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Philosophy and Theology: Is Giving Birth More Dangerous than Aborting?

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PHILOSOPHY AND THEOLOGY

In the debates about the ethics and laws governing abortion, it is sometimes claimed that the risk of death is higher in giving birth than in aborting. Three recent works take up this claim and provide powerful evidence that it is not justified.

The first work is Clarke Forsythe's *Abuse of Discretion: The Inside Story of Roe v. Wade*.¹ A full review of this work appeared in the Summer issue of the *National Catholic Bioethics Quarterly*, but it is worth noting here that Forsythe focuses particular attention on the question about the risks of abortion just prior to the infamous *Roe* decision. He carefully traces the articles and research supporting the claim that women risk death more in giving birth than getting an abortion, and finds that none of them were peer-reviewed, none of them were statistically reliable, and none of them provided sound evidence for the claim. The justices in favor of *Roe* also ignored evidence from Denmark and Sweden that childbirth is safer than abortion: "Although Denmark and Sweden had allowed legal abortion . . . they had abortion mortality rates that exceeded the mortality rates from childbirth."²

Indeed, the arguments presented in favor of legalizing abortion were not consistent with each other. On the one hand, advocates for legalized abortion argued that the law forbade abortion in the nineteenth century only because abortions were, at that time, dangerous for the health of women.³ The concern of the law was not about protecting fetal life. Since medical advances throughout the twentieth century led to very few women dying of abortion, the original purpose of the law to protect

¹ Clarke D. Forsythe, *Abuse of Discretion: The Inside Story of Roe v. Wade* (New York: Encounter Books, 2013).

² *Ibid.*, 171.

³ This claim is untrue, as is clear from the studies of Joseph W. Dellapenna, *Dispelling the Myths of Abortion History* (Durham, NC: Carolina Academic Press, 2006); and John Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (New York: Cambridge University Press, 2002).

women's health was no longer being served. On the other hand, abortion advocates also appealed to the numerous deaths caused by illegal abortions. The evidence in favor of the first argument (very few women died from illegal abortion in the 1960s and early 1970s) undermines the second argument based on the premise that illegal abortions lead to numerous maternal deaths. Forsythe's work tackles numerous other political, legal, social, and medical aspects of abortion in the early 1970s, but his analysis of the facts available to the Supreme Court in deciding both *Roe* and *Doe v. Bolton* did not provide solid evidence for the claim that abortion is safer than childbirth.

It might be said that the state of the question at the time of *Roe* has been surpassed by contemporary research. Yet more recent studies actually confirm the view presented by Forsythe that there is no credible evidence that giving birth is more risky than getting an abortion. For example, Byron Calhoun's article "The Maternal Mortality Myth in the Context of Legalized Abortion" takes up the claim that "the risk of death associated with childbirth is approximately 14 times higher than with abortion."⁴ This proposition is used to justify legalized abortion and to argue in favor of the moral permissibility of abortion. Calhoun argues that there is no credible scientific evidence to support this claim.

The maternal mortality rate is the number of deaths from pregnancy per one hundred thousand live births. Calhoun notes that the number of deaths resulting from pregnancy is difficult to determine because there is a lack of consensus regarding the timeline that should be used to link a pregnancy to the result of death. Should a death within a month, six months, or a year after birth be attributed to the pregnancy? In addition, there is another problem with determining the number of deaths per live birth. The numerator of maternal deaths includes deaths from ectopic pregnancies, molar pregnancies, miscarriage, and still births, none of which fall into the category of live births. "This means that 40 percent of the deaths are never represented in the denominator, resulting in a dramatically over-inflated maternal mortality rate. Moreover, the majority of women who survive ectopic pregnancies, miscarriage, and stillbirth will not be in the data at all since their pregnancies do not result in live birth."⁵

Calhoun makes an important point in terms of using maternal mortality as an argument for abortion. He notes that women who are aware they are pregnant and make a decision about abortion (either for or against) "have already survived beyond the period of the pregnancy's greatest risk."⁶ Although he does not state this explicitly, Calhoun is probably talking about ectopic pregnancy. "Ectopic pregnancy occurs at a rate of 19.7 cases per 1,000 pregnancies in North America and is a leading cause of maternal mortality in the first trimester."⁷ Such deaths from ectopic pregnancy, though of course tragic, are irrelevant for decisions about whether to abort. Deaths from

⁴ Byron Calhoun, "The Maternal Mortality Myth in the Context of Legalized Abortion," *Linacre Quarterly* 80.3 (August 2013): 264.

⁵ *Ibid.*, 269.

⁶ *Ibid.*, 270.

⁷ Josie L. Tenore, "Ectopic Pregnancy," *American Family Physician* 61.4 (February 15, 2000): 1080.

ectopic pregnancy are not relevant for the discussion of elective abortion, inasmuch as the choice to continue a pregnancy to live birth is no longer an option in cases of ectopic pregnancy. Despite some controversy about particular ways of treating ectopic pregnancy, everyone agrees that the general treatment of ectopic pregnancy is morally and legally legitimate, even though the developing human being will die as a side effect of the medical treatment.⁸ It is important to note that abortion actually increases the overall number of maternal deaths by increasing the likelihood of future ectopic pregnancy. Several studies point to an increased rate of ectopic pregnancy following abortion.⁹ More abortions lead to more ectopic pregnancies; more ectopic pregnancies lead to more maternal deaths.

Unfortunately, determining the risk of abortion, both in terms of maternal deaths and injuries, turns out to be a question that, at least in the United States, we cannot answer with precision. Like the maternal mortality ratio, a lack of consensus exists about the timeline that should be used to link an abortion to the result of death. Should death within a month, six months, or a year after an abortion be attributed to the abortion? This question is important in particular because ectopic pregnancy is the most common reason for death in pregnancy, and elective abortion increases the risk of ectopic pregnancy. So if the timeline for consideration is, say, a month after the abortion, then no increase in death rates due to ectopic pregnancy will be found. If in fact an abortion causes a woman to have a fatal ectopic pregnancy two years after her abortion, her death would not—simply by the timeline adopted in definition—be attributed to the abortion. Yet, in some cases at least, if she had not had an abortion, she would not have had an ectopic pregnancy that led to her death. In order to know how dangerous abortion is, it is also necessary to know how many abortions take place and the number of deaths and complications that result from these abortions. If either the numerator or the denominator of this ratio is unknown, it is impossible to determine the risk of death from abortion. If we cannot determine the risk of death from abortion, we cannot compare this risk to the risk of childbirth.

In the United States, since there is no federal reporting requirement, we do not know the number of abortions taking place each year. The Centers for Disease Control and Prevention relies on estimates based on voluntary submissions from individual states, including some states, such as California, that are not included in current estimates. A research arm of Planned Parenthood, the Guttmacher Institute (GI), also collects information on abortion, but these statistics also rely on voluntary submissions from abortion providers. GI is hardly a disinterested spectator in

⁸ For more on the topic, see Christopher Kaczor, “The Ethics of Ectopic Pregnancy: A Critical Reconsideration of Salpingostomy and Methotrexate,” *Linacre Quarterly* 76.3 (August 2009): 265–282.

⁹ See Osaheni L. Lawani, Okechukwu B. Anozie, and Paul O. Ezeonu, “Ectopic Pregnancy: A Life-Threatening Gynecological Emergency,” *International Journal of Women’s Health* 5 (August 19, 2013): 515–521; Jyotindu Debnath et al., “Ectopic Pregnancy in the Era of Medical Abortion: Are We Ready for It? Spectrum of Sonographic Findings and Our Experience in a Tertiary Care Service Hospital of India,” *Journal of Obstetrics and Gynecology of India* 63.6 (2013): 388–393; and Fabio Parazzini et al., “Induced Abortions and Risk of Ectopic Pregnancy,” *Human Reproduction* 10.7 (July 1995): 1841–1844.

discussions about abortion, since Planned Parenthood has a huge financial interest at stake in these debates as the largest provider of abortions in the United States. So the denominator, the total number of abortions, is not reliably known.

Nor is the numerator, the number of abortion related deaths, reliably known. Determining the number of deaths from abortion in the United States is difficult in part because these numbers are drawn from voluntary surveys of abortion providers. Calhoun points out that “in GI’s periodic survey of abortion providers, physicians performing abortions face an obvious conflict of interest: disclosure of abortion complications may fuel state laws restricting access if GI publishes all data gathered. In short, GI data are not credible as it is incomplete and inherently biased.”¹⁰ Abortions are also often underreported by women in their health histories, which makes it more difficult to determine whether particular health complications arise from abortion. In addition, Calhoun notes that at least seven different definitions of “abortion related deaths” are used, some of which do not distinguish between spontaneous abortions (involuntary miscarriages), elective abortions, and therapeutic abortions (such as ectopic pregnancy). For a woman contemplating the choice of elective abortions, the number of deaths from spontaneous abortions or therapeutic abortion is not relevant. Many women suffering from complications of abortion are treated by emergency room doctors who may not be made aware of the prior abortion. Deaths in these cases may be attributed only to the most immediate cause, such as sepsis or hemorrhage, without indication that it was an abortion which brought about the sepsis or hemorrhage. Other factors compounding the difficulty of finding reliable data are the substance abuse, depression, and suicide that result from abortion and lead to death. So the ratio of the total number of maternal deaths resulting from abortion is unknown. The claim that “childbirth is more risky than abortion” depends on a comparison of two ratios: the risk of giving birth and the risk of getting an abortion. Reliable data for either ratio is not available. Arguments for legalization or ethical permissibility of abortion cannot justifiably rely on the claim that giving birth is more risky than getting an abortion.

Is legalized abortion a boon for women’s health? One way to examine this question is to compare countries where abortion is legal to countries where it is not. “A carefully done study using 42 years of United Kingdom National Health data comparing England, Wales, and Scotland with Northern Ireland and parallel national data from the Republic of Ireland found that countries with legal abortion actually had a higher maternal mortality rate per 100,000 live births.”¹¹ In sum, Calhoun concludes, “the legal status of abortion had no relationship to the reduction in maternal mortality. Rather, the reduction in maternal deaths during pregnancy was related to the better education and obstetrical care for women available in the different time periods.”¹²

The third work considering whether abortion is more risky than birth focuses on Chile. Taking up the question of legalized abortion and women’s health from a South American perspective, Elard Koch’s article “Impact of Reproductive Laws

¹⁰ Calhoun, “The Maternal Mortality Myth,” 266.

¹¹ *Ibid.*, 272.

¹² *Ibid.*, 273.

on Maternal Mortality: The Chilean Natural Experiment” considers the view that restrictive abortion laws harm women’s health and legalized abortion helps women’s health.¹³ His aim in this article is to summarize a series of studies on maternal health that focus on Chile over the last one hundred years. Chile liberalized abortion laws in 1931 and then later banned virtually all abortions in 1989. The new law permits legalized abortion only to save the life of the mother, such as in ectopic pregnancy. In studying what happened in Chile, we can gain some insight into whether criminalizing abortion harms or helps women’s health.

Koch found that the number of women dying during pregnancy and childbirth, the maternal mortality ratio (MMR), dropped throughout the years from 1909 through 2009. During this one hundred year span, abortion was decriminalized and then recriminalized. When Chile liberalized abortion laws in 1931, there was no significant decrease in maternal mortality rates. In fact, Koch found that “the highest peak of the MMR during the last century in Chile occurred a few years after the implementation of this law [permitting abortion], in 1937. . . . In fact, there [was a] 32 percent increase [in] the MMR between 1931 . . . and 1937.”¹⁴ When Chile banned virtually all abortions in 1989, this did not lead to an increase in the maternal mortality ratio. After criminalization, the MMR as well as the number of women dying from abortions continued to drop. Koch notes, “If banning abortion actually resulted in increasing unsafe illegal abortions, as has been theorized, then a significant increase in hospitalizations due to complications from illegal abortion would be expected. On the contrary, hospitalizations due to any kind of abortion (whether spontaneous or induced) continued to decrease. Furthermore, if banning abortion resulted in more deaths from illegal abortion, then an increase in the AMR [Abortion Mortality Ratio] should have been observed. Remarkably, rather than increasing, the AMR decreased over 96 percent after abortion banning in 1989, from 10.8 to 0.39 per 100,000 live births.”¹⁵ The factors that made the biggest difference in lowering maternal mortality per capita were clean water, increasing female education achievement, systematic prenatal care, and complementary nutrition programs for children and pregnant women—not the legal status of abortion.

Examining the other side of the coin, the legalization of abortion in Guyana in 1995, did not reduce maternal mortality. Indeed, Koch notes, the maternal mortality ratio *increased* after legalization of abortion.¹⁶ What matters for improving women’s health, Koch argues, is increased female education, nutrition programs for mothers and children, access to prenatal health services, advances in emergency obstetrics, and advanced sanitation.

Another test case is the country of Poland, which had state-funded abortion for decades and then criminalized most abortions after the 1989 Solidarity revolution of independence from Communism. Did women’s health suffer after abortion was

¹³ Elard Koch, “Impact of Reproductive Laws on Maternal Mortality: The Chilean Natural Experiment,” *Linacre Quarterly* 80.2 (May 2013): 151–160.

¹⁴ *Ibid.*, 154.

¹⁵ *Ibid.*, 158.

¹⁶ *Ibid.*, 159.

criminalized? “To perhaps everyone’s surprise, there have been 25% fewer miscarriages and 30% fewer women dying compared with what it had been while abortion was legal. In the latest annual report, 21 women died from pregnancy-related problems, with none listed as dying from illegal abortions.”¹⁷ The experience of women in Chile, Guyana, and Poland suggests that legalization of abortion is unnecessary and perhaps even counterproductive for women’s health.

The argument about the relationship between women’s health and abortion is an important one, but it is only one aspect of a larger conversation. If the three studies mentioned in this narrative were to all be mistaken, this would not settle the ethical and legal questions about abortion. Let us suppose that giving birth were more risky for a woman’s health than getting an abortion. Let us suppose that legalized abortion did lead to lower overall rates of maternal mortality. Would it follow that abortion is morally permissible? Would it follow that abortion should be legalized? It seems clear that a few other questions must also be answered to come to a balanced and holistic judgment. These questions include, Is the human being in utero someone who has intrinsic worth and equal basic dignity? Is it permissible to intentionally kill one human being (one’s own son or daughter) to lower the likelihood of adverse effects for oneself? Is it permissible to use one person simply as a means, indeed, to destroy this person’s life, to achieve some worthwhile end? Francis Beckwith made the point that just because one course of action is less risky than another course of action does not mean that the safer course of action is legally or ethically permissible.¹⁸ It is also relevant to mention that abortion may be more or less risky for the woman involved, but it is always fatally risky for the child involved. Abortion may or may not leave one injured, but it always leaves one dead.

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¹⁷ Randy Alcorn, *Pro-Life Answers to Pro-Choice Arguments*, exp. ed. (New York: Multnomah Books, 2000), 175.

¹⁸ Francis J. Beckwith, “The Misuse of Maternal Mortality Statistics in the Abortion Debate,” *Ethics and Medicine* 7.2 (Summer 1991): 18–19.