The End of Roe & Women's Healthcare: Myths Exposed
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June 24th was a joyful day! It's hard to believe that *Roe* has finally fallen. A new era has begun: one where states now have the ability to protect human life in line with the values of the people within their state without having to follow a federal mandate that does not protect human life in the womb.

Before the ink dried on the Supreme Court's decision about the *Dobbs* case, the spread of disinformation by abortion advocates started flowing. Along with this disinformation is a lot of misinformation. What's the difference? Disinformation is a type of false information that has the intent of deceiving, much like political propaganda. In contrast, misinformation is incorrect information, not necessarily given to deceive; the sender was unaware that the information shared was false.
Pro-life people must be prepared to speak up about the untruths and dispel the **myths** surrounding the June 24 Supreme Court decision.

Myth #1: Abortion is illegal in all 50 states and territories.

False. The Supreme Court decision removed *Roe,* and therefore the issue of elective abortion has reverted back to the individual states to decide through their legislative process. This means some states will continue to allow elective abortions while others will not. It may take a few months for new state laws to go into effect; others went into effect immediately.

Myth #2: Women with ectopic pregnancies will not receive life-saving care.

False. The management of ectopic pregnancy remains the same pre and post *Roe*. This narrative derives from the misconception that the removal of an ectopic pregnancy is a type of abortion. That is untrue.
An ectopic pregnancy is one that develops outside the uterus, typically in the fallopian tube. Most of these embryos die spontaneously, but can still cause life-threatening internal bleeding for the mother. The typical treatment involves the use of medications or a surgical procedure to remove the embryo and possibly the fallopian tube. These interventions are designed to save the mother's life, but may have the unintended consequence of ending the baby's life (in the rare case where the embryo is found to have a heartbeat on ultrasound).
Most pro-life Christian physicians do not consider the separation of an embryo that is growing outside the uterus from the mother's body to be synonymous with induced abortion. We lack the knowledge of how to transplant an ectopic embryo into the uterus.
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Myth #3: Doctors will be hindered from treating women with miscarriages out of fear of being accused of performing an abortion and facing legal repercussions.

False. The Supreme Court decision was solely focused on induced elective abortion. Its reach simply does not extend to nonviable pregnancies. The options available to practicing obstetricians for managing miscarriages are likely to remain unhindered under the new ruling.
All Ob/Gyns are trained to manage miscarriage. Residency programs in obstetrics and gynecology train all physicians on how to surgically evacuate a pregnant uterus. Individual physicians are permitted to opt-out of procedures that involve ending the life of a living embryo. However, the surgical technique for treating a spontaneous abortion (medical terminology for what is commonly referred to as miscarriage) and induced abortion is the same. The difference is not about the mechanics of the procedure, but about under what

circumstances it is applied. There is a world of difference between ending the life of a living embryo and simply removing what remains of a deceased embryo.
Expectant management follows a “watch and wait” approach, allowing the woman’s body to naturally pass the failed pregnancy. In the absence of signs of infection, or other contraindications, it is an acceptable management option.
Surgical management may be utilized if expectant and/or medical management failed or was otherwise not selected.
Medical management uses drugs to cause the uterus to contract and expel its contents. Misoprostol is typically used and is generally effective. One small study indicated that the addition of mifepristone resulted in a higher success rate, but this is insufficient evidence to base strong clinical recommendations.[2]
It’s interesting that ACOG doesn’t list expectant management as the first-line treatment of choice while the UK’s National Institute of Health and Care Excellence (NICE) does. Further, the NICE recommendations caution against the use of mifepristone for the medical management of miscarriage. In contrast, ACOG has added “interim” updates to their *Early Pregnancy Loss Practice Bulletin* to promote the use of mifepristone, in addition to misoprostol, for the medical management of miscarriage.[3]
The practice of medicine surely has clinical conundrums, but diagnosing a failed pregnancy is usually not one of them. Taking the time to perform a proper evaluation, including repeat ultrasound exams and serial beta hCGs, as indicated, typically result in a definitive diagnosis. If practitioners rely upon standard diagnosis -- making certain there is not a living baby -- it seems highly improbable that there would be any grounds for claims of performing an abortion and associated legal repercussions.

Myth #4: Abortion is necessary to save the life of the mother. Separating the mother and the baby in order to save the life of the mother will not be allowed.

False. It’s important to understand terminology. First, the only purpose of an elective abortion is to end the baby’s life and no more. It is never done for the life of the mother. It is a false narrative to say that “abortion [induced, elective] is necessary to save the life of the mother.”
For example, treating a pregnant woman who has cancer does not require her baby's life to be ended, nor does the baby's death improve her outcome.
However, there are rare instances when an intervention is medically necessary **to separate the mother and her unborn baby to save the mother's life**. These are tragic situations when the baby is too premature to survive and the unintended consequence is that the baby’s life is lost. There is a fundamental difference between a medical treatment to save a life and induced abortion.
It's helpful to think in terms of fetal viability. When a life-threatening complication arises after the 22nd week of pregnancy and it is necessary to separate the mother and the baby, a premature delivery may be performed, preserving the life of both patients.
But what happens if the problem occurs prior to the time when the baby may have a chance to survive outside the womb?
For example, consider the case of a pregnant woman who is 20 weeks pregnant in a car accident. Her placenta begins to peel off (abruption) and she is hemorrhaging. There is no time to wait for the baby to mature and have a chance to survive outside the womb. The obstetrician must remove the placenta to stop the hemorrhaging, which has the unintended result in ending the baby’s life. This is NOT an induced abortion; this is a medical intervention to separate the baby and the mother with the intention of saving the mother’s life that has the unintended consequence of ending her baby’s life. Tragic, yes; abortion, no.
Another example includes chorioamnionitis which is an infection of the amniotic fluid and causes sepsis. The medically indicated treatment involves emptying the uterus and delivering the baby to treat the infection.[4]
Both patients’ lives are taken into consideration...neither has a chance of survival without delivery, but if the baby is very premature, he may not survive.

The public should be educated about these infrequent cases when a pregnant woman faces a life-threatening complication, and how the intervention to save her life has the unintended consequence of ending her baby's life and how these cases are critically different from induced abortion.

Myth #5: If mifepristone is unavailable, women's healthcare will be compromised.

False: Certain drugs to induce abortion, such as mifepristone and misoprostol, are also used for conditions unrelated to causing an elective abortion. For example, misoprostol, with or without the addition of mifepristone, can be used to treat a miscarriage. Misoprostol was originally approved by the FDA as ulcer prevention in patients taking nonsteroidal anti-inflammatory drugs. It is used off-label to ripen a woman's cervix during the induction of labor.[5] The Supreme Court decision did not address the distribution or availability of medications, even those used for abortion. In states that have outlawed abortion altogether, medical professionals should still have access to drugs like the ones mentioned for non-abortion related indications.

Myth #6: The U.S. maternal mortality rate will worsen in the wake of the Supreme Court ruling.

False: This statement is born out of the pro-abortion assertion that abortion is safer than childbirth. The disinformation surrounding this issue goes back to pre-*Roe* days when abortion advocates made up data about how many women were dying from illegal abortions.[6] Accurate statistics on abortion-related deaths are lacking, and what is available doesn't take into account death due to suicide. Dr David Reardon summarizes the problem excerpted from his article in the Journal of Contemporary Health Law and Policy:

> *"We must conclude that 'abortion is safer than childbirth' can no longer be characterized as an established fact. It is at best an unsubstantiated opinion, most likely a hope, and at worst, an ideologic mantra. At this time, it is almost impossible to accurately compare deaths related to abortion and deaths related to childbirth in the U.S. due to incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimates, political correctness, inaccurate and/or incomplete death certificates, incompatibility with maternal mortality statistics, and failing to consider other psychologic causes of death, including suicide. When we look abroad, we see a different conclusion, that women are far more likely to die in the year following an abortion than they are following childbirth. This assumption should no longer be the reason for keeping all abortions legal, especially at more advanced gestational ages, when the procedure becomes much more dangerous."*[7]

There is also much more discussion to be had on the topics of any restrictions on birth control, emergency contraception or in vitro fertilization (IVF) treatments. As it stands, the Supreme Court's decision does not address any of these concerns, though there may be the potential for state laws to look at these issues as they pertain to embryocidal activity (the destruction of a human embryo).