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The Truth About Crisis Pregnancy Centers  
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Crisis Pregnancy Centers, commonly referred to and abbreviated as CPCs, are centers whose primary purpose is to dissuade pregnant people from obtaining an abortion. Oftentimes they will provide services free of cost, such as ultrasounds and pregnancy tests. Their main feature is the counseling they provide against seeking abortion services. The way these centers advertise themselves generally varies. Some are open about being faith-based organizations that just provide ultrasounds and others try to actively disguise themselves as abortion clinics through their advertising and location. Many provide information that is inaccurate about the risks of abortion, birth control, and sex.

In the wake of a year of tremendous upheaval for reproductive rights with stringent abortion laws in several states and a Supreme Court that experts warn may not be sympathetic to reproductive rights, the issues these centers present could not be more topical. CPCs' larger business model is misleading women and elected officials about abortion, contraception, and reproductive healthcare as a whole. CPCs outnumber abortion clinics in the United States anywhere from a ratio of 2:1 to 3:1, depending on the estimates. Examining Crisis Pregnancy Centers is a crucial part of examining the landscape of reproductive healthcare in the United States.

This report is ultimately a comprehensive case against the continued funding for, support of, and operation of Crisis Pregnancy Centers based on their deceptive practices and manipulation of vulnerable populations they claim to support. The structure of and rationale behind these organizations is incongruent with any ultimate benefit for the United States. The goal of this report is to make clear the harm of these organizations and outline the true intent behind the existence of Crisis Pregnancy Centers.

## **I. Leading National Crisis Pregnancy Center Organizations**

### **01. Heartbeat International**

Heartbeat International is a faith-based worldwide network of Crisis Pregnancy Centers founded in 1971, and describes itself as the most expansive network of pregnancy help in the world. They boast over 2,600 affiliated CPCs - ranging from centers that provide ultrasounds to resource centers, maternity homes, and adoption agencies. They provide resources, training, and guidance to these centers and often shape how CPCs interact with patients and present themselves. Heartbeat International describes its mission "is to make abortion unwanted today and unthinkable for future generations" by reaching and rescuing women considering abortion and renewing "broken cities" with CPCs (Heartbeat International, n.d.). Its affiliates have to abide by its program policies - from the obvious of not referring to abortion services to discouraging birth control for any purpose (even in cases of disease control), promoting "God's Plan" for sexuality with a focus on sexual purity and a rigid adherence to heterosexuality, and adherence to Catholic, Protestant, and Orthodox Biblical teachings (Heartbeat International, n.d.). They offer a range of claims for their affiliates to circulate and teach, with ranging degrees of veracity that will be covered later in this paper.

### **02. CareNet**

CareNet is another CPC national network, similar to Heartbeat International. Its main distinguishing feature is a pregnancy helpline known as OptionLine, operated in conjunction with Heartbeat International. OptionLine offers counseling over the phone and online in the form of calls, emails, texts, and online chats that operate 24/7. According to CareNet president Melinda Delahoyde, OptionLine was designed "... so that it's one of the first places [a woman who suspects she's pregnant] visits. By putting her in touch with a local pregnancy center, OptionLine is connecting her to life-saving support for her and her unborn child." OptionLine is ultimately designed to bring the counseling of CPCs online or over the phone and connects people who contact them to their local Crisis Pregnancy Center (CareNet, 2010).

### **03. NIFLA**

The National Institute of Family and Life Advocates (NIFLA) is yet another umbrella organization that has largely spearheaded the inclusion of ultrasound services in Crisis Pregnancy Centers (Charlotte Lozier Institute, 2018). The NIFLA offers a course in Limited Obstetric Ultrasounds that they claim "offers window to the womb which can impact a woman's decision to choose life by more than 80 percent" (National Institute of Family and Life Advocates, 2019). They are also a considerable legal force that assists CPCs with their legal organization. In 2018, the NIFLA successfully won a Supreme Court case against a measure intended to regulate CPCs (National Institute of Family and Life Advocates v. Becerra, 2018). The NIFLA also offers training for a step-by-step "conversion program" known as The Life Choice Project. They now represent over 1,400 Crisis Pregnancy Centers across the United States (National Institute of Family and Life Advocates, 2019).

## **II. Truth in Advertising**

### **01. Intent to Mislead**

Robert Pearson, often cited as the founder of American Crisis Pregnancy Centers, was quoted in 1994 as saying "[O]bviously, we're fighting Satan... A killer, who in this case is the girl who wants to kill her baby, has no right to information that will help her kill her baby. Therefore, when she calls and says, 'Do you do abortions?' we do not tell her, No, we don't do abortions." The Pearson Manual (or *How to Start and Operate Your Own Pro-Life Outreach Crisis Pregnancy Center*) includes advice for CPCs to evade admitting they do not offer abortions to prospective patients as well as to list themselves in the Yellow Pages alongside abortion clinics to generate confusion. The purpose of this, according to Pearson, is because "[o]ur name of the game is to get the woman to come in as do the abortion chambers. Be put off by nothing... Let nothing stop you. The stakes are life or death." (Stacey, 2007).

Supporters of the Crisis Pregnancy Center movement would argue that the culture and practices of CPCs have changed since Pearson's time. However, multiple statements made by leaders in the national organizations of Crisis Pregnancy Centers echo much of his intent. Lauren Chenoweth, Heartbeat International's former media specialist, said at a 2015 Heartbeat International conference: "[t]hey're going to Google 'abortion,' or they're going to Google 'abortion services' or 'pregnancy help,' and that's why we want to focus on our websites." She later added, "[w]e want to be strategic in getting them to our centers" (Winter, 2015).

Abby Johnson was another presenter at this conference giving advice to Crisis Pregnancy Centers. Johnson gave a talk at the conference titled “Competing with the Abortion Industry”. She emphasized that CPCs should imitate the appearance of Planned Parenthood waiting rooms, in addition to utilizing their language as much as possible. The goal is to appear as much like an abortion clinic as possible to lure anyone seeking one inside to be talked out of it. (Winter, 2015).

Attempting to reach women seeking an abortion by any means necessary seems to still be a central tenet of the mission of Crisis Pregnancy Centers, and the practices they use to do so are still in use today. Though technology and advertising have evolved past Pearson’s recommendation of targeting Yellow Pages, the spirit of his intent is still evident.

## **02. Advertising Online**

Numerous CPCs were found to violate Google’s policy against misleading advertising, and the company removed a lot of deceptive advertising found when users search for abortion services. NARAL found that 80% of searches for “abortion clinics” in the 25 biggest cities in the United States yielded Crisis Pregnancy Center ads (Crockett, 2014). Despite Google’s promise to address this misleading advertising, searches for abortion services still retrieve ads for Crisis Pregnancy Centers.

Companies like NFLIA affiliate “Choose Life Marketing” advertise their skill in helping CPCs “reach more abortion-minded women”, offering various marketing tactics to help CPCs reach as many women seeking abortions as possible. Search Engine Optimization (SEO), paid search efforts, and other social media tools are just some of the strategies they list to prospective clients. They advertise themselves as a proud Google Partner as well as a Facebook Marketing Partner, and state they serve “Pro Life Organizations”. Many of the websites they display as part of their work have pages on “Abortion Information” that claim to offer unbiased counseling for women considering the procedure (Choose Life Marketing, n.d.).

They are not the only marketing firm to offer their services in such a way. Copley Advertising, for example, courted Crisis Pregnancy Centers with an elaborate advertising strategy. John Flynn, Copley Advertising’s CEO, touted his use of mobile geo-fencing to target the phones of women sitting in Planned Parenthood clinics to serve them advertisements for Crisis Pregnancy Centers. Marketers can infer a lot about a user from the pages they visit and the applications they use: age, sex, what they’ve bought online, what kind of car they drive, and so on. Flynn advertised his ability to use this information to target women considering an abortion to send them advertisements for Crisis Pregnancy Centers. Bethany Christain Services and a network of other CPCs have already utilized this advertising service. According to Flynn, these advertisements have attempted to serve millions of phones on behalf of CPCs and redirected thousands to their website (Coutts, 2016). Copley Advertising has since been sued by the state of Massachusetts for violating its consumer protection law and settled promising to not use its geo-targeting practices for healthcare facilities in the state. However, this advertising campaign was executed in five other states that so far have not brought any similar suit (Raymond, 2017).

## **03. Location Strategy**

Crisis Pregnancy Centers’ advertising campaigns do not just exist online. Geographically, they attempt to generate as much confusion as possible. In Nebraska for example, two of the

state's three abortion clinics have a CPC right next door. It is no secret that CPCs purposefully situate themselves next to abortion clinics in an attempt to reach women trying to visit the actual abortion clinic. As Laurie Steinfeld, a counselor at a pregnancy center in California, put it: "Right across the street from us is Planned Parenthood. We're across the street and it [their sign] says 'Pregnancy Counseling Center,' but these girls aren't — they just look and see 'Pregnancy' and think, Oh, that's it! So some of them coming in thinking they're going to their abortion appointments" (Winter, 2015).

Another aspect of the location strategy of Crisis Pregnancy Centers is how they place themselves next to public high schools and universities, as Dr. Andrea Swartzendruber found in Georgia. They may sponsor college parenting groups, cater at tailgates and offer free food to students, and establish a presence at the university through student organizations. This partnership with student organizations allows them to park mobile clinics nearby or offer satellite offices on campus. Mobile "clinics" are an increasingly popular strategy for CPCs. The vans offer ultrasound machines, exam tables, and waiting areas to reach more low-income, college-aged women. They even offer transvaginal ultrasounds despite often lacking licensing to do so. This also allows these mobile CPCs to park outside of abortion clinics, targeting women seeking an abortion even without a nearby lease (Gerson, 2019).

Multiple students who have been encouraged by the advertisement of free pregnancy counseling or STD and STI testing by organizations that appear to them to be clinics report feeling shocked and embarrassed after trying to receive help at them -- a student in Wisconsin was told the abortion pill would render her infertile and a sophomore seeking STD testing was encouraged to sign a chastity pledge and told various horror stories about sex (Gerson, 2019). Repeated stories have surfaced of women seeking abortion and instead having CPC staff use personal details to convince them not to seek the procedure, a cornerstone aspect of these centers' strategy (Quinn, 2019). The choice of location for Crisis Pregnancy Centers is very strategic, as their aim is to reach as many people seeking abortion as possible.

### **III. Misinformation Circulated by Crisis Pregnancy Centers**

Heartbeat International published a "List of Abortion Risks and Complications" to be used by their partners with a series of claims about abortion's effects on women's health. It claims that women who abort are "four times more likely to die in the following year than women who carry to term" and "[t]he risk of breast cancer almost doubles after one abortion, and rises even further with two or more abortions, or if the abortion is done on the first pregnancy" (Heartbeat International, 2000). Similarly, Heartbeat International also published a "List of Major Psychological Effects of Abortion" that claims that women suffer from "Post-Abortion Syndrome" after they terminate their pregnancy (Heartbeat International, 1997). These claims deserve to be handled with a level of scrutiny, as the evidence behind them is highly contested.

A study published in 2016 in the *Journal of Pediatric and Adolescent Gynecology* found that crisis pregnancy center websites often provided "inaccurate and misleading information about condoms, STIs, and methods to prevent STI transmission" (Bryant-Comstock, Bryant, Narasimhan, & Levi, 2016). The Waxman Report, a 2004 report done by the office of Representative Henry A. Waxman, analyzed the scientific accuracy of information circulated by abstinence-only programs as well as Crisis Pregnancy Centers. Investigators called 25 crisis pregnancy centers that received federal funding and found that 87% of the centers "provided false or misleading information about the health effects of abortion" on subjects such as the risk

of breast cancer, fertility, and mental health effects of abortion (U.S. House of Representatives Committee on Government Reform, 2006).

It would be one thing to state the risks of abortion if there were no medical consensus on these issues. Today rumors of Post-Abortion Syndrome, any link between breast cancer and abortion, and incredibly overstated risks of death have been repeatedly disproved by leading medical researchers and organizations. It is not just risks of abortion that they distort, but risks of birth control as well. It is easy to cherry-pick studies to justify an ideological viewpoint, but the body of research is clear.

### **01. Breast Cancer and Abortion**

Denmark conducted the largest and most reliable study of the rumored abortion-breast cancer link with a total of 1.5 million women using the National Registry of Induced Abortions and with the Danish Cancer Registry. It found no link between abortion and breast cancer (Braüner, Overvad, Tjønneland, & Attermann, 2013). Cohort study after cohort study has not found a link between the two. In 2003, the US National Cancer Institute held a workshop with 100 leading experts and came to these conclusions: breast cancer risk is increased for a short time after a full-term pregnancy and induced and spontaneous abortions (miscarriages) are not linked to an increased risk of breast cancer (The American Cancer Society, 2014). The American College of Obstetricians and Gynecologists (ACOG) Committee on Gynecologic Practice came to the same conclusion (American College of Obstetricians and Gynecologists Committee on Gynecologic Practice, 2009).

The Collaborative Group on Hormonal Factors in Breast Cancer reviewed 53 retrospective and prospective studies and found that, “the totality of worldwide epidemiological evidence indicates that pregnancies ending as either spontaneous or induced abortions do not have adverse effects on women’s subsequent risk of developing breast cancer” (Beral, Bull, Doll, Peto, & Reeves, 2004). The American Cancer Society is clear in its rebuke of false claims involving abortion and breast cancer, saying: “The public is not well-served by false alarms. At this time, the scientific evidence does not support the notion that abortion of any kind raises the risk of breast cancer or any other type of cancer” (The American Cancer Society, 2014).

### **02. Post Abortion Syndrome**

A similar consensus can be found with the rumored link between abortion and mental health. A review of 216 studies on mental health and abortion in the Harvard Review of Psychiatry found that any studies that claimed that there was a link between abortion and mental disorders were severely methodologically flawed (Robinson, Stotland, Russo, Lang, & Occhiogrosso, 2009). One study in particular, performed by Priscilla Coleman, has been repeatedly discredited after attempts at replication found critical flaws in her research methodology and showed no link between abortion and mental health disorders (Coleman, 2011) (Steinburg, Trussell, Hall, & Guthrie, 2012).

Again, as with abortion and breast cancer, the link between abortion and mental health disorders has been disproved repeatedly. The consensus among medical organizations supports this. The American Psychological Association Task Force on Mental Health and Abortion found no evidence of “Post Abortion Syndrome”, saying “Across studies, prior mental health emerged as the strongest predictor of post-abortion mental health. Many of these same factors also predict

negative psychological reactions to other types of stressful life events, including childbirth, and, hence, are not uniquely predictive of psychological responses following abortion.” (American Psychological Association, Task Force on Mental Health and Abortion, 2008). The American Psychiatric Association echoed this (American Psychiatric Association, 2018).

### **03. Abortion and Death**

The study cited by Heartbeat International as “proof” that women who get abortions are “four times more likely to die” is one performed in Finland that analyzed maternal mortality rates. It did not find that there was anything about the medical procedure of abortion that caused women to die. According to the text of the study itself:

“The age-adjusted risk for a violent death (accident, suicide, or homicide) was increased for women with a recent abortion compared to other women, probably because of factors related to social class and lifestyle. Furthermore, the age-adjusted risk for a natural death was decreased after a birth or miscarriage compared to that for women without a recent completed pregnancy. This may be explained by the fact that the women capable of and willing to have children are healthier than women in general” (Gissler, Kauppila, Merilainen, Toukomma, & Hemminiki, 1997).

A woman will not become four times more likely to die after having an abortion. The study does not say that. Lifestyle, health, and social class are the likely factors that affect mortality rates in this study, as the study itself states. The APA Mental Health Task Force included the Gissler study in their review and stated: “[a]bortion is a marker of risk for violence, not a cause of violence” (American Psychological Association, Task Force on Mental Health and Abortion, 2008). Women who are in violent circumstances may be more likely to terminate a pregnancy, but that does not mean that pregnancy termination puts someone at risk of violent death. Framing this research as evidence that abortion causes deaths is disingenuous, a willful misinterpretation of the information presented, and violates one of the most basic research principles: correlation is not the same as causation.

Reviews of research have repeatedly found that the risk of death from abortion is very low. A study published in *Obstetrics & Gynecology* in 2015 found that abortion has fewer complications attached to it than wisdom tooth removal. Only 2.1% of the over 54,000 abortions studied had a complication, and only 0.23% of those complications were serious. Fewer than 2% of abortions resulted in even a minor complication (Upadhyay, et al., 2015). The American Medical Association’s Council on Scientific Affairs found that “Legal-abortion mortality between 1979 and 1985 was 0.6 deaths per 100,000 procedures, more than 10 times lower than the 9.1 maternal deaths per 100,000 live births between 1979 and 1986” (Council on Scientific Affairs, American Medical Association., 1992). Abortion is one of the safest medical procedures there is.

The maternal mortality rate today is only rising. The CDC Foundation’s Maternal Mortality Review Committees found that in the United States, 700 women die every year as a result of pregnancy or pregnancy complications. Over 60% of these deaths were preventable (The CDC Foundation, 2018). The United States has the worst record of maternal mortality in the developed world, and it is only rising. It rose to 26.4 deaths per 100,000 pregnancies in 2015 (Martin & Montagne, 2017)). These are frightening statistics, and it is interesting that CPCs choose to mislead patients about the risks associated with abortion rather than inform them of the very real risks of pregnancy.

The biggest danger to women's health with regards to abortion is unsafe and illegal abortion. The World Health Organization cites unsafe abortions as incredibly dangerous procedures, caused by "restrictive laws, poor availability of services, high cost, stigma, conscientious objection of health-care providers, and unnecessary requirements". The risks of these procedures, often performed crudely and without medically trained persons, cannot be understated. The mortality rate of unsafe abortions in developed regions is 30/100,000, 220/100,000 in developing regions, and 520/10,000 in sub-Saharan Africa. To prevent these from occurring, the WHO recommends "comprehensive sexuality education, prevention of unintended pregnancy through use of effective contraception, including emergency contraception, and provision of safe, legal abortion" (World Health Organization, 2019). The greatest risk to women is not safe and legal abortion, but the absence of it.

#### **04. Risks of Birth Control**

Heartbeat International published a chart of birth control methods, listing the advantages and disadvantages of all of them. What is interesting to note about this chart is just how lopsided it appears. There are three methods of birth control for which Heartbeat International lists no disadvantages: abstinence, the Ovulation (Billings) Method, and the sympto-thermal method. According to the chart, the Ovulation Method and the Sympto-Thermal Method are 98-99% effective and have no side effects (Heartbeat International).

The Ovulation (Billings) Method is just another name for the cervical mucus method of birth control, which involves very thorough monitoring of cervical secretions and mucus patterns. It does not protect against any STDs or STIs. According to the Mayo Clinic, as many as 23 out of 100 women will get pregnant using this method typically. If it is done correctly, it can be reduced to as low as 3 out of 100. But given the formal training and daily rigorous monitoring involved in performing this method correctly, it seems incredibly difficult for the average woman to master (The Mayo Clinic, 2018).

The Sympto-Thermal Method of birth control is again, just another name for the basal body temperature method in combination with the cervical mucus method. It involves tracking your basal body temperature - or the temperature that you are while completely at rest - each day and determining when you are the least and most fertile. Your basal body temperature is fairly sensitive and can be affected by things other than fertility, including: illness, stress, irregular sleep patterns, alcohol, travel, medications, and some women do not even experience changes in basal body temperature while ovulating. It does not protect against STDs or STIs. And again, according to the Mayo Clinic "[a]s many as 24 out of 100 women who use fertility awareness-based methods to prevent pregnancy — such as the basal body temperature method — for one year will get pregnant" (The Mayo Clinic, 2018).

None of these disadvantages are listed on Heartbeat International's chart. Choosing not to include a significant risk of pregnancy and STD/STIs as even disadvantages with these methods seems to be a rather large oversight. The disadvantages of male condoms, on the other hand, take up nearly three pages of the chart. It includes everything from citing that some people have latex allergies and animal condoms are not as effective as others (there are non-latex and non-animal condoms), they must be used correctly every time (this is true of all birth control methods, including and especially fertility awareness methods), and they do not protect against all STDs/STIs (fertility awareness methods do not protect against *any*). The only advantage listed is

that it protects against some STDs/STIs, and the chart does not even mention how effective condoms are when preventing pregnancy in its advantage column.

The chart is particularly concerned with how difficult it is to use a condom, and lists all the things involved in using a condom correctly: opening a condom package, putting it on while erect, not having penis/vagina contact without the condom, the condom remaining in place, not reusing the condom, etc. It would be very helpful if the chart was as thorough in explaining complex fertility awareness methods as it is something as simple as the proper usage of condoms. It also makes clear that perfect use of condoms is necessary to only have a 2% risk of pregnancy, but does not make that clear with fertility awareness methods (Heartbeat International).

It is not just condoms that this chart is particularly harsh on. Heartbeat International even claims that the birth control pill is carcinogenic and “in the same classification as tobacco and asbestos” (Heartbeat International). The very review they indirectly cite from the World Health Organization states that while “the use of COCs modifies slightly the risk of cancer, increasing it in some sites (cervix, breast, liver), decreasing it in others (endometrium, ovary)” the committees that have studied the impact of combined oral contraception “have determined that for most healthy women, the health benefits clearly exceed the health risks”. It makes no mention of any risk of birth control pills being at all related to tobacco nor asbestos (UNDP/UNFPA/WHO/World Bank, 2005).

It seems misguided to evaluate methods of medical contraception to a much harsher degree than notoriously ineffective fertility awareness methods. But this should not be surprising, given that Heartbeat International explicitly states on their website:

“Heartbeat International does not promote birth control (devices or medications) for family planning, population control, or health issues, including disease prevention. All Heartbeat International policies and materials are consistent with Biblical principles and with orthodox Christian (Catholic, Protestant, and Orthodox) ethical principles and teaching on the dignity of the human person and sanctity of human life.” (Heartbeat International, 2019)

Given Heartbeat International’s stance on contraception, it is questionable that they are presenting themselves on experts on a subject that they have made clear they have a spiritual objection to and consider “the gateway drug to abortion” (Scheuring, 2019). Especially given just how misleading this information is, the chart provided as a resource to women seeking actual contraception seems more like deliberate misinformation than actual medical guidance. If these Crisis Pregnancy Centers are presenting themselves as a resource for pregnant women, they should not be distorting the facts.

## **05. Abortion Reversal**

Many CPCs recommend something they refer to as an “abortion reversal”. CareNet, Heartbeat International, and the NIFLA all have referenced the procedure (CareNet, 2018) (Heartbeat International, 2019) (National Institute of Family and Life Advocates, 2019). A medical abortion involves taking two medications: a dose of mifepristone and a dose of misoprostol one to three days later. Abortion reversal claims to reverse the effects of the first pill with a large dose of progesterone, leading to the first step of a medication abortion being “reversed” and the pregnancy not terminated.

The American Congress of Obstetricians and Gynecologists have vocally criticized “abortion reversal”. Arizona gynecologist Ilana Addis commented, "There is no science to support this. ACOG does not support advising women on treatments that are not evidence-based. These women would be unknowing and unwilling guinea pigs." The ACOG also makes the point that patients “who only take the first pill already have a 30 to 50 percent chance of continuing their pregnancy normally”. The two pills are necessary for the procedure to be complete, regardless. There is no evidence that the additional dose of progesterone works to “reverse” the abortion any more than simply not taking the second pill does (Khazan, 2015).

Dr. Dan Grossman, vice president of research at Ibis Reproductive Health, points to the lack of evidence that the procedure does anything at all. He does express concern about giving a dose of progesterone without a medical reason to do so, saying “I think this is really outside of standard of care to just begin doing this kind of treatment, without collecting more rigorous studies about its effectiveness”. The use of progesterone for the purpose of “abortion reversal” has not been approved by the FDA (Boden, 2015). The additional dose of progesterone is just an unpleasant placebo, and as Dr. Addis puts it: "There can be cardiovascular side effects, glucose tolerance issues, it can cause problems with depression in people who already had it. And there are more annoying things, like bloating, fatigue, that kind of stuff. It's an unpleasant drug to take." There is no scientific evidence that the “abortion reversal” does what it claims to (Khazan, 2015).

#### **IV. Medical Practices**

##### **A. Ultrasounds**

Crisis Pregnancy Centers sort women into categories as they walk through the door. The Focus on the Family manual “Excellence of Care: Standards of Care for Providing Ultrasound and Other Medical Services in a Pregnancy Resource Clinic”, lists these categories as abortion-minded, abortion-vulnerable, and carry to term. They also provide criteria and definitions for these categories (Focus on the Family, 2004).

The abortion-minded patient is one that is seeking, has scheduled, or has started the process of an abortion. She asks for abortion services from the CPC and is clearly confused about the services the CPC offers. The manual lists the questions these women often ask, such as: “How much does an abortion cost?” “Can you give me a referral for an abortion?” The manual recommends scheduling them for an ultrasound. It does not recommend explaining to the woman that this clinic is not what she is looking for.

The abortion-vulnerable woman is one that is intending on carrying her pregnancy to term but has doubts about her ability to do so. This also includes any woman that considers herself “pro-choice”. The counselor and the personnel that work with them are instructed to evaluate the situation and schedule the woman for an ultrasound (Focus on the Family, 2004).

The carry to term woman is one that is against abortion and intending on carrying her pregnancy to term. An ultrasound for this woman is not recommended, though the manual does reference referring her to a resource. It is worth noting that the manual does not recommend the ultrasound for women intending to carry their pregnancies to term, it is only recommended for women the clinic deems “abortion-minded” or “abortion-vulnerable”. Those categories include everyone from women who have already scheduled their abortions to women that are fully intending on continuing their pregnancies but support any woman’s right to choose an abortion (Focus on the Family, 2004, p. 6).

In that same Focus on the Family training manual, part D of the guidelines for performing ultrasounds in a CPC states “[s]ervices will be provided for abortion-minded and abortion-vulnerable women to help them in the decision-making phase of their pregnancy. The provision of ultrasound services to women who are not abortion-minded or abortion-vulnerable is at the discretion of the medical director” (Focus on the Family, 2004, p. 1). To these clinics, or at least to this manual, ultrasounds are necessary to prevent abortion but not to provide information to women who are intending to carry their pregnancy to term.

These intentions are not unique to this particular training manual or to Focus on the Family. The manual (the PDF that is accessible online) is being circulated by Heartbeat Services of Heartbeat International. Thomas Glessner, the president of NIFLA, ran an advice column for the “At the Center” magazine. In that advice column, he repeatedly advised CPCs to become medical centers and provided guidance on how to do so. Glessner makes clear the primary motivation for providing medical services and operating as a medical clinic. In his guide to “Converting Your Pregnancy Help Center into a Medical Clinic”, Glessner states:

“Providing medical services to abortion-minded and abortion-vulnerable clients has proven to be an effective way not only to serve the needs of these women, but also to empower them to choose life. Through medical services such as ultrasound, these women are introduced to the humanity of their unborn children and thus bond with these children very early their pregnancies” (Glessner, 2006).

There again is the language on “abortion-minded” and “abortion-vulnerable” women, and there again is the guidance to focus medical services on these women in order to persuade them not to terminate their pregnancies. He dissuades CPCs from referring to doctors, saying “Referrals to competent doctors are, of course, valuable to provide. However, such referrals are not as effective in reaching abortion-minded and abortion-vulnerable women as providing medical services on site.” (Glessner, 2006).

Glessner’s top two reasons for CPCs to become medical clinics are “[b]ecoming a medical clinic increases the number of abortion-minded clients served” and “[b]ecoming a medical clinic empowers abortion-minded women to choose life”. The other two reasons listed are increasing donor support and credibility in the community. Nowhere listed are motivations like “providing a needed medical resource for pregnant women” or “offering expectant mothers who intend to carry their pregnancy to term resources”. All of the language is focused on preventing a woman from obtaining an abortion that she wants (Glessner, 2006).

Glessner offered similar advice in 2003, in his column, “Determining Whether to “Go Medical” -- A Board Assessment Survey”. He advised boards of directors of CPCs to evaluate whether or not they should become medical clinics based on an assessment of the number of women seeking abortions who come through the doors of their CPCs. The assessment includes questions like: “How many [of your clients] are abortion-minded or abortion-vulnerable?”, “How many abortion-minded or abortion-vulnerable women call on the 24-hour hotline every month?”, “Of all abortion-minded and abortion-vulnerable women seen each month, how many are choosing life?”, and “How many client visits each month are for support services only, such as maternity clothes and baby accessories?” It also asks, for all of these questions, if these numbers are increasing or decreasing (Glessner, Determining Whether to “Go Medical” -- A Board Assessment Survey, 2003).

Just in case Glessner’s intentions to attract women seeking abortions - a service that CPCs obviously do not provide - isn’t clear enough, he states: “Many centers around the nation have reported a disturbing trend that they are seeing a decreasing number of abortion-minded

clients each year. Centers that have converted their operations to medical clinics, however, report that they are attracting at-risk clients in record numbers” (Glessner, Determining Whether to “Go Medical” -- A Board Assessment Survey, 2003). The intention behind converting CPCs into medical centers is to mislead women seeking abortions and persuade them into keeping the pregnancy.

The primary medical service that CPCs provide is ultrasounds. In a blog post written for CareNet, Jeanneane Maxon describes:

“Without a doubt, ultrasound imagery of unborn babies is powerful. As pregnancy center directors, volunteers, and leaders, we have all experienced this: A client considering abortion receives an ultrasound and God does something miraculous. The baby appears perfectly, and the parents feel more bonded with their child and choose life” (Maxon, 2015).

The Option Ultrasound program, recommended by organizations like Focus on the Family and NIFLA, gives grants to CPCs to alleviate the costs of ultrasound machines and sonography training. It boasts, “Since 2004, Option Ultrasound has saved an estimated 390,000 precious lives!” CPCs must meet the criteria listed by Option Ultrasound in order to qualify for these grants. Among them are: “[p]ublic funding for abortion is available in the state beyond funding for rape, incest, or “life of the mother.”, the state is graded A or B by NARAL's Report Card indicating that state abortion laws are lax, [and] four or more public abortion providers that actively market their abortion services are located in the city the organization serve” (Focus on the Family, 2019). In other words, grant funding for CPCs is specifically set aside for communities that Option Ultrasound deems, “abortion-vulnerable”.

Elective, unnecessary ultrasounds have been derided by a number of different medical groups. The Food and Drug Administration issued an advisory against women seeking ultrasounds elsewhere than at a hospital or their doctor’s office. The American Congress of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA) and the American Institute of Ultrasound in Medicine (AIUM) have denounced keepsake, medically unnecessary ultrasounds (Thayer, 2015). The AIUM, the American College of Radiology (ACR), the American College of Obstetricians and Gynecologists (ACOG), the Society of Maternal-Fetal Medicine (SMFM), and the Society of Radiologists in Ultrasound (SRU) all specifically warn against fetal ultrasounds performed without a medical purpose, stating in their guidelines, “Fetal ultrasound should be performed only when there is a valid medical reason, and the lowest possible ultrasonic exposure settings should be used to gain the necessary diagnostic information” (AIUM, ACR, ACOG, SMFM, SRU, 2018).

NIFLA president Thomas Glessner recognizes this, and even quotes the AIUM guidelines in his guide to “The Legal Basics of the Pregnancy Resource Medical Clinic Model”. According to him, in order to be compliant with the guidelines listed by the AIUM and the warnings of other medical groups, an ultrasound should be justified as a means to “diagnose” pregnancy, confirm gestational age, and verify the presence of a fetal heartbeat (Glessner, The Legal Basics of the Pregnancy Resource Medical Clinic Model, 2012). But considering that sonograms are recommended by both training manuals and Glessner himself as a means to persuade abortion-minded or abortion-vulnerable to change their minds and not recommended for pregnant women intending to carry to term, it seems unlikely that CPCs perform ultrasounds with a truly medical motivation.

Dissuading women from getting the health service that they are seeking is not a medically necessary reason to perform an ultrasound or to convert to a medical clinic. Given that all

leading medical experts have advised against elective ultrasounds, it seems irresponsible for Crisis Pregnancy Centers to push them for the purpose of persuasion rather than medical necessity.

## **B. Medical Licensing and Qualifications**

According to a paper published in the American Medical Association Journal of Ethics, most Crisis Pregnancy Centers are not licensed medical clinics. Most of their staff, likewise, does not include medical professionals (Bryant & Swartz, 2018). According to a report from the pro-life Lozier Foundation, Crisis Pregnancy Centers across the United States have had around 67,400 volunteers. 7,500 of those volunteers have been medical professionals, meaning only roughly 11 percent of Crisis Pregnancy Center staff are medical professionals (Charlotte Lozier Institute, 2018). The number of CPCs that offer STI testing has more than doubled over the past ten years, and after getting licensing can bill Medicaid and potentially receive more federal grants. By turning CPCs into labs and patient rooms, they can seem more like a medical facility to potential patients (Colliver, 2018).

Dr. Andrea Swartzendruber, an Epidemiology & Biostatistics professor at the University of Georgia, identified 2,537 CPCs in the United States. Two-thirds of those offer limited medical services in the form of STI testing or even breast exams and pap smears. In Georgia, 22 percent of CPCs offer STI testing but only 5 percent offer treatment. They may not offer these tests in a way that meets public health standards, but prenatal care can be a bit of a grey area (Henderson, 2019)

There are completely different standards for CPCs that offer limited medical services like STI testing and fully licensed health clinics like Planned Parenthood. Nebraska's Essential Pregnancy Services, which offers STI testing, has a LAB-CLIA certification from the Nebraska Department of Health and Human Services. Nebraska's Planned Parenthood clinics are licensed as Health Clinics (Nebraska Department of Health and Human Services, 2019). LAB-CLIA certified facilities do require testing on patients for medical purposes and can include waived tests for less complex tests. These waived tests may only require a Certificate of Waiver (COW) that are only subject to routine surveys if a complaint is filed against the facility, and may not have specific personnel requirements (Centers for Medicare and Medicaid Services, 2019).

Health clinics in the state of Nebraska, on the other hand, are subject to routine inspection and held to a number of different standards on best practices, proper use of medical records, staff requirements, infection control, pharmacy services, and all aspects of running a clean and healthy medical clinic (Nebraska Health and Human Services, 2007). Even when Crisis Pregnancy Centers do have a degree of licensure, they are not held to nearly the same criteria as licensed health clinics are.

## **V. Crisis Pregnancy Centers in Government**

### **01. Informed Consent Laws**

What is particularly unfortunate about the level of misinformation presented by anti-abortion organizations is the impact they have on policy. As explained in "Misinformation Circulated by CPCs", the health and psychological risks of abortion that CPCs claim exist are not supported by medical consensus or oftentimes even the research they cite. "Informed Consent"

laws have been passed in 29 states, and they require physicians to warn patients of all the possible risks of abortion. The problem is that some of the risks described either do not exist or are greatly exaggerated (Beusman, 2016). A study of these informed consent laws found that some were “are exaggerated, misleading, or simply false”. Misleading claims of infertility, psychological consequences, and breast cancer are unfortunately common (Vandewalker, 2012, pp. 14-19).

Dr. Diane Horvath-Cosper, who performed abortions in South Dakota, was legally required to tell her patients that abortion increased their risk of breast cancer and suicide, then immediately told them these claims were baseless and not backed by medical fact. She typically told patients, “What I would say was, 'The state requires me to give you this information. We have excellent medical evidence to say that it's actually not true, but I'm required to tell you this.'” Seven states require or suggest providers give brochures to patients that imply that there is a link between abortion and breast cancer, three imply that “Post Abortion Syndrome” exists, four imply a link between abortion and infertility, and four mention suicide as a risk of abortion (Beusman, 2016). A study of these informed consent laws and brochures found that “nearly one-third of the informed consent information is medically inaccurate” (Daniels, Ferguson, Howard, & Roberti, 2016).

Nebraska’s brochure states, “[s]ome reports suggest that some women experience reactions such as sadness, grief, regret, anxiety and guilt” (Nebraska Department of Health and Human Services, 2008). It does not describe the feelings of relief that occur after an abortion, as a study from the University of California San-Francisco finds that 95% of women who obtained an abortion thought it was the right decision and 90% of women who obtained an abortion near the gestational age limit of their state’s laws reported feelings of relief (Rocca, Kimport, Gould, & Foster, 2013).

## **02. A Proactive Strategy**

In 2008, Heartbeat International, CareNet, and the NIFLA partnered up to develop a legal and legislative strategy document for CPCs. The guide, “A Pro-Active Strategy to Defend Your Pregnancy Center Against Legislative Attacks”, was meant to be a confidential resource but was easily accessible in an online PDF. In it, they state a key part of the messaging and strategy of CPCs have been purposefully obscuring their connection to pro-life political activism as to not scare away those who are seeking an abortion. As more and more research and attention have been brought to these centers, they made a turn to instead proactively present themselves to state elected officials “[f]or the sake of God’s glory and protecting the ongoing work of pregnancy centers” (CareNet, NIFLA, Heartbeat International, 2008).

A big part of this initiative was counteracting plans to regulate or shut down Crisis Pregnancy Centers by reproductive rights advocacy organizations. By preempting any attacks on their organizations and advising centers to reach out directly and strategically to elected officials, the aim was to convince even the most staunchly pro-choice legislator that the CPC was just providing resources to pregnant women. Scheduling meetings and offering tours was a key part of this initiative, as was adhering to the messaging provided (CareNet, NIFLA, Heartbeat International, 2008).

The messaging mainly focused on the free services provided, an emphasis that the center received no federal or state funding, empowering women to make informed decisions, and caring for clients with integrity. As previously covered in the “Misinformation Circulated by Crisis

Pregnancy Centers” section, claims of informed decisions may be arguable. The claim that centers receive no federal or state funding is also untenable, as this paper will explore later.

This guide even offers a model resolution for state legislators to introduce to indicate support for Crisis Pregnancy Centers. The legislation praises pregnancy resource centers for their work in their community, states the services these centers provide with emphasis on pregnancy testing and ultrasounds, and emphasizes that these centers operate primarily off of voluntary donations (CareNet, NIFLA, Heartbeat International, 2008). The exact resolution supplied has appeared in Kansas, Kentucky, Arkansas, Oklahoma, and Nebraska (S.R. 1606, 2013), (H.R. 29, 2011), (S.R. 24, 2015), (S.R. 82, 2010), (L.R. 23, 2011). It is likely this legislation has also been used in other states, but these are just the verbatim copies of the bill that were easy to find.

A crucial part of this strategy is the emphasis that Crisis Pregnancy Centers are simply there to provide resources to pregnant women that want them, with limited cost to states. The reality of the funding and goals of these CPCs is much different than the messaging provided to legislators.

### **03. Government Funding**

A key part of the argument Crisis Pregnancy Centers have used to persuade lawmakers that their centers are essential is that they receive no federal or state funding. This is patently untrue, and has been for decades. As the Waxman Report details, from 2001 to 2004 CPCs received over \$30 million in federal funding, most of it coming from funding for abstinence-only education designated as a priority by the Bush administration. “Capacity-building grants” also went to CPCs in 15 different states in a \$150 million Compassion Capital Fund initiative, and centers have “been the beneficiaries of earmarks in appropriations bills” (U.S. House of Representatives Committee on Government Reform, 2006). In 2018, 14 states designated a total of \$40.5 million to CPCs. In 2017 Texas allotted \$38.8 million over two years to the state’s “Alternatives to Abortion” program (Wilson, 2018). In 2019, CPCs received \$3 million through the Trump Administration’s Competitive Abstinence Program (Henderson, 2019).

Under the Trump Administration’s recent proposals, CPCs are positioned to receive even more in government funding. Under current regulations, to be eligible for Title X funding you have to provide a range of family planning services, from access to contraception to referrals for abortion. CPCs offer neither, but the Trump Administration has proposed getting rid of these restrictions and even barring recipients of Title X funding from discussing abortion as an option at all in addition to discouraging contraception in favor of “natural family planning”, a favorite of Crisis Pregnancy Centers. Obria Medical Clinics, a network of CPCs that was rejected for Title X funding in the past, is set to receive \$1.7 million of Title X dollars under the Trump Administration (Henderson, 2019).

It is not just funding set aside for abstinence-only education or Title X providers that is going to CPCs, but money meant to provide assistance for needy families. At least 7 states are directing block grant funding meant for Temporary Assistance for Needy Families (TANF) to crisis pregnancy centers (Crockett, 2016). In 2018 more than \$13.4 million federal dollars marked for TANF block grants went to CPCs (Wilson, 2018).

Some states direct TANF funding to CPCs in a manner that can only be described as underhanded. Nebraska was not included in either list of states that fund CPCs through TANF block grants or otherwise. Nebraska’s 2013 TANF State Plan mentions a program known as Positive Alternatives that uses TANF funding to provide “professional counseling, abstinence

education, natural family planning, birth control risk education, pregnancy tests and counseling..." and more that directly fall under the types of services CPCs typically provide (Nebraska Department of Health and Human Services, 2013). A 2013 document from DHHS details, "Contract oversight utilizing TANF funds to deliver services statewide to women who are pregnant or think they are pregnant continues. With these resources, the contractor is promoting access to crisis pregnancy, adoption, parenting education and outreach services, including fathers." (Nebraska Department of Health and Human Services, 2013).

The Nebraska DHHS' Abstinence Newsletter from 2007 details what the Positive Alternative program is. The contractor for Positive Alternatives is the Nebraska Children's Home Society, an adoption and foster care agency. The program began as a grant in 2005 and was extended until at least 2014. In the newsletter, the partners of the program are mentioned and include: Essential Pregnancy Services, AAA Center for Pregnancy Counseling (now Assure), A Woman's Touch Crisis Pregnancy Center (now Essential Pregnancy Services), Nebraskans United for Life, A Women's Care Center of the Heartland, and Lincoln Crisis Pregnancy Center. All are Crisis Pregnancy Centers operating in the state of Nebraska (Nebraska Department of Health and Human Services, 2007). Nowhere in the Nebraska state budget did it describe how TANF funding was being used to promote Crisis Pregnancy Centers, finding this information instead required combing through since-deleted webpages of Health and Human Services documents.

## **VI. Connection to Adoption Agencies**

Nebraska's funding for CPCs was carried out through a contract with the Nebraska Children's Home Society. There is a pattern of adoption agencies and CPCs developing mutually beneficial relationships. Some adoption agencies, such as Bethany Christian Services, double as CPCs. Other CPCs encourage adoption even over parenting, such as CareNet's former director Curtis Young who described women who put their children up for adoption as more "mature" and described adoption as a path of redemption from "selfishness" and "evil" (Young, 2010). The Infant Adoption and Awareness Act was pushed by NCFCA, and provided funding for trainings around the country about encouraging adoption -- often at the expense of portraying other options (abortion and parenting) with the accuracy they deserve.

The largest adoption agency in the nation, Bethany Christian Services is notorious for manipulating women to keep their pregnancies and treating "birth mothers" terribly. Bethany Christian Services run a CPC-like pregnancy counseling apparatus. Critics argue that they artificially produce orphans even for women that want to carry their pregnancy to term and parent and make tens of thousands from adoptive parents. Kathryn Joyce detailed many of these concerns and experiences of women who interacted with Crisis Pregnancy Centers in a 2009 article from *The Nation*. Some stories come from CareNet in the 1990s, such as this one:

"In 1994 the Village Voice investigated several California CPCs in Care Net, the largest network of centers in the country, and found gross ethical violations at an affiliated adoption agency, where director Bonnie Jo Williams secured adoptions by warning pregnant women about parenthood's painfulness, pressuring them to sign papers under heavy medication and in one case detaining a woman in labor for four hours in a CPC." (Joyce, 2009)

Others describe the psychological damage of these practices:

“Joe Soll, a psychotherapist and adoption reform activist, says that CPCs “funnel people to adoption agencies who put them in maternity homes,” where ambivalent mothers are subjected to moralistic and financial pressure: warned that if they don’t give up their babies, they’ll have to pay for their spot at the home, and given conflicted legal counsel from agency-retained lawyers.” (Joyce, 2009)

There are multiple agencies that offer women assistance with their financial needs during their pregnancies. The problem arises when these agencies manipulate women and give them false information, maternity homes, and adoption agencies affiliated with CPCs purport warnings of “post-abortion syndrome” regardless of medical professionals’ continuous disapproval of such a condition (Matchar, 2013). Mari Gallon, a woman who a CPC tried to convince to give up her child, describes CPCs as “adoption rings” with a “multistep agenda: evangelizing; discovering and exploiting women’s insecurities about age, finances or parenting; then hard-selling adoption, portraying parenting as a selfish, immature choice” (Joyce, 2009). It is not just practices of a few CPCs, but federal law to encourage adoption.

“The federally funded NCFCA has a large role in spreading teachings like these through its Infant Adoption Awareness Training Program, a Department of Health and Human Services initiative it helped pass in 2000 that has promoted adoption to nearly 18,000 CPC, school, state, health and correctional workers since 2002. Although the program stipulates “nondirective counseling for pregnant women,” it was developed by a heavily pro-adoption pool of experts, including Kenny, and the Guttmacher Institute reports that trainees have complained about the program’s coercive nature.” (Joyce, 2009)

The National Council For Adoption lobbied for the authorization of funds in the Infant Adoption Awareness Act “for a grant to a “national adoption organization” for the purpose of training Title X and other federally supported health care providers in how to “promote” adoption”. The IAAA also lifted the gag rule on Title X, as it specified “adoption information and referrals to pregnant women on an equal basis with other courses of action included in nondirective counseling.” Training directed by the NCFCA seemed coercive in its encouragement of adoption to some. It often framed clients as naive and “not in reality”, discouraged abortion, and a number of participants noted the training environment was hostile and overtly-Christian. Some trainers and trainees came from CPCs and anti-choice facilities. Adam Pertman, the executive director of the Evan B. Donaldson Adoption Institute described the situation: “The type of adoption that the NCFCA curriculum promotes is the old-style, closed, secretive and still-stigmatized form that is no longer accepted by most adoption practitioners, who favor greater honesty and openness in the process” (Dailard, 2004).

There is nothing wrong with a woman choosing adoption as the best thing for her and her pregnancy. There is something incredibly wrong with manipulating women and using CPCs to funnel more children into a system that is notoriously traumatic.

## **VII. A Legal History of Crisis Pregnancy Centers**

### **A. Legal Loopholes**

As previously mentioned, CPCs are not licensed medical clinics. A benefit of such lack of licensing is a lack of accountability - licensed medical clinics are held to regulations and standards that must meet medical standards of care. As organizations that do not charge for services, they also do not have to meet Federal Trade Commission standards, putting these organizations in a sizeable legal loophole (Bryant & Swartz, 2018). There has been legislation, such as California's FACT Act, that has attempted to require Crisis Pregnancy Centers to meet certain standards of accountability - like telling patients that the state offers services including family planning services, prenatal care, and abortion. The Supreme Court struck down this legislation in a 5 - 4 decision. The majority opinion, written by Justice Thomas, argued that such legislation was a violation of Crisis Pregnancy Centers' freedom of speech. Justice Breyer argued in the dissenting opinion: "If a state can lawfully require a doctor to tell a woman seeking an abortion about adoption services, why should it not be able, as here, to require a medical counselor to tell a woman seeking prenatal care or other reproductive healthcare about childbirth and abortion services?" (Barnes, 2018). Other similar measures such as Austin's truth in advertising ordinance that required CPCs to disclose they do not offer abortions or referrals for the procedure have been overturned (Tuma, 2019). Crisis Pregnancy Centers, as neither businesses nor medical clinics, are simply just not held legally accountable.

## **B. HIPAA**

One such example of a legal loophole is CPCs' relationship with HIPAA - a law that holds medical centers accountable for ensuring the privacy of their patients. According to CareNet, CPCs are not bound by HIPAA because they offer free services. Kurt Entsminger, CareNet's president, details "Even if your center offers limited medical services such as ultrasounds or STD testing, it may be exempt from the requirements of HIPAA so long as it does not engage in electronic transactions related to insurance claims and payments". He recommends that CPCs voluntarily comply with HIPAA to both enhance the professional image of the center and make it appear more like medical clinics as well as make the transition easier if CPCs are ever forced to comply (Entsminger, 2004). But as HIPAA is not mandated, it is easy for CPCs to violate. The privacy laws are more of a suggestion than a rule, which provides a concerning environment for women dealing with very sensitive information.

A woman from Hawaii visited a CPC in 2014 and was harassed by them so frequently she had to send a cease and desist letter just to get them to leave her and her personal information alone. Dr. Shandhini Raidoo, an OB-GYN in Hawaii, described: "We've had instances here ... the centers have used personal health information that patients disclosed to contact their employers and families to intimidate them not to pursue an abortion" (Knight, 2017).

One incident in Indiana involved a 17 year old girl mistakenly entering a CPC thinking it was a Planned Parenthood. The CPC collected her personal information and claimed that they made her an appointment at their "other office" -- the Planned Parenthood next door. When the girl came to what she thought was her appointment, the police met her. The CPC tipped off the police that a minor was being "forced to abort" despite knowing it was not the case. Afterward, the staff stalked her at her home, called her parents, and even encouraged her classmates to harass her about her pregnancy (Marcotte, 2016).

When a 17 year old in Texas confided to a teacher that she was pregnant, a school staffer contacted someone to drive her across state lines to a CPC. They had her sign a "Patient Notice

of Intent”, that states: “I have decided to continue my pregnancy to term. However, I am being subjected to coercion by others that is meant to compel me to terminate my pregnancy against my will.” Police threatened her mother with charges of fetal homicide after she took her daughter to an abortion clinic, despite the fact that her daughter wanted an abortion. She was texted and called constantly by anonymous strangers telling her it was wrong, and clinic staff did not perform the abortion after receiving a call saying that she did not want one. An attorney that she did not know she had sent threatening letters to the clinic, and her personal information -- including her social security number, name, and medical information -- were faxed to countless doctors, police officers, and strangers (Coutts, Anti-Choice Activists, Using Bogus Legal Threats, Trick Teens Into Signing Away Abortion Rights, 2016).

The document that the CPC had the girl sign was not legally binding, but they are frequently circulated by CPCs to coerce women into keeping their pregnancies. When she tried to go to the clinic a second time, she was again turned away from the clinic as the lawyer she did not ask for threatened legal action. Finally, her mother was able to draw up paperwork explaining that the lawyer involved was not her daughter’s lawyer and that the document she signed was not legally binding. The 17 year old was ultimately able to get the abortion she wanted (Coutts, 2016). CPCs are not bound by HIPAA requirements, and have proven time and time again that they have no problem violating them.

### **VIII. The Goal of Crisis Pregnancy Centers**

It would be easy to laud the mission of CPCs. There is nothing wrong with pregnant women in need of ultrasounds or reassurance as they are getting tested going to a clinic where they can get those services for free. There is something wrong with clinics that set up shop for the express purpose of misleading and manipulating women about their personal healthcare decisions to serve their agenda. If CPCs were just determined to help pregnant women find the resources they need, why have they been documented interfering with Google results? Why is the emphasis repeatedly put on “abortion-minded” women rather than just pregnant women as a whole?

All three of the main national CPC organizations point to a Commitment of Care, put forth in 2001 as a tool that “[p]regnancy center affiliation organizations continue to use and refer to [...] in responding to attacks from our opposition” (CareNet, NIFLA, Heartbeat International, 2008). CPCs are well aware of the critiques that are leveled at them. Their Commitment to Care is meant to serve as proof to the public, legislators, and critics alike that CPCs are doing the right thing.

Included in that commitment are guidelines like “[c]lients receive accurate information about pregnancy, fetal development, lifestyle issues, and related concerns”, “[w]e do not offer, recommend or refer for abortions or abortifacients, but we are committed to offering accurate information about abortion procedures and risks”, and “[a]ll of our advertising and communications are truthful and honest and accurately describe the services we offer” (CareNet, NIFLA, Heartbeat International, 2008). All of this sounds fair and is a great way to assuage the concerns of those hesitant to support CPCs.

The problem with this Commitment to Care is CPCs do not seem all that committed to it. Throughout this report are multiple instances of CPCs intentionally misleading patients and the public about the risks associated with pregnancy, contraception, and abortion. It is not just missteps made by a few clinics that make up this violation of their Commitment to Care, it is the

training and policy laid out by the national CPC organizations themselves. Misleading advertising has also been a central component of the work of CPCs, and the Commitment of Care stating otherwise does not change that.

A paper published in *The American Medical Association Journal of Ethics* argues that while Crisis Pregnancy Centers may technically be legal, they are unethical. They violate all four principles of medical practice: beneficence, nonmaleficence, respect for autonomy, and justice. Providing inaccurate information about a patient's medical options violates beneficence and nonmaleficence by actively manipulating these patients rather than centering their needs as a patient first. Misleading patients about their options can lead to more unintended consequences, like creating anxiety about contraception that can cause patients to become more likely to contract sexually transmitted diseases and/or infections. It also violates respect for autonomy, by not creating an environment for women to make truly informed decisions when deluged with misinformation. Distributive justice is also challenged when Crisis Pregnancy Centers target vulnerable women with deliberate misinformation that can impede their own ability to make decisions about their healthcare (Bryant & Swartz, 2018).

There is no evidence that Crisis Pregnancy Centers are even fulfilling their missions. A study published in 2018 found that there was no "evidence that pregnant women regularly seek CPC services or that CPCs persuade women who are certain abortion is the right decision for them to continue their pregnancies". Prenatal patients reported receiving inaccurate information, and patients generally recognized that these centers were not medical clinics. Only 3 of the 383 people surveyed reported visiting a CPC that impacted their decisions regarding abortion. For organizations that center their operations on persuading women not to go through with abortion, their tactics do not seem to be very effective (Kimport, Kriz, & Roberts, 2018)

As organizations that receive government assistance and taxpayer funding both federally and in a long list of states, it is fair to demand accountability from Crisis Pregnancy Centers. The mission of Crisis Pregnancy Centers is not to provide resources or information to women seeking to carry to term. They are extensions of a larger political apparatus that has the main objective of targeting women about their own personal medical decisions and persuading them to adhere to their organization's political or religious beliefs. The fact that they lie to and manipulate women in this process is inexcusable.

If these organizations committed themselves to providing medically accurate information and promoting transparency about their purpose and practices, that would be more than acceptable. There should be room for organizations that provide resources to pregnant women and mothers. The problem is that this would require these organizations to fundamentally change their strategy and mission. The purpose of all of the practices of Crisis Pregnancy Centers - advertising, ultrasounds, even the auspices of a medical environment - is not just to provide help to women intending to carry to term. It is to get "abortion-vulnerable" women who want and are actively seeking an abortion in the door and find a way to talk them out of that decision. It is a fundamental violation of the autonomy of patients and any medical best practices for this to remain the mission of these organizations. As a result, ethical practice and Crisis Pregnancy Centers may be permanently at odds.

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