

Questions and Answers on Late-Term Abortion

What is a Late-Term Abortion?

“Late-term” abortion is an imprecise term. Authorities have disagreed on how the phrase should be defined, with some including any abortion performed after the 20th week of gestation and others limiting the term to the third trimester (approximately 27 weeks of gestation to delivery). Use of the term is also sometimes rooted in the concept of viability, or that stage of pregnancy where, on average, an unborn child can survive on its own outside the womb, albeit with artificial support. Besides being individual to a particular baby’s overall physical condition, “viability” itself is a term whose application varies over time, occurring earlier in pregnancy as active treatment resources increase and medical equipment and skills improve. The U.S. Centers for Disease Control’s abortion surveillance system uses greater than or equal to 21 weeks of gestation to delivery as its upper category, and the system does not distinguish abortions by week at that limit or above.

How Are Late-Term Abortions Performed?

In the past certain methods of abortion created legal jeopardy and personal quandaries for abortionists and patients – what one physician called [“the dreaded complication”](#) – a child born alive despite the effort to kill him or her in utero. These methods of abortion included instillation of saline solution or prostaglandins, that induce contractions and vaginal delivery of the child. A number of victims of these procedures are [alive](#) today and testify to their experiences. To avoid these outcomes, abortion practitioners today take steps to ensure fetal demise before delivery. One method to finesse this challenge – partial-birth abortion, which involved delivering the child into the birth canal up to its shoulders and killing it through vacuuming out its brain and crushing its skull – was banned by Congress in 2003. The ban was upheld by the Supreme Court in *Gonzales v. Carhart* in 2007.

Currently, a day or two before the abortion is performed, the abortionist prepares the cervix with osmotic and/or pharmacologic dilators (e.g., laminaria) to open the cervix. About the same time, he usually administers an injection of potassium chloride or digoxin into the heart or head of the unborn child, to ensure that he or she is dead upon delivery. On the day of the procedure, if further cervical dilation is needed, this is performed with mechanical dilators just prior to the procedure. Uterine evacuation is then performed. For younger babies this can be primarily accomplished using suction to remove as much tissue and soft body parts as possible, followed by forceps for removal of larger and harder body parts. For older and larger babies, dismemberment using forceps is used (grasping and pulling off limbs for removal). The brain is usually then removed by suction and the skull crushed for removal. In partial-birth abortion (now illegal), the legs are grasped and pulled through the cervix, as in a breech delivery. The body can be delivered this way, but the skull will be too large to deliver through the partially dilated cervix. The abortionist will then introduce an instrument such as scissors into the base of the skull creating an opening. The brain is suctioned out, and the skull then crushed with clamps and extracted. Misoprostol may also be given to the mother to induce uterine contractions, especially to help expel all the body parts and placenta.

How Many Late-Term Abortions Are Performed in the United States Each Year?

Total abortions have been steadily [declining](#) in the United States since 1980, although preliminary 2017 data from more than 30 states reviewed by the Charlotte Lozier Institute suggests total abortions may be leveling off. The most recent data from the U.S. Centers for Disease Control and Prevention (CDC) on total abortions and late-term abortions suggests that approximately 1.3% of abortions are carried out at 21 weeks of gestation and above. The true percentage is likely

even higher, as 12 reporting areas are not reflected in the CDC's estimate. These reporting areas account for more than half of all abortions performed in the United States, and all but one permit abortion on demand after 20 weeks. The most recent national abortion total from the Guttmacher Institute and its direct surveys of abortion facilities found that there were an estimated 926,200 abortions in the United States in 2014. Even using the low estimate of 1.3% from the CDC, that translates into an estimated 12,040 late-term abortions in that year. This exceeds the number of deaths due to homicides by [firearm in 2013](#). Late-term abortions constitute as much as 3 percent of all abortions in Colorado.

Are the Vast Majority of Late-Term Abortions Performed in Cases of Threat to the Mother's Life/Fetal Abnormality?

Defenders of late-term abortion frequently make the assertion that late-term abortions are "[almost always](#)" carried out in cases of severe fetal abnormality or danger to the mother's life. Reporting on the results of a study of late-term abortions in 2013 (Fisher, Kimport) in the journal *Perspectives on Sexual and Reproductive Health*, a publication of the pro-choice Guttmacher Institute, the authors [acknowledge](#) that "data suggests that most women seeking later terminations are not doing so for reasons of fetal anomaly or life endangerment." Using interviews and questionnaires, the authors compared 272 women who had abortions at 20 weeks with 169 women who had abortions prior to 20 weeks and found that the rationales cited by the two groups were essentially the same – stressful circumstances of unprepared pregnancy, single-motherhood, financial pressure, and relationship discord. The Fisher-Kimport study excluded for comparison an unidentified number of women who had abortions for reasons of life endangerment or fetal anomaly, a significant limitation. In an April 2018 [report](#) for the Congressional Research Service, however, Dr. Foster is cited as believing "that abortions for fetal anomaly 'make up a small minority of later abortion' and that those for life endangerment are even harder to characterize."

Why is the Data on Late-Term Abortion Inadequate and How Can It Be Improved?

Few states report the reasons why women choose abortion, and even fewer report those reasons by gestational age. In 2017, only Florida and Utah reported the reasons given for late-term abortions. State abortion reporting is inconsistent, and some states (California, Maryland, and New Hampshire, two of them home to especially late-term abortion facilities) collect no abortion data at all. To improve available data on late-term abortions, states that already collect information on reasons for abortion and the gestational ages at which abortions are performed could cross-tabulate these data. Additionally, states that do not collect this information from abortion providers could add gestational age and reasons for abortion to their state abortion reporting forms. Compounding the problem, the CDC does not request this information from the states, and the standard U.S. Report of Induced Termination of Pregnancy, which many states use as a model, does not collect reasons for abortion. Some pro-choice policy groups consider government tracking of these data to be "[intrusive](#)" and "[unnecessary](#)" – while [acknowledging](#) that information on women's reasons for abortion is critical to an understanding of abortion trends, public policy, and public opinion.

What Do Obstetricians and Perinatologists Say about Late-Term Abortion?

"Most late term abortions are done for the same social reasons that earlier abortions are done. Late-term abortions are much more dangerous for the mother than giving birth. Late-term abortions involve much higher risk of death from the abortion procedure itself, as well as higher risk of perforating the womb, massive bleeding, and damage to the womb. Late-term abortions are only safe for the abortionist, not for the mother, or her child. If a baby has died in the womb, the procedure is not an abortion. The purpose of an abortion is to kill the unborn child to ensure that the child is born dead." - **Dr. Donna Harrison, M.D., Executive Director, American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG)**

"Women carrying children with life-limiting conditions need to be cared for in a way that not only maximizes maternal health, but also honors the life of their child. Delivering a child intact and then administering the appropriate medical care for that child - whether that be palliative care or active treatment - is the medically appropriate and ethical thing to do. This scenario is one that every OB/GYN faces. Given that 85% of OB/GYNs do not perform abortions, third-trimester abortions do not need to be legal in order to optimally care for women and their children, no matter what the circumstances." - **Christina Francis, M.D., Chair of the Board, AAPLOG**

“There is never a reason to take the life of an unborn child since there is no maternal condition that requires the death of the fetus to save her life. The infant may need to be delivered prematurely and die as a result of that, but it is not necessary to take the infant's life. Further, if a fetus has an adverse prenatal diagnosis all patients should be offered perinatal hospice care since this is far better for maternal health than any elective abortion. Perinatal hospice allows the parents to be parents and provide all the love they can for their child.” - **Dr. Byron Calhoun, perinatologist**

Conclusion

The Issue of late-term abortion is not going away. The American Board of Medical Specialties recently approved a new sub-specialty euphemistically titled “Complex Family Planning Fellowship.” Per the American Board of OB/GYN's application for formation of this fellowship, “A subspecialist in complex family planning will be capable of managing complex problems in pregnancy prevention, abnormal pregnancy, early pregnancy loss, and pregnancy termination and serve as a leader in the clinical application, research, and public policy aspects of contraception and abortion.” In fact, the ONLY thing this new subspecialty will focus on that every other OB/GYN isn't already trained in is late-term abortion procedures. A Maternal Fetal Medicine subspecialty (requiring 3 additional years of training beyond residency) already exists for the management of high-risk pregnancies. The formation of this new sub-specialty of OB/GYN because of a supposed need for more intense and specialized training in how to do abortion procedures directly contradicts the trend in some states of allowing non-physicians, without even basic residency training, to perform abortions. If abortions are such “simple” procedures, why is this specialized training needed? For all of these reasons, the American Association of Prolife OB/GYN's, along with several other medical organizations, has strenuously objected to the formation of this grisly and unethical subspecialty, whose unique aim is to kill fetal human beings who are capable of surviving outside of the womb.

- *Fact sheet prepared by David Prentice, Ph.D., Christina Francis, M.D., Charles A. Donovan, Sr., and Tessa Longbons*