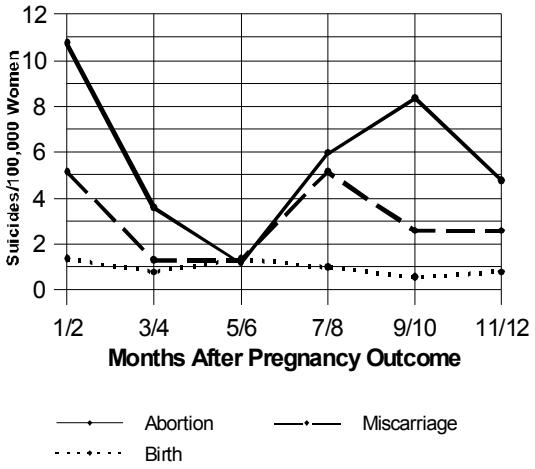
Unfortunately, there is often no clear way of determining when there is any causal connection between a death and a previous pregnancy, birth, miscarriage, or abortion. According to the lead author of the STAKES study, Mika Gissler, in maternal health reports throughout the world, "[t]here is no consensus concerning which cases should be included as maternal deaths. Problematic are, for example, some cancers, stroke, asthma, liver cirrhosis, pneumonia with influenza, anorexia nervosa, and many violent deaths, such as suicide, homicide, and accidents."[21]

By stepping back from a predefined notion of what constitutes a pregnancy-related death, the STAKES team has shown that deaths among women following a pregnancy cannot easily be tracked when a study is based purely on short-term post-operative recovery. This is particularly true following an abortion. Maternal deaths after an abortion are seldom identified as such unless the death occurs on the operating table, if even then (see accompanying article on page 5). By examining all death certificates and all pregnancy events in the prior year, the STAKES team avoided the basic problem of pre-defining what deaths will be included or excluded in maternal mortality reports.

Even this study, however, has shortcomings. The most obvious limitation is that the researchers examined only a single year of the reproductive history of women who had died during the study period. Since suicide attempts are often associated with the anniversary date of the abortion, some portion of deaths from suicide or accidents that occurred slightly over one year after a prior abortion were probably missed.

As seen in Figure 6, the distribution of suicides by month following the pregnancy event indicate an increased level of suicides at seven to ten months following an abortion. This may correspond to a negative anniversary reaction related to the expected due date of the aborted child. A similar spike is seen among women who had miscarriages, though it peaks a couple of months earlier, perhaps because the miscarriages generally occurred further along in gestation than the abortions.

Fig. 6



Another disadvantage of the one-year limit on the STAKES data set is that it does not reveal how long the protective effect of birth extends, or conversely, how long the odds ratio of death for those who abort remains elevated. A study spanning a longer period of time would be needed to identify these longer term effects.

Finally, the STAKES study does not shed any light on whether or not women who died from suicide or risk-taking behavior after an abortion were already self-destructive before their abortions. It is probable that many were. Women with a propensity for risk-taking would be more likely to become pregnant and perhaps more likely to choose abortion. In such cases, while abortion may not be the underlying cause of their problems, it probably contributed to their psychological deterioration and was a contributing cause of their death.

On the other hand, it is also clear from other studies that many women who were not previously self-destructive become so as a direct result of their traumatic abortion experience. Whether this latter group represents a major or minor portion of those who died in the STAKES sample is unknown.

Additional insights could be gained by looking back over several more years of the women's medical records. It is likely that prior suicide attempts, a high incidence of treatment for accidents, prior psychological treatments, and other prior pregnancy losses would all be associated with an increased risk of subsequent death by suicide, homicide, or accident.

Abortion advocates will naturally argue that abortion did not "cause" any of these deaths, but rather that these women were simply self-destructive or ill beforehand and would have died anyway. This is a flimsy argument, since clearly this same data shows that giving birth has a protective effect. Even women who committed suicide after giving birth waited until after their children were born to take their own lives.

It is quite probable that the best way to help a self-destructive woman to change her life, and value her own life, is to encourage her to cherish the life of her unborn child. Conversely, it is clear that aiding and encouraging a self-destructive woman to undergo an abortion is likely to aggravate her self-destructive tendencies.

These findings underscore the importance of holding abortion clinics liable for screening women who are seeking an abortion for a history of suicide, self-destructive behavior, and psychological instability. The failure to screen for these risk factors is clearly gross negligence. In addition, when abortion clinic counselors falsely reassure women that abortion is safer than childbirth, they

should be held accountable for false and deceptive business practices.

-DCR

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The Cover-Up

Why U.S. Abortion Statistics Are Meaningless

On March 1, 1989, Erica Richardson, a 16-year-old Maryland resident, bled to death from a punctured uterus only hours after undergoing an abortion. During the next five months, two adult women, Gladys Estanislao and Debra Gray, also died from abortion complications. They too were residents of Maryland.

Shockingly, none of these three women was even granted that smallest of recognitions—becoming a statistic. The official statistics issued by Maryland public health officials showed that *there were no deaths* from abortion in 1989. Indeed, Maryland only reported a single abortion-related death for the entire decade of 1980 to 1989.[1]

There was actually a fourth maternal death related to a 1989 abortion in Maryland. In this case, Susanne Logan fell into a coma during her abortion and awoke four months later as a quadriplegic, unable to talk. She survived for three years, dying in 1992. Since Susanne's death was not an *immediate* result of her abortion, it has not been counted in any of the official abortion mortality statistics.[2]

These are four deaths that occurred in one small state that reported no abortion deaths for 1989. For that same year, the Abortion Surveillance Unit of the Centers for Disease Control (CDC) reported only 12 deaths for the entire country. But, as we will see, the CDC doesn't look very hard.

Uncovering the Abortionists' Tracks

In the late 1980's, Kevin Sherlock, an investigative reporter who specializes in public document searches, undertook an extensive review of death certificates for women of reproductive age in Los Angeles County. Looking for indications of "therapeutic misadventure," he pulled autopsy reports and was able to find 29 abortion-related deaths in L.A. County alone between 1970 and 1987. Four of these deaths occurred during a one-year period for which the CDC reported zero abortion-related deaths for the entire state of California and only 12 deaths for the whole country.

Using a similar technique, Sherlock eventually documented 30 to 40 percent more abortion-related deaths throughout the country than have been reported in the "official" national statistics published by the CDC. Furthermore, Sherlock accomplished this without any assistance from the CDC, which obstructed his every effort to examine their records. Sherlock admits—and even insists—that with his limited resources and the tendency of abortionists and state health authorities to minimize or obscure the paper trail surrounding abortion-related deaths, he has documented only a fraction of the deaths that are actually occurring as a direct result of abortion.[3]

The scope of the coverup is hinted at in a memo from Steven C. Joseph, M.D., the Commissioner of Health for New York City, to all of his city's abortion providers. Dated June 5, 1987, the friendly memo simply cautioned against the overuse of general anesthesia, stating: "During the period between 1981 and 1984, there were 30 legal abortion-related deaths in New York City . . . one-third of these (10) were due to general anesthesia, whereas in the rest of the United States less than 10 percent of abortion-related deaths were due to general anesthesia (12/146)."[4]

While not intended for release to the general public, this memo is

clear evidence that public health authorities know far more about abortion-related deaths than is being shared in the "official" statistics. For this same time period (1981-1984), New York's top health official had identified 30 deaths in New York City alone, while the CDC's official report shows only 42 abortion-related deaths during this period for the *entire nation.*

In addition, the memo also suggests that the Commissioner of Health had access to unpublished information identifying another 146 abortion-related deaths for that same time period outside of New York. Combined with the 30 deaths in New York City, that is 176 abortion-related deaths in all—419 percent higher than was reported in the official CDC numbers.

Only a minute number of abortion deaths are classified as such.

Similar admissions of cover-up have been made by other public health authorities.[5] For example, following the death of Barbara Lee Davis from hemorrhage after a routine first-trimester abortion, the chief of the Illinois Department of Public's Division of Hospitals and Clinics admitted to reporters, "It's unfortunate, but it's happening every day in Chicago, and you're just not hearing about it."[6] Just one year later, during an investigation of only four Chicago-based abortion clinics, investigative reporters for the *Chicago-Sun Times* identified twelve abortion-related deaths that had not been reported in the state's official statistics.[7]

How can there be such an extensive cover-up of abortion-related deaths? Prior to legalization, abortion-related deaths were carefully and accurately reported because these deaths resulted from an illegal activity.[8] But today, abortion is not only legal but is politically protected. Indeed, the CDC's abortion surveillance unit is not only run by abortion advocates, it has regularly employed practicing abortionists! This is like putting consultants for Phillip Morris' cigarette manufacturing division in charge of the CDC's lung cancer surveillance unit. Clearly, the CDC's abortion surveillance unit is more interested in protecting the health of the American abortion industry than in protecting the health of American women.[9]

Furthermore, the cover-up of abortion-related deaths has actually been furthered by the World Health Organization's coding rule number 12 of the International Classification of Diseases. This rule requires that deaths due to medical and surgical treatment must be reported under the complication of the procedure (embolism, for example) and not under the condition for treatment (elective abortion). According to researcher Isabelle Bégin:

> In effect, this makes the "abortion" category a "ghost" category under which it is simply impossible to code a death due to abortion. Medical coders have in fact relayed that any attempt to code a death due to abortion under abortion yields a "reject message" from the computer programs provided by the National Center for Health Statistics of Washington D.C., a division of the U.S. Centers for Disease Control in Atlanta, Georgia. Only a minute number of abortion-related deaths actually qualify to be declared under abortion, i.e. those for which the medical certificate of death categorically and unequivocally gives abortion as the underlying cause of death.[10]

Racial Minorities at Risk

One final note. Both the "official" statistics on abortion-related deaths of women and the findings of private investigators have found that non-white women are two to four times more likely to die or suffer serious injury from an abortion than are white women. The best explanation for this discrepancy would appear to be that non-white patients are at greater risk of suffering from negligence, or even hostility, that is rooted in racial bias. This is because many abortion providers believe that abortion is essential for "suppressing poverty, crime, and other problems of society."[11]

In an unguarded moment, Dr. Edward Allred, owner of the largest chain of abortion clinics in California, made his racist attitudes frighteningly clear:

> Population control is too important to be stopped by some right-wing pro-life types. Take the new influx of Hispanic immigrants. Their lack of respect for democracy and social order is frightening. I hope I can do something to stem that tide; I'd set up a clinic in Mexico for free if I could . . . The survival of our society could be at stake . . . When a sullen black woman of 17 or 18 can decide to have a baby and get welfare and food stamps and become a burden to all of us it's time to stop.[12]

Four years after Allred made these comments, Patricia Chacón, a sixteen-year-old Hispanic girl, and Mary Peña, a 43-year-old married Hispanic woman, both bled to death after having abortions performed by Allred. The autopsy reports do not disclose whether either woman was "sullen."[13]

Other known deaths at Allred-owned clinics are those of Deanna Bell, a 13-year-old black girl; Josefina García, a 37-year-old Filipino woman; Laniece Dorsey, a 17-year-old black girl; and Joyce Orenzio, a 32-year-old Hawaiian woman.[14] Clearly, Dr. Allred has contributed more than his share to suppressing the population of minority women and their children.

-DCR

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1. Kevin Sherlock, *Victims of Choice*, (Akron, OH: Brennyman Books, 1996) 134-135.
2. James A. Miller, "'Safe and Legal'--Back in New York and Maryland," *HLI Reports,* 11(2):8-9, Feb, 1993.
3. Sherlock, *Victims of Choice,* 115-117.
4. Ibid*,* 165-167.
5. For a more complete discussion with additional examples, see Reardon, *Aborted Women Silent No More,* 109-113, 282-293.
6. Ann Saltenberger, *Every Woman Has a Right to Know the Dangers of Legal Abortion* (Glassboro, NJ: Air-Plus Enterprises, 1982, 27.
7. Pamela Zekman and Pamela Warrick, "The Abortion Profiteers," *Chicago Sun-Times*, special reprint 3 December 1978 (original publication 12 November, 1978)
8. Reardon, 282-293.
9. For a more extensive review of CDC complicity, negligence, and conflicts of interest, see Mark Crutcher, *Lime 5*, (Denton, TX: Life Dynamics, 1996), 135-170.
10. Isabelle Bégin, "World-wide Abortion Statistics Scam Exposed," *Reality*, Oct. 1999.
11. See also the interview with abortionist Edward Allred in the film *A Matter of Choice* (New Liberty Pictures).
12. "Doctor's Abortion Business Is Lucrative", *San Diego Union*, Oct. 12,, 1980 B1:1.
13. Sherlock, 13-14.
14. Sherlock, 172.

Informed Consent Booklets Hide True Risk of Abortion

Please share "The Deadly Risks of Abortion" article on page 1 of this issue of *The Post-Abortion Review* with the pro-life groups and pro-life legislators in your state, especially if you have a Woman's Right to Know Act in effect. These laws generally require the State Department of Public Health to prepare a booklet describing the risks of abortion.

These risk disclosure booklets routinely reflect pro-abortion propaganda, unequivocally reassuring women that the mortality rate of abortion is less than the mortality rate of childbirth. They do not inform women that there are no reporting requirements for abortion complications and that the actual mortality rates for abortion in the United States are highly speculative.

Public pressure should be brought on the states to remove such misleading and poorly qualified claims from these booklets. Instead, the full comparison of pregnancy-associated deaths as documented by STAKES should be given to women.

In addition, these booklets should also be amended to provide specific warnings regarding increased risk of suicide attempts, suicide, and substance abuse. Whenever possible, this information should also be given to the patient's parents or spouse so they may be watchful for any signs of emotional deterioration after an abortion.

Conversely, these booklets should also be amended to explain the protective effect of childbirth in lowering the risk of many physical and psychological problems compared not only to abortion, but also to the general population of women. Choosing life is not only good for children, it's good for the health of young women.

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and die from complications of your intervention without your being in some way professionally accountable, involved in their care, and at the very least, made aware of it—except abortion.

Abortion is an invasive medical procedure, which in my own singular experience as ONE DOCTOR, has led to the death of one woman and the near death of another, yet its practitioners are not held to the same standards of care as the rest of the medical community.

Abortion is bad medicine. It is bad because it pushes sloppy medical care upon women who have been led to believe that their only choice is to abort their babies. It will always be bad medicine because it takes away an innocent human life. Our nation, our community, our mothers, sisters, daughters deserve better.

Dr. Lenora W. Berning, M.D., practices medicine at Lancaster General Hospital in Pennsylvania. This article is exceprted from a press statement made by Dr. Berning. Reprinted with permission.

"Victims and Victors" Now Available

Our new book on sexual assault pregnancies and abortion, *Victims and Victors: Speaking Out About Their Pregnancies, Abortions and Children Resulting from Sexual Assault*, is now available. It dispels the myths about sexual assault pregnancies and lays out a clear argument against abortion for rape and incest pregnancies. A "must read" for every pro-lifer!

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Abortionists Not Held Accountable for Mistakes

Dr. Lenora Berning, M.D.

Abortion is one of the most frequently performed surgical procedures in the United States—yet it is the least regulated. It is the only elective surgical procedure that I know of in which the doctor performing the procedure is not responsible for follow-up care, nor does he or she take an active role in dealing with the complications. Not only this, but the very nature of abortion clinics, which practice in isolation from the rest of the medical community, keeps the abortion provider free from accountability for these complications.

Those who support abortion on demand will claim that the reported complication rate for abortions is low. They may be right. Not necessarily because there are few complications, but because the complications are underreported. They are underreported because there is no accurate process in place today to quantify the harmful repercussions of abortion. The abortion industry has successfully kept abortion and abortionists free from the type of review, regulation, and accountability that is an integral part of the rest of the medical profession. Let me give you some real life examples.

I recently took care of a woman who almost died because she'd had an abortion. A few days before I saw her, she'd had an abortion because of a positive pregnancy test. Now, after an abortion, the clinic will examine the remains which have been scraped from the uterus to take inventory of fetal parts in order to ensure that the entire pregnancy was totally eliminated. This clinic noted that there were no fetal parts, which meant that the pregnancy had not been in the uterus.

This situation is known as an ectopic pregnancy, where the pregnancy is not in the womb, but in the fallopian tube. An ectopic pregnancy is a life-threatening condition; the ectopic must be removed or it will grow to a size that will rupture the fallopian tube and result in massive internal bleeding that can kill the mother.

In any legitimate medical facility, a woman with an ectopic pregnancy would have an immediate ultrasound to assess the ectopic, be admitted to the hospital, and have surgery before it could rupture and potentially take her life. In this abortion facility, the woman was sent home and told to call her doctor. Unfortunately, time was not on her side — before she ever had the chance, her ectopic pregnancy ruptured, she was rushed to the ER by ambulance, and taken immediately to the operating room.

Had this quality of care been provided by any other medical provider—family physician, obstetrician, or emergency physician—it would be considered grossly negligent. By an abortion provider, it does not even cause a stir. In fact it goes unnoted and unreported.

A few years ago, a young woman about twenty years old came to the ER because she was feeling very sick. She'd become increasingly ill ever since the abortion she'd had about a week earlier. I had her admitted to the hospital from the ER with a severe pneumonia. The following days revealed that the pneumonia was just a part of the problem—she had overwhelming sepsis, which is infection throughout her entire body which had, at its source, the abortion.

This woman died. The admitting physician never reported the incident as abortion-related, nor did she inform the abortion provider of the results of his "care." He was still practicing, without the slightest idea that his intervention had led to his patient's death.

The medical diagnosis reads "severe pain"—the real cause is abortion. The record reads "vaginal bleeding"—the real cause is abortion. The operative note says "ruptured ectopic pregnancy and internal hemorrhage"—the real cause is abortion. The autopsy states "cause of death—overwhelming sepsis"—the real cause is abortion.

There is no other practice of medicine where people can suffer

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