



Life Matters Journal

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LETTER FROM THE EDITOR

Hello Reader,

When I first became convicted to act against the injustice of abortion, many people both within and outside of the pro-life sphere viewed the overturning of *Roe v. Wade* as an impossible goal.

Now, exactly one year out from the *Dobbs v. Jackson* decision that did just that, I find myself reflecting on how little has actually changed after celebrating the victory. It is undeniable that individual lives have been saved by legislation in certain states that restrict some abortions. Each one of those unique and unrepeatable human lives make worth it the time and energy that activists and movement leaders put into making this possible. However, few would say that the ultimate goal of creating a genuine Culture of Life has actually been achieved in these past twelve months.

There are a number of states with little to no restrictions on unborn child-killing; several have even expanded access to abortion with new laws and government policies. Perhaps even more importantly, many pregnant people still lack the support and material resources they need to feel confident choosing life, and they are left feeling as though abortion is their only option.

With the overturning of *Roe v. Wade* also came a flood of media disinformation about what pro-life Americans want and what pro-life laws actually do. In part to counter this pervasive narrative, we have launched a new project which seeks to provide a platform for pro-life doctors, nurses, midwives, and other medical professionals. In Pro-Life Provider Insights, ethicist and Rehumanize staff writer Grattan T. Brown interviews pro-life medical professionals and presents their perspectives on complicated issues in the field of bioethics, particularly that which relate to the beginning of life. In this issue, you can read four articles from this series; more are available on our website.

Also in this issue, you will find a compelling case for nuance in pro-life legislation that protects pregnant people experiencing pregnancy loss written by Sophie Trist. Finally, you will read from staff writer Briana Grzybowski about how pro-life people can step up as a community for those experiencing unplanned or difficult pregnancies as students.

Thank you for reading.

For life,

Herb Geraghty



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Life Matters Journal

JUNE 2023

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This journal is dedicated to the aborted, the bombed, the executed, the euthanized, the abused, the raped, and all other victims of violence, whether that violence is legal or illegal.

We have been told by our society and our culture wars that those of us who oppose these acts of violence must be divided. We have been told to take a lukewarm, halfway attitude toward the victims of violence. We have been told to embrace some with love while endorsing the killing of others.

We reject that conventional attitude, whether it's called Left or Right, and instead embrace a consistent ethic of life toward all victims of violence. We are *Life Matters Journal*, and we are here because politics kills.

Disclaimer

The views presented in this journal do not necessarily represent the views of all members, contributors, or donors. We exist to present a forum for discussion within the Consistent Life Ethic, to promote discourse and present an opportunity for peer-review and dialogue.



Pro-life Laws Must Protect Pregnant People as Well as Babies

By Sophie Trist

Editor's note: Colloquially, when most people refer to "abortion," they are discussing the medical procedure that intentionally causes the death of a human being in utero. Because of this, the phrase "medically necessary abortion" may sound confusing. However, it is important to note that in a medical context, "abortion" can refer to pregnancy loss that is both intentional and not intentional (typically known as miscarriage). Texas law distinguishes between these two scenarios, however, some advocates believe that the law needs to be clarified further to protect women experiencing pregnancy loss.

Texas's heartbeat law bans abortion after a fetal heartbeat can be detected unless the pregnant person's life is in immediate danger. Until last summer, such laws were largely an exercise in philosophy, but with the long-overdue overturning of *Roe v. Wade*, this law and others like it now have tangible effects on people's lives. Five women who were denied medical care during pregnancy complications for fear of running afoul of the law are suing Texas, along with two OB/GYNs who say that the law creates a culture of fear and confusion around pregnancy care. The plaintiffs are not seeking to overturn the law, but to clarify when a medically-necessary abortion may be performed. They want a reading of the law which gives physicians more discretion in determining what counts as unacceptable risk to the pregnant person's health.¹ A similar debate is playing out in Tennessee, where the legislature is considering two proposals which would narrowly expand medical exceptions to the state's abortion ban by clarifying that doctors may remove a fetus in the case of a miscarriage, medically futile pregnancy, ectopic pregnancy, or if the child is nonviable.²

The Texas lawsuit is spearheaded by the Center for Reproductive Rights, a pro-abortion group which would love nothing more than to see free abortions on demand and without apology nationwide.³ No doubt they imagine this lawsuit as the first step to dismantling Texas's heartbeat law and all other protections for preborn children. However, that doesn't mean the case has absolutely no merit.

Given that abortion is the violent death of a human being, the phrase "medically necessary abortion" may sound oxymoronic, even ghoulish. But we cannot discount the physical and

emotional trauma the women named in this suit suffered. Amanda Zurawski began losing her unborn child at eighteen weeks, but her life was not in danger and doctors could still detect the baby's heartbeat. Ms. Zurawski was sent home and later became septic, a life-threatening condition. She lost her baby and, because of delayed care, one of her fallopian tubes is now permanently closed. Another plaintiff, Anna Zargarian, was denied care after her water broke at just nineteen weeks, before her child was viable. "I've never felt my life matters less than it did during this situation," Ms. Zargarian said later.⁴

Marlena Stell, another Texas woman not named in the lawsuit, was traumatized after being forced to carry a dead baby for two weeks, a grave health risk. Ms. Stell says that after an ultrasound confirmed her child's death, she asked her doctor to perform a D&C procedure, the same surgery used to kill preborn children. Because of the new law, Ms. Stell had to undergo a second ultrasound to confirm her miscarriage, which she described as being very emotionally traumatic.⁵

Ms. Zargarian, Ms. Zurawski, and Ms. Stell did not seek elective abortions. They suffered medical complications which led to the tragic loss of their unborn children. These babies almost certainly could not have been saved. And while none of these women were in lethal danger in the strictest sense of the word, they suffered lasting physical and mental harm for no sound reason. Doctors' fear of violating a state law that is vague and unclear led them to delay or deny care. As people deeply invested in saving the lives of both preborn children and their mothers, we cannot shy away from these uncomfortable stories and the questions they raise.

The human body is extremely complicated, even more so when that body is supporting another unique human life. The legislators drafting pro-life laws are not always aware of the myriad medical complications that can arise during pregnancy. This ignorance was on full display when Ohio lawmakers passed a law in 2019 requiring doctors to reimplant ectopic pregnancies, which is not medically possible.⁶ Neither is it true that a fetus implanting in the fallopian tube is the only truly life-threatening condition that can arise during pregnancy. Pro-life laws must be extremely medically explicit so that physicians can provide the best care for both of their

patients: the pregnant person and the unborn child. If the baby has already passed away or absolutely cannot be saved, doctors should be able to perform all medical procedures necessary to save the pregnant person's life without fearing legal reprisal.

To be clear, I am not advocating for a return to the overly broad definition of health spelled out in *Doe v. Bolton*, in which a woman could receive a post-viability abortion for basically any physical, psychological, emotional, economic, or familial reason.⁷ But our laws should be flexible enough that women who are losing their babies, or who have a substantial risk of dying from pregnancy complications, can get the care they need without undue trauma or delay. The first precept of pro-life laws should be to do no harm. As pro-life/whole-life advocates, we must be just as passionate in valuing and defending pregnant people's lives as those of unborn children. We cannot fall into the trap of treating the pregnant person as disposable to save the unborn child or vice versa. While pro-life laws are important, surveillance and punishment are not the solutions to abortion violence. Our laws must be compassionate and medically sound enough to create a life-affirming landscape of care for pregnant people and their children.

Notes

1. Klibanoff, Eleanor. "Five Women Denied Abortions in Texas Sue to Affirm Exceptions to the Laws." *The Texas Tribune*. <https://www.texastribune.org/2023/03/07/texas-abortion-lawsuit/>.
2. Kruesi, Kimberly. "Tennessee GOP Advance New Narrow Abortion Exemption Bill" *Medical Express*. <https://www.wdef.com/tennessee-gop-advance-new-narrow-abortion-exemption-bill/>.
3. Klibanoff. "Women Denied Abortions Sue Texas."
4. *Ibid.*
5. Etienne, Vanessa. "Texas Beauty YouTuber Forced to Carry Dead Baby for Two Weeks Because of Abortion Ban." *People Magazine*. <https://people.com/health/beauty-youtuber-texas-forced-to-carry-dead-fetus-for-2-weeks-after-miscarriage-due-to-ban-on-abortion/>.
6. Glenza, Jessica. "Ohio Passes Law Ordering Doctors to Reimplant Ectopic Pregnancies or Face Abortion Murder Charges." *The Guardian*. <https://www.theguardian.com/us-news/2019/nov/29/ohio-extreme-abortion-bill-reimplant-ectopic-pregnancy>.
7. *Doe V. Bolton*. U.S. Legal Information Institute. Cornell University. <https://www.law.cornell.edu/supremecourt/text/410/179>





Undoing Mifepristone Abortion for the First Time

By Grattan Brown, STD, and Matthew Harrison, MD

In the current legal fight to ban mifepristone,¹ the first pill in a two-part pill regimen for a chemical abortion, it is easy to lose sight of the issue that makes elective abortion controversial in the first place: deliberately ending the life of a human being. But that is what makes women hesitate to choose abortion. It is also what makes women who have started a chemical or medication abortion try to reverse it.

In the story below, Dr. Matthew Harrison tells about his first encounter with such a woman, how his clinic welcomed her, and how he figured out how to save her child.

Meeting Ashley

Late one Thursday morning in the clinic, I received a call from the local Crisis Pregnancy Center. They had a young woman who had gone to an abortion clinic, had taken the abortion pill, and had changed her mind. The desperate mom then went to the Crisis Pregnancy Center wanting to know what she could do to save her baby.

At that time, chemical abortions were so new that I had no idea what I could do. But the best thing is always to meet these moms face-to-face and offer any help you can. So I told the caller to send the young woman right over.

Ashley was 19 years old and was distraught. She had a boyfriend who had always promised that if she ever got pregnant, he would support her and the baby. She was reluctant to be intimate with him because she came from a Christian family, but she loved him and thought that they would spend the rest of their lives together.

When she did become pregnant, he told her to get an abortion. He said that if she didn't, then her parents would not understand and would kick her out of the house, that she would have to quit school and that she would never fulfill her dreams. He would not support her and her baby and gave her the \$265 to go to the abortion clinic and have it "taken care of."

She reluctantly went to the abortion clinic. The clinic's staff estimated her pregnancy at just over seven weeks, but they did not let her see the ultrasound and the baby's heartbeat. They handed her mifepristone, also known as RU-486, the abortion pill. They said to take it right there and would not let her leave with it. After she took the pill, they gave her the misoprostol to take 48 hours later.

Ashley knew it was wrong and immediately felt regret. She left the office hoping she could throw up or somehow get rid of the drug. Twenty-four hours went by, and she was getting desperate. Thankfully she went to her mother and told her what had happened. To Ashley's relief, her mother was supportive and loving. She said "Let's see what we can do to get help." That is when they went to the local Crisis Pregnancy Center that led her to me.

Undoing An Abortion

Back in 2006, Ashley's story amazed me. I had never heard anything like it. I was familiar with the abortion pill, which the FDA had approved in 2000. By 2006, it was being used in about 15% of all abortions.²

I had no idea what to do if a woman wanted to stop a chemical abortion once it had started. They do not teach this in medical school. But I've always known not to give up and not to make snap decisions in these life or death situations.

Ashley had not started bleeding or cramping yet, so I thought there might still be time to save her child. I asked her to excuse me as I went to my office and thought about it. I pulled out the *Physician's Desk Reference* and reviewed mifepristone's mechanism of action. It is a powerful progesterone blocker that was initially developed as an adjunct cancer treatment for hormone-dependent tumors which cannot be resected.

Mifepristone mimics the action of naturally occurring progesterone and attaches to the progesterone receptors in layers of the placenta. When that happens, the placenta does not grow the blood vessels that supply nutrition and oxygen to the developing embryo or fetus, which dies. Mifepristone also prevents naturally occurring progesterone from getting into the receptor, which would support life.

I went back to thinking about how to counteract the abortion pill. Was there any type of antidote that we could use to improve the chances of survival? And then I started to ask the bigger question "How did I get here?" How did I get to a place where doctors in our society were using the art of medicine to take life, and I was sitting in my office researching how to undo what they had done.

Because of my background in biology, and specifically in protein-receptor mechanics, I knew that mifepristone could be out-competed by an abundance of progesterone, which would reactivate the progesterone receptor. If we supplied enough good keys into this patient's system, then we could override the bad keys locking the progesterone receptor.

I had never heard of progesterone being used in this way, but I did know that taking progesterone was safe in pregnancy, especially the bio identical type that we used. I could give it to Ashley immediately because we kept some in our office as a fertility treatment for women who had low progesterone.

I took this idea to Ashley, and she was ready to do whatever it would take to save her baby. We gave her an injection of progesterone and hoped for the best. The next day she started to bleed, and we asked her to go to the emergency room for an ultrasound. The ultrasound showed the formation of a blood pocket on her placenta, which was starting to separate from her uterus. But she was also able to see her baby's heartbeat for the first time. Later, she told me that alone would have made the treatments worth it.

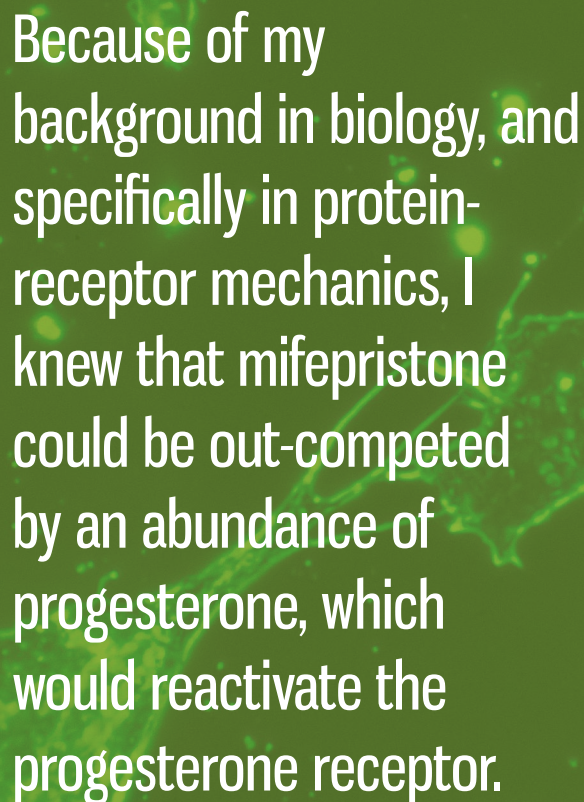
The emergency room doctor told her to go home and hope for the best. By Monday, she had stopped bleeding and came by our office. We were able to confirm a heartbeat, and we continued progesterone replacement.

The rest of her pregnancy was unremarkable. She continued progesterone replacement until about 28 weeks. At 40 weeks, Ashley gave birth to a beautiful baby girl, Kaylie. Her daughter had no birth defects, and Ashley's placenta was normal. Today, Kaylie is a healthy 16-year-old girl.

Over the years, a protocol to counteract mifepristone developed. I teamed up with Dr. George Delgado and Dr. Mary Davenport to support the Abortion Pill Reversal Network.^{3,4} In 2016, the network had expanded so much that we turned it over to Heartbeat International. To date, there are more than 2000 providers in 65 countries that will offer Abortion Pill Reversal, and there have been more than 4000 babies born healthy through the protocol.

Notes

1. Raman, Sandhya. "Dual court rulings throw confusion into abortion drug debate." Roll Call. <https://rollcall.com/2023/04/07/federal-judge-in-texas-blocks-use-of-abortion-drug/>.
2. "Medication Abortion Now Accounts for More Than Half of All US Abortions." Guttmacher Institute. <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions>.
3. "How to STOP Planned Parenthood's Favorite Pill." Edify. <https://youtu.be/PJMhIOtN4cM>.
4. Abortion Pill Reversal Network. <https://www.abortionpillreversal.com/>.



Because of my background in biology, and specifically in protein-receptor mechanics, I knew that mifepristone could be out-competed by an abundance of progesterone, which would reactivate the progesterone receptor.



Love in Extreme Hardship

By Grattan Brown, STD, and Michael Egnor, MD

Caring for severely disabled kids takes heroic efforts, especially on the part of the parents. No one wants to force such suffering on a child or their family and community, but this scenario is one of the most powerful pro-choice arguments. If you can abort the pregnancy early on and relieve everyone, including the child, of suffering, then why would you not do it? But even this hard case is not so easy.

Avoiding those difficulties by ending the life of a disabled child in the womb amounts to an act of killing. What else can you call arresting the development of a human (embryo, fetus, child) who would be born? People who claim to protect human rights cannot protect only part of life. The fact that the child would suffer quite visibly and require the care of many people does not make deliberately ending their life any different than ending the life of a normally developing human being.

The problem is not the burden of disability but how human strength, weakness, and social organization meet the difficulties of care. There are two intertwined problems. A severely disabled child puts people into circumstances that make life extremely difficult for them. It feels uncharitable to allow those circumstances to continue. On the other hand, it also seems uncharitable to end the life of the child whose disability causes those circumstances.

Hard cases like Dr. Michael Egnor's below show how great those difficulties are. But this story also tells us about the community that emerged when one family decided to give birth to and care for their severely disabled child.

The Hard Case

David was born with Down's Syndrome and hydrocephalus, which don't generally go together. Most of the time kids with hydrocephalus are quite functional. They go to school and live pretty long lives. But David was so disabled that he was never able to even sit up on his own or talk or feed himself. He lived to about the age of 10 and required constant care.

His parents were middle class working people. They had other kids, and they cared for David in their home most of his days. But

he was in and out of the hospital, and it wasn't uncommon for him to be in the hospital for a week or two at a stretch. If he got an infection, he could be there for a month. That's tough on the family, too, because someone has to be there in the hospital with the child.

I wouldn't normally be involved with a child with Down's, but I got involved because of David's hydrocephalus. Follow up visits were typically once a year, but I saw him a lot more than that. I must have performed at least 50 procedures on him myself. His hydrocephalus caused all kinds of problems, and he needed his shunts revised a lot. He was in the hospital for all kinds of medical issues, including heart issues.

When it came time for the funeral, it seemed like the whole town turned out. There was not enough space, and people were spilling out into the hallway. Some were family and friends. Others were people from the hospital. The pastor leading the service had gotten to know David and his family very well.

Toward the end of the service the pastor said the natural thing is to think that because of his handicap, he was never able to do things that most people can do. That's not completely true. He looked out at the crowd and people spilling out into the hallway and said he would doubt that when any of us pass away, we will pack this room and have people spilling out into the hall. David brought people together and perhaps that was his purpose, even if he was hardly aware of it. As far as accomplishments go, he brought people together better than any of us will in our lives.

The Suffering and Benefit of Disability

With such an inspiring message, it is easy to downplay the suffering of the child and the family. That downplay makes it easier to argue against abortion, but you end up overlooking the sheer number of people whose strenuous efforts it takes to care for a child like David.

The pro-choice movement will say "Well, it's good that that family had that choice. They cared. They spent a decade of their life and a lot of money caring for that child where other families would say it's too much. People should have the choice not to spend the time and the money."

But this pro-choice argument is too simple. When you focus on the suffering of families like this one, especially their child, it is easy to despair that any good would come of it. That makes it easier to argue in favor of abortion. But the focus on suffering and choice leads you down a dark road. You could make exactly the same argument after David was born. This baby at home has so many problems that it would be better off without them. You can also turn extreme cases like this one into a fearsome expectation, exaggerate the typical burdens of disability, and eliminate children who would live long lives with disabilities but good health.

Reflecting back on this boy and his family, here is what stuck with me. There's tremendous suffering. It can be really, really difficult. But I have never encountered a family who told me that they regretted caring for their child. If on day one, they had known what suffering was coming, they might have been overwhelmed. And if on day one, they had known the unique blessings the child would bring, they would have been encouraged. But we cannot know either one in advance, and I'm pretty sure just from knowing this family that if they had to do it over again, they would do just the same thing.



Making Difficult Pregnancy Positive

By Grattan Brown, STD, and Elizabeth Nelson, MD

Sometimes what a pregnant woman needs most during a complicated pregnancy is emotional support, practical wisdom about navigating pregnancy, and a birth plan. It may be challenging enough for those supporting her to empathize emotionally or plan practically. Her doctors and nurses have to do all of it. But confident healthcare providers can give a pregnant woman the confidence to avoid choosing to abort her child.

It is not surprising that medical professionals in a *Roe*-shaped profession consistently recommend elective abortion. Doing so avoids risk to both mother and professional, and it avoids a lot of immediate suffering. But it does not avoid the longer term suffering of having chosen to end a child's life and the missed opportunity to learn how to take care of oneself and loved ones facing a great, unexpected challenge.

After the US Supreme Court issued its decision in *Dobbs v Jackson Women's Health*, I began seeking the stories of medical professionals with wisdom to share from practicing pro-life medicine in a *Roe*-shaped profession.

Dr. Elizabeth Nelson has this story to tell.

I retired in 2021 after 44 years as an OB/GYN in private practice. During my career, I did perform procedures to address complications during pregnancy and sometimes lost the child in the womb, but never intended to end the life of any child, especially a disabled or unwanted child.

In 1989, a family practice physician referred a woman to me for hormone replacement therapy because she was approaching the age of menopause. She had a history of polycystic ovarian syndrome and had never conceived. She never had regular menses and took Provera to induce them. She had been taking Provera as usual but had had no menses for five months. When I examined her, it was obvious that she was not menopausal. She was five months pregnant!

This woman was not only older but also an out-of-control diabetic who did not follow her diet or take her medications. Because these conditions correlate to a high risk of birth defects,

many doctors today would have simply advised her to abort the pregnancy immediately. She would have refused that recommendation, and at that point many doctors would have encouraged her to test for chromosomal abnormalities and abort if the results showed a problem, even if she would have had to leave the state to do so at five months of pregnancy. The risk of birth defects in any pregnancy is 2-5%. In older women, the risk is slightly higher for chromosomal problems. In an out-of-control-diabetic, the risk may be as high as 20%.

Instead of testing, she agreed to see a maternal fetal medicine specialist, who performed an ultrasound. There were no visible abnormalities on the ultrasound, but he still recommended terminating the pregnancy because of her out-of-control diabetes.

She came straight to my office distraught and in tears. She did not want amniocentesis because of the slight risk of loss of the pregnancy, and she desperately wanted this chance to have a child.

The experience changed her life. We reviewed the risks of her diabetes and age, and she agreed to take her medications and follow her diet. The maternal age risks were on her side for chromosomal problems (99 cases out of 100 have no problem), but the diabetes could cause problems for the fetus that would become evident only after delivery. Some of those problems, such as macrosomia (large size) and hypoglycemia (low blood sugar), could be minimized by excellent control of diabetes. She became compliant, did all that was requested of her, and stuck with it.

She wanted me to be present for her delivery, but I could not guarantee that I would be there because I too was pregnant and due about the same time. In the end, I was able to be present at her Cesarean delivery, but my hands were so swollen from my own pregnancy that I could only assist by cutting the suture. She was delighted with the emotional support and delivered a perfectly healthy baby.

Postpartum, we addressed continued compliance so that diabetes would not shorten her life and she would be present for everything from kindergarten graduation to high school graduation and a wedding.

That is all I know. She went on with her life without keeping in touch. But I am confident that the work she did to care for her child in the womb prepared her to raise her daughter.



Unexpectedly Expecting in Graduate School

By Grattan Brown, STD, and Megan Blum, PA

Some women seek elective abortions because they decide the time is not right to start raising a child. If they become pregnant while working on a graduate degree, they are still looking at a lot of hard work in school and a workplace to establish a career. They and their partners may want to have children, perhaps even more than they want their careers, but want to pursue both and see no path forward without an abortion.

For those who do find a path forward, the culture of abortion has become so strong that women who become pregnant in graduate school inevitably encounter a number of people who judge them for not getting an abortion. Those people are a minority, but they can have an outsized impact on a pregnant woman's morale, even when she is surrounded by supporters.

Megan and her husband, Michael, figured out how to navigate an early career in women's health while starting a family.

Here's how they did it, in Megan's words.

The Pregnancy and the New Plan

It was the third semester of my Masters program in Physician Assistant Studies at Gardner-Webb University when I found out we were expecting. We had married on August 5, 2017 and had taken our honeymoon during a break from school.

I had been having some cycle abnormalities and was using natural family planning (NFP) methods and a local doctor to diagnose the problem. Our NFP teacher advised us to do a pregnancy test because the clinic would probably require it anyway at our next appointment. It was September 11, 2017, and since my husband was in Atlanta for work, we ended up doing the pregnancy test over Skype. I remember being super nervous waiting for him to come online, and he flipped when he saw that it was positive.

We were very surprised. We had been using NFP for three or four years and felt really confident. We knew we had to approach the PA program about the pregnancy but waited a few weeks to confirm it. The interim program director was a very devout Christian and a mom as well. I remember feeling so relieved that she was the one that I had to tell first and not somebody else.

When I told her the news, she was quite excited and very sweet and kind. I remember her telling me that it can be hard to navigate being pregnant in a graduate program. She said that some people might have strong opinions, but I should never let anyone rob my joy about expecting and entering motherhood. I always remembered those words when things got really tough.

We laid out a rough plan. The baby was due in May, the weekend after final exams. We thought I should be able to finish up exams, go out on maternity leave for the summer, and hop back into clinical rotations with my classmates in the fall. We would use holidays to make up any lost time so that I could walk with my classmates at graduation.

People Responded

I went to some professors one on one and shared the news. Most of them had young kids and were happy for me. At one point, a professor used ultrasound to show my classmates our baby's heart-beat. It was a powerful pro-life moment for many of them, who were not married and didn't have children. I did have one professor who quipped "Don't you guys know how to prevent pregnancy while you're in school?" There was a really long, awkward pause. Then I explained to him that our Catholic faith helps us see problems with contraception, and we do not consider it an option.

I shared the pregnancy with my classmates during a weekly prayer time when we would ask for prayers or share good news of God working in our lives. I remember talking with another

professor who had a baby in medical school back in the 1980s. She talked about how it wasn't done in those days. She became my cheerleader and always encouraged me to keep at it, like she had done when people told her that she couldn't do it.

Most people were excited and happy for me, but some were clearly taken aback by how we were open to pregnancy. Some people simply avoided talking about it. Some friends and family had expected us to postpone having kids until our mid 30s and took it a bit personally that we started a family during graduate school. Some said I would have to drop out. They seemed to think that it is the mark of highly educated people to abort when the time is not right. But we didn't think that, even though my husband and I both have graduate degrees. Through our prayer and all the doors God opened, we never discerned that I would need to stop.

Working the New Plan

PA school really wasn't physically taxing. It felt really good to be sitting down most of the day, taking notes on lectures or studying for exams. For most of the pregnancy, I was more mentally than physically tired. I studied pretty much every day from nine to five and when necessary after hours and early in the morning. When I wasn't studying, I was working out with my classmates in the gym. I really felt I was doing what I should be doing during pregnancy.

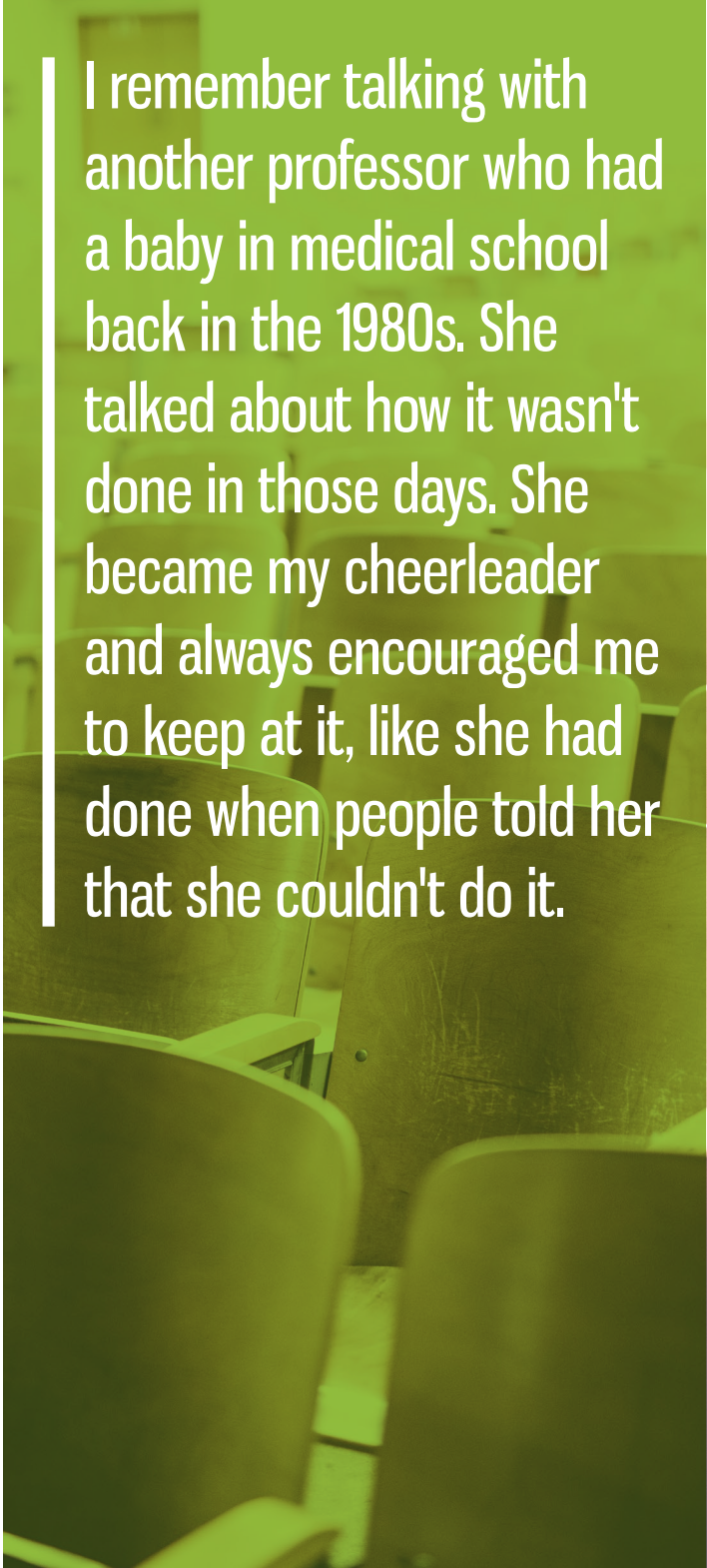
The morning sickness in the first trimester was rough. Fatigue really maxed me out during those few weeks. It was hard to focus. I remember struggling with cardiology, which didn't come naturally to me. Some members of the family were not being supportive, but it just stoked a more intense drive in me. By my third trimester, I was super pregnant going through our obstetrics module. It was tough, but to this day I believe that God had a plan in mind and wouldn't have sent us a child if he didn't think I would also complete the program and graduate.

After exams, we had a two-week break, which I spent waiting to go into labor. I eventually chose to be induced, and after a 30-hour delivery, we discovered we had a daughter. We named her Eleanor Grace after St. Helena and Our Lady of Grace. Eleanor also means light. We really felt like she was a bright, bright light that God interjected into our best laid plans. Eleanor surprised us and forced us to change our plans and live differently. But through her, God gave us the opportunity to show what pro-life, pro-family decision making can be.

At the end of the summer, my clinical professors helped me schedule rotations when I would have babysitters. My husband and my mother in law helped out, and sometimes even my brother in law took a turn when I was stuck at a clinic site pretty late, which happened a few times. I was working in the mountains in rural western North Carolina at a hospital with emergency medicine and lots of family medicine and internal medicine clinics. Sometimes I had to drive up to an hour away, but I was able to get a sense of the health needs in those rural communities.

I would not trade my graduate school experience for anything. It might look a little bit different to navigate graduate school or medical school while pregnant, but can be an advantage and not something to be afraid of. I got to experience OB care as a patient and a practitioner. It just drove me even more to want to practice in women's health. I feel like those lessons carry over into my patients' struggles whether they have a baby or a miscarriage or infertility.

I can really stand with them through those difficult spiritual moments and tell them from experience that God really does have a plan for them. Looking back, our best laid plans were not bad, just not the best plans. It always shocks me to think that if we had not become pregnant or had aborted, we'd only have one child at this point. Now we have three because God sent us some so early.



I remember talking with another professor who had a baby in medical school back in the 1980s. She talked about how it wasn't done in those days. She became my cheerleader and always encouraged me to keep at it, like she had done when people told her that she couldn't do it.



Support for Pregnant and Parenting Students

By Briana Grzybowski

I have a friend who had her first child

when she was working towards her PhD in psychology at Florida State. For the first two years of their daughter's life, she and her husband were able to successfully balance work and family life with the help of onsite daycare at the school. But they lost access to that when the Covid-19 pandemic hit. My friend and her fellow parenting students then had to totally rearrange their lives to accommodate their kids' needs while continuing their own education. This is one example of a real life issue the pro-life community needs to be mindful of in this time after *Roe vs. Wade*: How do we support pregnant and parenting college students and their families?

According to research published by the Guttmacher Institute in 2005, 38% of women who had had abortions did so because they thought having a child would interfere with their education.¹ Furthermore, according to the 2009 National Survey of Family Growth, 61% of pregnant community college students drop out of school. Seeing numbers like this, it's easy to see why pregnant college students would at least be tempted to consider having an abortion. Being a parent is a full-time job. Being a student is also a full-time job. Not only that, but students who do choose to raise their kids have to take on outside work to provide for themselves and their families and fund their education.

We're quick to applaud student parents who successfully complete their education while caring for their children, and we should. I don't want to downplay their accomplishments at all. But I also don't want the pro-life side to downplay the unique challenges they face. Just because we hold these parents up to be superheroes doesn't mean they don't need help and support in achieving their goals.

On the other hand, the fact that they often lack the extra help and support they need leads some in the pro-choice community to believe that aborting their babies is the only reasonable course of action for them to take. Pro-choice authors Ilana Horwitz, Kaylee Matheny, and Natalie Milan said as much in a September 2021 article: "As sociologists of education, we were curious why nearly a third of all college students still don't have a degree six years later.

We analyzed longitudinal interviews from a diverse sample of 220 American teenagers who were interviewed repeatedly between 2003-2013 as part of the National Study of Youth and Religion. We found that people dropped out of college for several reasons: financial hardship, academic difficulties, health crisis, and yearning to enter the workforce. But the most common reason was unplanned pregnancy."²

Yes, having a child is a major responsibility. Yes, it's difficult to juggle school, work, and caring for a child. But why should we be so quick to say that babies are a liability that ruin their parents' chances at success? Why do we blame their existence as the problem? As pro-lifers, we think the lack of support these students are facing is the real problem and want to see those issues addressed instead of offering up abortion as the solution.

The people in charge of the Baby Steps program at Auburn University understand this well. Michelle Schultz, its founder and Executive Director, got pregnant while she was a student there with her future husband Matt. She chose to have an abortion but regretted that decision. One of the main reasons motivating her to abort her child was the feeling that she had no place to turn to for support. Twelve years later, the couple founded Baby Steps so no other Auburn student would feel as alone as they had.

The program offers students free housing and child care, counseling services, access to food and necessary baby items, a support group for student moms, resources for financial aid and school scholarships, academic advising and tutoring, medical care, and life skills classes. In addition to Auburn, the program has spread to the University of Alabama and the University of Central Florida. It eventually hopes to set up shop on college campuses nationwide.

Serrin Foster and her organization Feminists for Life of America have been instrumental in spearheading a movement to combat the issues pregnant and parenting students are facing. In 1997, they hosted the first annual Pregnancy Resource Forum at Georgetown University, a panel discussion for the purpose of evaluating what resources student parents had on campus and identifying areas where the school could improve.³ They also started an advertising campaign on more than 600 college campuses nationwide to

give students information about life-affirming pregnancy support.⁴ Years later, this group's work has had a positive effect: within the first ten years of Feminist for Life's College Outreach Program, Planned Parenthood reported a 30 percent drop in abortions amongst college educated women.⁵

This is what the future of the pro-life movement needs to look like. We need to talk about these issues. We need to talk about affordable education, child care, housing, and maternity care for student parents and their kids. And we should do it in a way that we're not dismissive of the pro-choice side's arguments. After all, they do have legitimate concerns surrounding this topic. Instead, we should pay close attention to what they're saying and brainstorm ways that we can move forward together. That's what will bring about positive and lasting change in our country. As Serrin Foster once said, "Don't look at each other as the enemy. The only enemies we have are the status quo and accepting failure."⁶

Notes

1. Finer, Lawrence B., Lori F. Frohirth, Lindsay A. Dauphinee, Susheela Singh, and Ann M. Moore. "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives." *Perspectives on Sexual and Reproductive Health* 37, no. 3 (2005): 110-118. https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf.
2. Horwitz, Ilana, Kaylee Matheny, and Natalie Milan. "Abortion bans could deepen the college drop-out crisis." *Contexts*, September 8, 2021. <https://contexts.org/articles/abortion-bans-could-deepen-the-college-drop-out-crisis/>.
3. Foster, Serrin M. "The Feminist Case Against Abortion: the pro-life roots of the women's movement." *America: The Jesuit Review*. January 7, 2015. <https://www.americamagazine.org/faith/2015/01/07/feminist-case-against-abortion-pro-life-roots-womens-movement>.
4. *Ibid.*
5. *Ibid.*
6. Meehan, Mary. "Feminists for Life on Campus." *The Human Life Review*. Summer 2008. Archived online at <https://www.meehanreports.com/fll-campus.html>.

