A Serious Misrepresentation of the Relative Safety of Induced Abortion Compared to Childbirth Published in a Leading Medical Journal

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The recent study in *Obstetrics and Gynecology* by Elizabeth Raymond and David Grimes comparing mortality statistics associated with induced abortion and childbirth is a dangerous distortion based on seriously incomplete data. In arriving at their conclusion that abortion is many times safer than childbirth, Raymond and Grimes relied only on data from the Center for Disease Control (CDC) to secure numbers of deaths related to childbirth and induced abortion. However, the data reported by abortion clinics to state health departments and ultimately to the CDC significantly underrepresents abortion morbidity and mortality for several reasons: 1) abortion reporting is not required by federal law and many states do not report abortion-related deaths to the CDC; 2) deaths due to medical and surgical treatments are reported under the complication of the procedure (e.g., infection) rather than the treatment (e.g., induced abortion); 3) most women leave abortion clinics within hours of the procedure and go to hospital emergency rooms if there are complications that may result in death; 4) suicide deaths are rarely, if ever, linked back to abortion in state reporting of death rates; 5) an abortion experience can lead to physical and/or psychological disturbances that increase the likelihood of dying years after the abortion and these indirect abortion-related deaths are not captured at all. The authors acknowledge underreporting, but they make no attempt to address the factors associated with this shortcoming, nor do they discuss the magnitude of the problem: *"Weaknesses include the likely under-reporting of deaths, possibly differential by pregnancy outcome (abortion or childbirth.)"*

Raymond and Grimes also fail to address abortion-related deaths beyond the first trimester. Abortions beyond the first trimester constitute 12-13% of all abortions [1-2]. Using national U.S. data spanning the years from 1988 to 1997, Bartlett and colleagues reported the relative risk of mortality was 14.7 per 100,000 at 13–15 weeks of gestation, 29.5 at 16-20 weeks, and 76.6 at or after 21 weeks [3].

Further, the authors never mention the wealth of data showing childbirth is protective in the immediate and long-term against death from non-obstetrical causes, both from natural causes such as breast cancer and unnatural causes including suicide [4-8]. When deaths from direct obstetric causes are removed, death rates among women during pregnancy or within 90 days of delivery have been shown to be significantly lower than in women who have never been pregnant [9]. Pregnant women are 1/20th as likely to commit suicide when compared to non-pregnant women of childbearing age [4].

In a description of the difficulties inherent in measures of maternal mortality and the resulting unreliability of all existing estimates, the World Health Organization (WHO) reported *"Maternal deaths are hard to identify precisely because this requires information about deaths among women of reproductive age, pregnancy status at or near the time of death, and the medical cause of death. All three components can be difficult to measure accurately, particularly in settings where deaths are not comprehensively reported through the vital registration system and where there is no medical certification of cause of death."*[10]. Even under the most ideal conditions where countries have routine registration of deaths in place, maternal deaths are significantly underreported [11]. Horon noted that U.S. physicians fail to report recent or current pregnancies on a minimum of 50% of death certificates [12].

Death certificates alone are inadequate for tabulating deaths of women related to or associated with pregnancy outcomes. A study of pregnancy associated deaths in Finland revealed that without data linkage to complete pregnancy and abortion records, 73% of all pregnancy associated deaths could not have been identified from death certificates alone [13]. Incomplete data confined to a limited time frame has left society largely in the dark regarding true mortality risks associated with pregnancy generally and with particular outcomes, both immediately after pregnancy resolution and across the years that follow.

Large population-based record-linkage studies, containing complete reproductive history data in conjunction with data related to deaths, provide the best opportunity to bypass many of the limitations of the currently available maternal mortality data in most countries. Record-based data allows for exploration of the potential mortality risks associated with particular pregnancies and enables researchers to look more broadly at the possible cumulative health impact and death rates associated with experiencing pregnancies with variable outcomes.

In a record-based study by Reardon and colleagues, U.S. women who aborted, when compared to women who delivered, were 62% more likely to die over an 8 year period from any cause after adjustments were made for age [14]. Further, in a large Finnish population-based study led by Gissler, post-pregnancy death rates within one year were reported to be nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000) [15]. In a later study, Gissler and colleagues again found that mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000) [16].

What is needed is more record-based research, not politically-driven analyses of unreliable data that are presented as comprehensive and definitive. Shamefully, these researchers failed to use this platform as an opportunity to call for improved methods of data collection and analysis. These researchers rightly note that *"pregnant women considering their options deserve accurate information about comparative risks,"* so why have they chosen to disrespect women and medical professionals by knowingly offering a false impression of the relative risk of death between these two outcomes? With a couple paragraphs of their report devoted to political discussion of state-level informed consent laws, the answer to this question seems pretty obvious.

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