



Testimony before the Senate Committee on the Judiciary
“The Assault on Reproductive Rights in a Post-Dobbs America”

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Good morning, Chairman Durbin, Ranking Member Graham and members of the committee.

Thank you for inviting me to testify. I am Dr. Ingrid Skop, a board-certified obstetrician/gynecologist practicing in Texas for 30 years. Today I sit before you to advocate for both of my patients, a woman and her unborn child. Every successful abortion ends the life of one of my patients, and often harms the other as well.

In the coming legislative sessions, you will have disparate legislative proposals to choose from. Senator Graham will likely reintroduce federal minimum protections, limiting elective abortion after 15-weeks’ gestation, with exceptions for rape, incest, and the life and physical health of the mother.

Conversely, Senator Baldwin has reintroduced “The Women’s Health Protection Act,” which ironically does nothing to protect the health of a pregnant woman from a dangerous abortion. The unborn human life is never acknowledged, the words “embryo” and “fetus” never appear, and abortion is presented as procedurally and morally equivalent to vasectomy or colonoscopy. This proposed legislation insists there can be no common-sense safety limits to protect a woman. The words “choice,” “voluntary,” and “consent” are completely missing, opening the door to others who will benefit from abortion-sex traffickers, incestuous abusers, and unwilling fathers. An abortion provider is not required to be a physician or even medically licensed. Despite its euphemistic name, this legislation prioritizes the death of the unborn human at the expense of the health or even the desires, of a pregnant woman.

Let's compare how a second trimester limits versus unlimited abortion throughout pregnancy will actually impact American women. The physical risks of abortion increase as pregnancy progresses. The risk of maternal death is 76 times higher in the second half of pregnancy, compared to an early abortion. The dilation and evacuation procedure, used for most later abortions, involves forcing open a strong muscular cervix and blind insertion of sharp instruments to dismember and extract a struggling fetus. Hemorrhage, cervical damage, retained fetal tissue and uterine perforation are common complications.

It has been extensively argued by abortion advocates that all abortions are extremely safe and do not require legislative intervention to protect women from complications. It is important to be aware that any abortion can result in complications, particularly if performed by a poorly skilled or compromised abortionist. Misdirection of cervical dilators or accidental insertion of suction curettes or grasping forceps into the soft, gravid uterine wall may cause injury to adjacent major blood vessels and/or gynecologic, genitourinary, or gastrointestinal organs, which may require emergency abdominal surgical exploration to perform a hysterectomy, bowel resection, bladder repair, or other repairs. Maternal death can occur due to hemorrhage, sepsis, thrombotic emboli, intravascular amniotic or air emboli, complications of anesthesia and cardiac or cerebrovascular events.¹

Abortion is increasingly dangerous to a woman as the gestational age increases. Concerns regarding the quality of abortion providers and clinics is real, as poor-quality providers are far more likely to induce complications. It has been documented that abortion providers are less likely to maintain hospital privileges, less likely to be board certified and more likely to have graduated from foreign medical schools, than non-abortion providing peers.²

Nonetheless, because abortion is a gynecologic procedure, it should be subject to following the standards of care that all other medical procedures follow. Due to its political nature, professional organizations such as the American College of Obstetricians & Gynecologists (ACOG), which exhibits a pro-abortion ideology, have neglected to establish reasonable standards for performance of abortion. In the absence of oversight, it is reasonable for the government to establish a minimum threshold for the standard of care in order to protect women from unsafe procedures and compromised providers.

¹ Autry A, Hayes E, Jacobson G, Kirby R. A comparison of medical induction and dilation and evacuation for second trimester abortion. *Am J Obstet Gyn* 2002;187:393-397; Cunningham F. *Williams Obstetrics*. 19th edition. Appleton & Lange. Norwalk, CT. 1993; 81-246; Lalitkumar S, Bygdeman M, Gemzell-Danielsson K. 2007. Mid-trimester induced abortion: a review. *Hum Reprod Update* 13:37-52; Practice Bulletin 135: Second Trimester Abortion: *Obstetrics & Gynecology*. 2013;121(6):1394-1406.

² Studnicki J, Longbons T, Fisher JW. Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. *Health Services Research and Managerial Epidemiology*. 2019;6:1-8.

An abortion beyond the first trimester is usually performed by Dilation & Evacuation (D&E), accounting for about 95 percent of abortions after the early second trimester.³ In a healthy pregnancy the cervix is strong and difficult to dilate, and thus cervical ripening (usually with a water-absorbing laminaria or prostaglandin insert) may be performed for one to three days prior to the abortion. If mechanical dilation remains difficult, cervical damage can occur or a false channel can be created, possibly leading to laceration of cervical vessels or injury to adjacent organs such as bladder, ureter or bowel.⁴ Once dilation has been completed, the surgeon introduces a suction curette into the uterus to vacuum out amniotic fluid and soft tissue such as the placenta.⁵

At this advanced gestational age, the fetal bones are calcified, and must be removed in a piecemeal fashion with grasping clamps, hence the layman's description, "dismemberment abortion." Multiple passes are required to remove all the fetal tissue, as each pass may yield an arm, leg or section of torso. The cranium is often the most difficult portion of tissue to remove as it may require crushing in order to fit through the incompletely dilated cervix. Complications which may occur with this operation include instrumental perforation of the soft, distended uterus, with injury to surrounding bowel or vasculature, potentially leading to sepsis or uncontrollable bleeding, or the incomplete removal of all the fetal tissue. If sharp, lacerated fetal bones are left behind, or if the sharp surgical instruments cause uterine damage during their blind insertion, this may lead to hemorrhage, infection, chronic pain, or future infertility. Additional surgery may be needed to correct these damages.⁶ Additionally, surgery to remove retained pregnancy tissue can cause uterine damage leading to future pregnancy complications such as abnormal placental attachment or premature labor. Severe complications can also lead to an abnormal activation of a woman's blood clotting system, disseminated intravascular coagulation, which can lead to death from uncontrollable bleeding due to inability to create blood clots.⁷

Intuitively, the risk of D&E rises with gestational age as the amount of fetal and placental tissue and blood volume increases, and the uterine wall becomes more distended and easier to puncture. A review of 243,000 D&E procedures documented the mortality rate when the procedure was performed between 13-15 weeks was

³ Practice Bulletin 135: Second Trimester Abortion: Obstetrics & Gynecology. 2013;121(6):1394-1406.

⁴ Paul, Lichenberg, Borgatta, Grimes, Stubblefield. A Clinician's Guide to Medical and Surgical Abortion. 1999. Churchill Livingstone. New York. 197-216.

⁵ Lerma. Current and potential methods for second trimester termination. Best practice and research clinical obstet and gynecol. 2020;63:24-36.

⁶ Mentula M, Niinimäki M, Suhonen S, et al. Immediate Adverse events after 2nd trimester termination of pregnancy. Human Reproduction. 2011;26(4):927-32.

⁷ Kerns. Disseminated Intravascular Coagulation and Hemorrhage After Dilation and Evacuation Abortion for Fetal Death. Obstet Gynecol. 2019;134,(4):708-713.

5.6/100,000, but jumped to 14/100,000 when performed ≥ 16 weeks. They compared this to the mortality rates of dangerous prostaglandin and saline instillation techniques (which are rarely performed today due to high risks of complications) of 9-13.9/100,000. The authors of the study noted that “the lower risk of dying from D&E compared with instillation techniques appears primarily related to the relative advantage of D&E in the 13–15-week period. After 15 weeks gestation, the death:case ratios for D&E and instillation abortions are quite similar.”⁸

Beyond 21 weeks, around the cutoff for fetal viability, the risk of maternal mortality from D&E exceeds the risk from childbirth.⁹ CDC data further document that the risk of mortality increases by 38% for each week an abortion is performed beyond eight weeks, reaching a 15-fold increase early in the second trimester, 30-fold increase in the mid-second trimester, and 76 fold after viability.¹⁰ Another CDC study documented that almost 20% of deaths occurred after abortions performed for “life of the mother” indications, demonstrating that even abortion may fail to save a mother who is seriously ill.¹¹

Experience of the physician also appears to impact risk because D&E is a very complex procedure. This fact was acknowledged by the Accreditation Council for Graduate Medical Education (ACGME) when it introduced a two-year fellowship-Complex Family Planning-to provide additional training for ob/gyns on this complicated procedure.¹² Whereas most high-volume abortionists report D&E complication rates of 4-7%,¹³ resident physicians in training documented 11% major complications (death, prolonged hospitalization, transfusion, exploratory surgery, stroke, heart attack, pulmonary embolus, and deep venous thrombosis), and had 24% readmission rates.¹⁴ Other studies document even higher complication rates: the University of California at San Francisco, a high-volume late abortion provider, reported 13% complications/10% hemorrhage for treatment of a late miscarriage with D&E, 10% complications/7% hemorrhage for D&E

⁸ Cates W, Grimes DA. Deaths from second trimester abortion by dilation and evacuation: causes, prevention, facilities. *Obstet Gynecol* 1981;58(4):401-408.

⁹ Epner. Late-term abortion. *JAMA*. 1998;280(8):724-729.

¹⁰ Bartlett, Berg, et al, Risk Factors for Legal Induced Abortion Related Mortality in the U.S. *OBG*. 2004;103:(4)729-737.

¹¹ Zane. Abortion-related mortality in the United States. 1998-2010. *Obstet Gynecol*. 2015;126(2):258-265

¹² ACGME. The complex family planning milestone project. Available at: <https://www.acgme.org/globalassets/pdfs/milestones/complexfamilyplanningmilestones2.0.pdf>, accessed September 29, 2026.

¹³ Peterson. Second trimester abortion by dilation and extraction: An analysis of 11,747 cases. *Obstet Gynecol*. 1983;63:185-190; Autry. A comparison of medical induction and dilation and evacuation for second trimester abortion. *AJOG*. 2002;187(2):393-397; Sonalkar. Comparison of complications associated with induction by misoprostol vs dilation and evacuation for second trimester abortion. *IJOG*. 2017;138(3):272-275.

¹⁴ Turok. Second trimester termination of pregnancy: a review by site and procedure type. *Contraception*. 2008;77(3):155-161.

abortion.¹⁵ Two recent studies documented hemorrhage rates of 52% and 51.2% after D&E using standard measures to prevent bleeding.¹⁶

A sobering look at what these complications look like can be obtained from the 1996 book, *Lime 5: Exploited by Choice*, written by an investigative journalist, documenting abortion complications recorded in medical malpractice cases. He was able to document 39% more deaths from abortion than the CDC reported during that time period,¹⁷ even though women and their families are usually hesitant to initiate a malpractice case following harm from abortion, due to shame and stigma, demonstrating the data deficiencies in the U.S. Centers for Disease Control (CDC) abortion-related maternal mortality reporting (to be discussed in more detail later). Deficiencies in pre-operative counseling, abortionists compromised by poor skills or substance abuse, egregious violations in standard practice resulting in fatal complications, and inadequate postoperative recovery care were all shown to be common factors in these poor outcomes. Uterine rupture resulting in lacerated intestines, compromised ureters, even damaged kidneys (located far from the uterus in the upper back) were all documented.¹⁸

As an example, the surgeon who performed a hysterectomy to save the life of one severely injured woman testified in court; “It would take a lot of force—an extreme amount of force—to do that kind of damage”. Regarding that case, the medical board stated that, “having nearly eviscerated his patient and with her clearly in critical condition, he sent her to the hospital in a private car during rush hours...A more egregious example of incompetence and gross negligence is difficult to imagine”.¹⁹

Even today, many abortion providers are unsupervised by organizations such as Planned Parenthood or National Abortion Federation,²⁰ and the political nature of abortion makes it unlikely that local health departments provide oversight unless reports of egregious violations of standard practice occur. This reality was recently

¹⁵ Kerns. Disseminated Intravascular Coagulation and Hemorrhage After Dilation and Evacuation Abortion for Fetal Death. *Obstet Gynecol.* 2019;134,(4):708-713.

¹⁶ Fairchild K, Altinok M, Kram J, et al. Using prophylactic antihemorrhagic medications in second trimester surgical abortions. *Obstet Gynecol.* 2022;140:663-666; Kerns. A randomized controlled trial of methergine after D&E abortion. *Contraception.* 2021;103:116-120.

¹⁷ Reardon D, Thorp J, Pregnancy Associated Death in record linkage studies relative to delivery, termination of pregnancy, and natural losses: A systematic review with a narrative synthesis and meta-analysis. *Sage Open Medicine.* 2017;5:1-17.

¹⁸ Mark Crutcher. *Lime 5: Exploited by Choice.* 1996. (Life Dynamics, Inc. Denton Texas) P 29

¹⁹ Mark Crutcher. *Lime 5: Exploited by Choice.* 1996. (Life Dynamics, Inc. Denton Texas) P 26.

²⁰ Abortion clinics near you. Available at <https://www.plannedparenthood.org/abortion-access?>, accessed December 15, 2022; National Abortion Federation membership, available at <https://prochoice.org/naf-membership/>, accessed December 15, 2022; Studnicki J, Longbons T, Fisher J, et al. Doctors who perform abortions: Their characteristics and patterns of holding and using hospital admitting privileges. *Health Serv Res Manag Epidemiol* 2019;6:1-8.

demonstrated in Pensacola, Florida, where an emergency suspension order was imposed on the Integrity Medical Care abortion clinic. The clinic was closed because of a finding by the Florida Agency for Health Care Administration that the clinic posed an “immediate serious danger to the public health.”²¹

In that clinic, one patient presented on March 23, 2022, for an abortion at 20 2/7 weeks gestation and her procedure was complicated by catastrophic bleeding. She was transferred to a local hospital where her pulse was undetectable, and she was responsive only to painful stimuli. She required an emergency hysterectomy for a ruptured uterus. Another patient presented on May 5, 2022, for an abortion at 19 6/7 weeks gestation. Her uterus was perforated during the procedure, causing her to bleed. She remained unmonitored for six hours, after which her husband was directed to take her to an emergency room across state lines (which presumably would not report the complication to Florida as mandated). On arrival, she was “hemodynamically unstable” and required “mass transfusion protocol to replace egregious blood loss.” When news was released that a third woman had been similarly seriously injured by the same provider, the abortionist’s medical license was finally suspended.²²

As the fetus becomes even bigger, D&E becomes harder to perform due to the difficulty in eviscerating and disarticulating the fetus, so the abortion provider may choose to perform an induction abortion. (On average, the unborn child weighs 300 grams and is 16 cm long at 20 weeks.)²³ The abortionist may induce labor with vaginal prostaglandins, intravenous Pitocin, or rarely, saline or prostaglandin intraamniotic infusion. Infection, hemorrhage, or retained tissue may require a surgical dilation and sharp or suction curettage afterward to treat these complications. Saline can also cause life-threatening electrolyte imbalances.²⁴

“The dreaded complication” of later labor induction abortions, the birth of a live baby, is rarely discussed, but may occur more frequently than acknowledged. European studies have documented that more than half of anomalous fetuses aborted between 20-24 weeks will survive the induction if feticide is not performed first.²⁵ There are several available methods by which the abortionist can kill the

²¹ State of Florida, Agency for Health Care Administration v Integrity Medical Care Emergency Suspension Order. 5/20/22.

²² Florida suspends medical license of abortionist after 3 women injured, citing ‘no gynecologic surgical training’. Available at: <https://www1.cbn.com/cbnnews/2022/august/fl-suspends-medical-license-of-abortionist-after-3-women-injured-citing-no-gynecological-surgical-training>, accessed September 27, 2022.

²³ Fetal growth chart. Available at <https://babyyourbaby.org/pregnancy/during-pregnancy/fetal-chart/>, accessed December 15, 2022.

²⁴ Mannistoa J, Mentula M, Bloiguc A, et al. Medical termination of pregnancy during the second versus the first trimester and its effects on subsequent pregnancy. *Contraception* 2014;89:109–115.

²⁵ Springer S. Fetal survival in mid trimester termination of pregnancy without feticide. *Obstet Gynecol.* 2018;131(3):575-579.

fetus before labor induction, but a recent survey of abortion providers demonstrated that 69% of abortion providers do not routinely provide feticide after 18 weeks gestation.²⁶ Feticide may occur by umbilical cord transection early in the procedure or may involve fetal intraamniotic or intracardiac potassium chloride or digoxin injection but entails additional risks to the woman if these potent cardiotoxic medications should enter her bloodstream.²⁷ A vocal abortion advocate advises against feticide, stating that women who request it are responding to misinformation, and are “inappropriately concerned about the potential for fetal pain, a biologic impossibility at these gestational ages”.²⁸ This conclusion is based on ideology rather than scientific evidence, as will be discussed shortly.

Forcibly opening a cervix that is designed to remain closed until natural childbirth may result in cervical trauma and cervical incompetence in future pregnancies. This weakened cervix may dilate early, predisposing the woman to premature rupture of membranes, intrauterine infections and possibly sepsis. Many statistically significant studies show a connection between abortion and preterm birth. One meta-analysis found that there was a 25 percent increased risk of premature birth in a subsequent pregnancy after one abortion, 32 percent after more than one, and 51 percent after more than two abortions.²⁹ Another meta-analysis found a 35 percent increased risk of delivery of a very low birth weight infant after one abortion, and 72 percent after two or more abortions.³⁰ Obstetrical interventions for the management of preterm birth, such as cesarean section, magnesium sulfate administration, and expectant management of ruptured membranes, raise the risk of maternal mortality. So sadly, both the mother and subsequent siblings of the aborted child are at higher risk after an abortion.

Instrumental trauma to the endometrium may result in faulty placentation in subsequent pregnancies. The Placenta Accreta Spectrum (PAS) is abnormal placentation in which the placenta invades into the cervix, uterine wall, or other adjacent organs. In 1950 the incidence of PAS was 1:30,000 deliveries but in 2016 the incidence was reported to be 1:272 deliveries. This 110-fold increase in incidence raises the risk of pregnancy-related mortality.³¹ Occurring more commonly in

²⁶ White. Second trimester surgical abortion practices in the U.S. *Contraception*. 2018;98:95-99.

²⁷ M Molaei. Effectiveness and Safety of Digoxin to Induce Fetal Demise Prior to Second Trimester Abortion. *Contraception*. 2008;77(3):223.

²⁸ Grimes DA, Stuart GS, Raymond EG. Feticidal digoxin injection before dilation and evacuation abortion: Evidence and ethics. *Contraception*. 2012;85:140-143.

²⁹ Swingle H, Colaizy R, Zimmerman M, Morriss F. Abortion and the risk of subsequent preterm birth: a systematic review and meta-analysis” *J Reprod Med* 2009;54:95-108.

³⁰ Liao H, Wei Q, Ge J, Zhou Y, Zeng W. Repeated medical abortions and the risk of preterm birth in the subsequent pregnancy. *Arch Gynecol Obstet* 2011;284:579-586.

³¹ Mogos MF, Salemi JL, Ashley M, Witeman VE, Salihu HM. Recent trends in placenta accreta in the United States and its impact on maternal-fetal morbidity and healthcare-associated costs, 1998-2011. *J Matern Fetal Neonatal Med* 2016;29:1077.

women with a history of uterine surgery, including induced abortion, PAS can cause massive hemorrhage. Deaths occur even in high-level hospitals, and the fortunate survivors often require transfusion of scores of units of blood to save their lives.³² Additionally, an insecure placental attachment can lead to premature separation-placental abruption-which can also put the lives of mothers and babies at risk.

When considering the safety of abortion in the U.S., it is important to be aware of the many data limitations affecting the accuracy of abortion statistics. Due to privacy concerns and out-of-pocket payment for most abortions, there is no accurate central governmental database that tracks the numbers and complications of this voluntarily reported procedure. For example, in the most recent year calculated (2020), the U.S. Centers for Disease Control (CDC), receiving data from the state health departments, reported 620,327 abortions,³³ whereas the Guttmacher Institute, receiving data directly from abortion providers, reported 930,160.³⁴ Some states (28) require abortion providers to report their complications, but there is rarely an enforced penalty for noncompliance. Even fewer states (12) require other physicians, coroners, or emergency rooms to report abortion-related complications or deaths for investigation.³⁵ Even when mandated, scant oversight and limited enforcement mechanisms allow abortion providers to avoid reporting their known complications. Often, frightened women with complications present to emergency rooms for treatment, often leading the abortion provider unaware that a complication occurred. Because abortion providers often do not maintain hospital privileges or travel to several clinics in disparate geographic areas,³⁶ they may be unable to care for hospitalized women even if they become aware of the complications. Since only 7-14% of gynecologists will perform an abortion, most abortions are performed by abortion providers for women with whom there is no previous (or subsequent) physician-patient relationship, making it less likely that the abortion provider will provide care for complications afterward. Additionally, when women are seen in emergency rooms, complications are frequently miscoded

³² Heather J Baldwin, Jillian A Patterson, Tanya A Nippita, Siranda Torvaldsen, Ibinabo Ibiebele, Judy M Simpson, Jane B Ford. Antecedents of Abnormally Invasive Placenta in Primiparous Women: Risk Associated With Gynecologic Procedures. *Obstet Gynecol* 2018;131:227-233.

³³ Kortsmit K, Nguyen AT, Mandel MG, et al. Abortion Surveillance — United States, 2020. *MMWR Surveill Summ* 2022;71(No. SS-10):1–27.

³⁴ Abortion incidence and service availability. Available at <https://www.guttmacher.org/article/2022/11/abortion-incidence-and-service-availability-united-states-2020>, accessed December 19, 2022.

³⁵ Overview of abortion laws. Available at <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>, accessed December 9, 2022.

³⁶ Studnicki J, Longbons T, Fisher JW. Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges. *Health Services Research and Managerial Epidemiology*. 2019;6:1-8.

as resulting from miscarriages rather than abortion,³⁷ leaving epidemiologists unable to accurately estimate complications from hospital chart reviews.

The claim that abortion is safer than other commonly performed procedures, such as wisdom tooth extraction and tonsillectomy, is not supported by complete and reliable data. This allegation has been made by an outspoken abortion advocacy organization, Advancing New Standards in Reproductive Health (ANSIRH).³⁸ They also claim that abortion at any time in pregnancy is safer than childbirth. To make these comparisons, abortion advocates ignore the known serious deficiencies in abortion safety statistics. Many studies are performed by researchers employed by the abortion industry and their ideological colleagues implying that abortion is extremely safe for women. Due to the political nature of abortion in the United States and the voluntary reporting of complications, the data derived largely from the abortion industry must be examined with some skepticism.³⁹

Recent studies documenting apparent low complication rates have been performed by high-volume abortionists and do not reflect the quality of all abortion providers in the U.S.⁴⁰ Additionally, these pro-choice researchers make the undocumented assumption that the large numbers of women lost to follow-up have had uncomplicated abortions, undoubtedly leading to underestimations of abortion complications.⁴¹

As an example, a frequently referenced 2015 study performed by prominent abortion advocates from Advancing New Standards in Reproductive Health (ANSIRH), reported that only 0.87% of 54,911 women receiving California Medi-Cal financed abortions presented to an emergency room with an abortion complication within six weeks.⁴² However, a similar but larger records-linkage study of 423,000 Medicaid financed abortions in seventeen states, documented 2.2% of women presented to an ER with a surgical abortion related complication, and 5.2%

³⁷ Studnicki J, Harrison DJ, Longbons T, et al. A longitudinal cohort study of emergency room utilization following mifepristone chemical and surgical abortions, 1999-2015. *Health Serv Res Manag Epidemiol* 2021;8:1-8.

³⁸ ANSIRH Issue Brief #6, December 2014. Safety of abortion in the United States. Accessed at <https://www.ansirh.org/sites/default/files/publications/files/safetybrief12-14.pdf> June 13, 2022.

³⁹ Studnicki J, Reardon D, Harrison D, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. *Online Journal of Public Health Informatics*. 2019;11(2):e17; Skop I. Abortion safety at home and abroad. *Issues in Law & Medicine*, 2019;34(1):43-75.

⁴⁰ Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. *Obstet Gynecol*. 2015;126:22-28; Cleland K, Creinin M, Nucatola D. Significant adverse events and outcomes after medical abortion. *Obstet Gynecol* 2013;121:167-171.

⁴¹ Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. *Obstet Gynecol*. 2015;126:22-28.

⁴² Upadhyay U, Desai S, Zlidar V, et al. Incidence of emergency department visits and complications after abortion. *Obstet Gynecol* 2015;125:175-83.

presented with a medical abortion related complication within thirty days.⁴³ What accounts for the disparity between those two results? The study performed by the abortion advocates only recorded complications with a diagnostic code specifically related to abortion (ICD-9 635.0-635.82).⁴⁴ The independent researchers looked at all pregnancy related codes documenting complications (ICD-9 630-639, because they had previously documented that all the women had abortions, thus all pregnancy complications were caused by abortion, even if not coded as such). These same researchers documented that 60% of known abortion related complications in 2015 were miscoded as due to miscarriages, further documenting deficiencies in abortion complication detection.⁴⁵

It is well established that the CDC has incomplete statistics regarding abortion-related maternal mortality because most of their data is obtained from maternal death certificates, and maternal death certificates frequently do not document preceding pregnancies, especially early pregnancy events such as abortion or miscarriage.⁴⁶ Even if related to childbirth, at least 50% of maternal deaths are not reported as pregnancy-related on death certificates.⁴⁷ Mortality from events in the first half of pregnancy, which are unable to be linked to a birth certificate, are even more difficult to detect, but high-quality records-linkage studies from Finland document that 73% of all maternal deaths and 94% of abortion-related deaths are not documented as such on the maternal death certificate.⁴⁸ Relying primarily on death certificate data as the CDC does will inevitably undercount maternal deaths.

Thus, the frequent assertion that legal abortion is far safer than childbirth is based on conjecture by researchers associated with the abortion industry. A close analogy would be if the U.S. had allowed the tobacco industry to control the studies and narrative regarding the safety of smoking. The data regarding abortion-related

⁴³ Studnicki J, Harrison DJ, Longbons T, et al. A longitudinal cohort study of emergency room utilization following mifepristone chemical and surgical abortions, 1999-2015. *Health Serv Res Manag Epidemiol* 2021;8:1-8.

⁴⁴ Upadhyay U, Desai S, Zlidar V, et al. Incidence of emergency department visits and complications after abortion. *Obstet Gynecol* 2015;125:175-83.

⁴⁵ Studnicki J, Harrison DJ, Longbons T, et al. A longitudinal cohort study of emergency room utilization following mifepristone chemical and surgical abortions, 1999-2015. *Health Serv Res Manag Epidemiol* 2021;8:1-8.

⁴⁶ Studnicki, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. *Online Journal of Public Health Informatics*. 2019;11(2):e17; Marmion P, Skop I. Induced abortion and the increased risk of maternal mortality. *The Linacre Quarterly*. 2020;87(3):302-310; Jatlaoui TC, Boutot ME, Mandel MG, et al. Abortion Surveillance-United States 2015. *Surveillance Summaries*. 2018;67(13):1-45, accessed August 1, 2022.

⁴⁷ Horon IL. Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality. *AJ of Public Health*. 2005;95:478-82; Deneux-Tharoux C, Berg C, Bouvier-Colle MH, et al. Underreporting of pregnancy related mortality in the U.S. and Europe. *Obstet Gynecol*. 2005;106(4):684-692.

⁴⁸ Gissler M, Berg C, Bouvier-Colle MH, Buekens F. Methods for identifying pregnancy associated deaths: Population based data from Finland 1987-2000. *Pediatric and Perinatal Epidemiology*. 2004;18:448-455. DOI:10.1111/j.1365-3016.2004.00591.x; Gissler M, Berg C, et al, Pregnancy Associated Mortality After Birth, Spontaneous Abortion or Induced Abortion in Finland. 1987-2000. *AJOG* 2004;190:422-427.

complications and maternal mortality is similarly compromised. The authors of one misleading study claiming that deaths from childbirth occur fourteen times as often as deaths following abortion are vocal abortion advocates who are well aware of the limitations of the data the CDC used. The study used four disparate and difficult to calculate numbers with non-comparable denominators: abortion-related deaths were compared to the number of legal abortions, maternal deaths were compared to the number of live births.⁴⁹ Comparing a maternal mortality ratio to an abortion mortality rate is a meaningless exercise, even if all deaths following all pregnancy events were accurately recorded, which abundant data demonstrates is not the case.⁵⁰ Confident assertions about mortality from the various pregnancy outcomes just cannot be made with certainty in the U.S.⁵¹

Just one example of abortion-related mortality misattribution is a well-publicized case from New Mexico. Keisha Atkins died while undergoing an induction abortion at 24-weeks gestation. She developed a uterine infection and rapidly decompensated. She was taken to the operating room for completion of the abortion where she died of a cardiac arrest. Her death certificate lists her cause of death as “pulmonary embolism due to pregnancy”.⁵² Based on this diagnosis, her death would be recorded by the CDC as a pregnancy-related death, not an abortion-related death, even though it was clearly the latter.

The definition of maternal mortality encompasses all deaths that occur up to a year from the end of the pregnancy. While catastrophic complications directly related to the pregnancy separation event are more likely to be detected, mental health complications remote from the event are likely not to be detected or attributed to the method in which the pregnancy was resolved. Yet, one finding in the investigation of recent increases in U.S. maternal mortality is the increase in “deaths of despair”—substance abuse and overdose, suicides, homicides, and excessive risk-taking behavior.⁵³ Mental health issues may contribute to drug

⁴⁹ Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. *Obstet Gynecol* 2012;119:215–9; David A Grimes. <https://www.huffpost.com/author/david-a-grimes> accessed December 9, 2022.

⁵⁰ Studnicki, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. *Online Journal of Public Health Informatics*. 2019;11(2):e17; Marmion P, Skop I. Induced abortion and the increased risk of maternal mortality. *The Linacre Quarterly*. 2020;87(3):302-310; Jatlaoui TC, Boutot ME, Mandel MG, et al. Abortion Surveillance-United States 2015. *Surveillance Summaries*. 2018;67(13);1–45, accessed August 1, 2022.

⁵¹ Reardon D, Strahan T, and Thorp J. Deaths Associated with Abortion Compared to Childbirth-A Review of New and Old Data and the Medical and Legal Implications. *J. Contemp. Health Law & Policy*. 2004;20(2):1-51; Mark Crutcher. *Lime 5: Exploited by Choice*. Life Dynamics, Inc. Denton, TX. 1996.

⁵² Keisha Adkins’ autopsy report. Available at <https://abortiondocs.org/wp-content/uploads/2017/08/Autopsy-Report-Keisha-Atkins.pdf>, accessed August 31, 2022.

⁵³ MacDorman MF, et al. Recent Increases in the U.S. Maternal Mortality Rate Disentangling Trends From Measurement Issues. *Obstet Gynecol* 2016;128:447–55.

overdoses, suicides, homicides, or even accidents due to risk-taking behavior, but current systems of data collection are not capable of linking these events to induced abortion.

Better quality data than the CDC reports can be obtained from records-linkage studies, where all deaths in reproductive aged women are linked to records on all pregnancy outcomes. When this analysis is applied to this question, a far different result is obtained: deaths are more frequent in the year following abortion than childbirth.⁵⁴

An eight-year retrospective California study showed that women who aborted had significantly higher age-adjusted risks of death from all causes (162%) and suicide (254 %) compared to those who delivered a baby.⁵⁵ Comprehensive record linkage studies from Finland found that following an abortion, a woman was two to four times as likely to die within a year, six times as likely to commit suicide, four times as likely to die from an accident, and fourteen times as likely to be murdered, compared with a woman who carried to term.⁵⁶ Similar results have been documented in Danish studies, with a 39% increased risk of death after first-trimester abortions and a 341% increased risk after later abortions.⁵⁷

Mental health complications, including anxiety, depression, substance and alcohol abuse, and suicide are higher after abortion, particularly late or coerced abortions, or if there are pre-existing mental health issues. European records-linkage studies document a woman has six times the risk of suicide in the year following abortion compared to childbirth. Unfortunately, the U.S. CDC does not even attempt to link mental health deaths to abortion in its dramatically incomplete maternal mortality data.

Abortion advocates frequently allege that abortion has no deleterious effects on mental health. It is the case that many women seek abortion during a social crisis,

⁵⁴ Reardon D, Strahan T, and Thorp J. Deaths Associated with Abortion Compared to Childbirth-A Review of New and Old Data and the Medical and Legal Implications. *J. Contemp. Health Law & Policy*. 2004;20(2):1-51.

⁵⁵ Reardon DC, Ney PG, Scheuren F, Cogle J, Coleman PK, Strahan TW. Deaths associated with pregnancy outcome: a record linkage study of low-income women. *South Med J* 2002;95:834-841.

⁵⁶ Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland, 1987-94. Register linkage study. *Br Med J* 1996;313:1431-1434; Karalis E, Ulander V, Tapper A, Gissler M. Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy associated deaths in Finland 2001-2012. *BJOG* 2017;124:1115-1121; Gissler M, Berg C, Bouvier-Collie M, Buekens P. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *Eur J Public Health* 2005;15:459-463; Gissler M, Kaupilla R, Merilainen J, Toukoma H, Hemminki E. Pregnancy-associated deaths in Finland, 1987-1994—definition problems and benefits of record linkage. *Acta Obstet Gynecol Scand* 1997;76:651-657.

⁵⁷ Reardon DC, Coleman PK. Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004. *Med Sci Monit* 2012;18(9):71-76; Coleman PK, Reardon DC, Calhoun B. Reproductive History Patterns and Long-term Mortality Rates: A Danish population-based record linkage study. *Eur J of Public Health*.

which may predispose them to mental health complications and make direct causation difficult to prove. But the unambiguous assertion of many abortion advocates that there could not possibly be any harm to a woman from abortion has not been proven. Unfortunately, many professional medical organizations have a pro-choice bias which affects their interpretation of the literature. The American Psychological Association (APA) tried to reassure the public with their 2008 statement: “There is no credible evidence that a single, elective abortion of an unwanted pregnancy, in and of itself, causes mental health problems for the adult woman.”⁵⁸ The APA has previously shown its bias on abortion, when it stated in 1969, “Termination of pregnancy should be considered a civil right of a pregnant woman.”⁵⁹ Nonetheless, the APA’s claim is misleading. Most women obtaining abortions are excluded by the APA’s claim. In fact, 40-50 percent of American post-abortive women have had multiple abortions.⁶⁰ Some 20-60 percent of women obtaining abortions may desire their pregnancy but experience pressure or coercion to terminate.⁶¹ Some women terminate a desired pregnancy due to perceived health risks for themselves, or abnormalities in the baby. Minor women account for 15-30 percent of abortions⁶² and one study showed that these young women have a ten times higher suicide rate than their peers.⁶³ An abortion may trigger or aggravate preexisting mental health conditions held by 20-50 percent of women who undergo the procedure.⁶⁴ A late abortion is also a significant risk factor for psychological problems.⁶⁵ Thus, the APA’s claim does not address a significant segment of woman who are known to be at a higher risk of mental health complications.⁶⁶

Abortion advocates frequently reference the “Turnaway Study”, a series of dozens of scientific papers from a cohort seeking abortions, some of whom were denied an

⁵⁸ Report of the American Psychological Association Task Force on Mental Health and Abortion. 2008. <https://www.apa.org/pi/women/programs/abortion/mental-health.pdf>. Accessed June 17, 2022.

⁵⁹ American Psychological Association. Abortion resolutions 1969. <https://www.apa.org/about/policy/abortion>. Accessed June 17, 2022.

⁶⁰ United States Abortion. <https://www.guttmacher.org/united-states/abortion>, accessed June 17, 2022; M. Tornbom et.al. Repeat Abortion: A Comparative Study. *Journal of Psychosomatic Obstetrics and Gynecology* 1996;17:208-214.

⁶¹ Rue V, Coleman P, Reardon DC, Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Med Science Monitor*. 2004;10(10)SR5-16.

⁶² United States Abortion. <https://www.guttmacher.org/united-states/abortion>, accessed June 17, 2022.

⁶³ Garfinkel. Stress, Depression and Suicide: A Study of Adolescents in Minnesota. *Univ of Minnesota Extension Service* 1986; Mota NP, Sareen BM. Associations between abortion, mental disorders, and suicidal behavior in a nationally representative sample. *Canadian J of Psychiatry*. 2010;55(4):239-247.

⁶⁴ Women and mental health. <https://www.nimh.nih.gov/health/topics/women-and-mental-health/index.shtml>, accessed June 17, 2022.

⁶⁵ Lalitkumar. Mid-trimester induced abortion: A review. *Hum Rep Update*. 2007;13(1):37-52.

⁶⁶ Coleman PK, et al. Women who suffered emotionally from abortion: a qualitative synthesis of their experiences. *J of American Physicians and Surgeons*. 2017;22(4):113-118; Reardon D. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *Sage Open Medicine*. 2018;6:1-38.

abortion due to an advanced gestational age. These researchers reportedly found that mental health outcomes were worse in those denied abortion, and that 95% of those who obtained an abortion did not regret their decision.⁶⁷ Yet, the study had many methodological flaws, most notably the poor participation rate. Only a small fraction of women obtaining abortions in 29 clinics were included in the study cohort. Less than half of the screened women were invited to participate, leaving one to wonder if those suspected of having a more severe emotional response might have been prescreened out. Only 39.4% of the invited women agreed to participate, and only 516 women (a very small sample size) remained in the study for the planned five years (basing conclusions on only seventeen percent of eligible participants). It is likely that women who found the abortion experience particularly stressful would decline to participate and revisit their traumatic experience, and even the study authors acknowledged that these women were self-selected to be those most confident in their decision.⁶⁸ The study did not control for other confounding factors, such as mental health history or history of other abortions, and the study did not record key data like gestational ages or numbers participating in each arm of the study group.⁶⁹ In an international study that did control for these factors (and had a much higher retention rate of eighty-eight percent), the risks of mental health disorders were found to be thirty percent higher in women who procured abortions than in those who did not.⁷⁰ While the small Turnaway cohort and the many studies it has spawned have received much media attention, extensive literature has been ignored which demonstrates that abortion increases the risk for mental health problems including substance abuse, anxiety, depression, suicidal ideation, and suicide.⁷¹

⁶⁷ www.anshirh.org/research/turnaway-study, accessed November 11, 2019; Rocca C. Women's emotions one week after receiving or being denied an abortion in the U.S. *Persp on Sexual and Reproductive Health*. Aug 2013; Foster D, et al. A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychol. Med.* 2015;45(10):2073-2082; Biggs MA, et al. Does abortion increase women's risk for post-traumatic stress? Findings from a prospective longitudinal cohort study. *BMJ Open*. 2016;6:e009698.

⁶⁸ Dobkin L, et al. Implementing a prospective study of women seeking abortion in the U.S.: Understanding and overcoming barriers to recruitment. *Women's Health Issues*. 2014;24(1):e115-123.

⁶⁹ Reardon, D. C. The Embrace of the Pro-Abortion Turnaway Study. *Wishful Thinking? or Willful Deceptions?* *Linacre Quarterly*. 2018;25(3):204-212; Coleman PK. The Turnaway study: A case of self-correction in science upended by political motivation and unvetted findings. *Frontiers in Psychology*. 2022;13:905221.

⁷⁰ Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders, evidence from a 30-year study. *BJPsychiatry*. 2008;193(6):444.

⁷¹ Coleman, P. K. Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: individual and Family Predictors and Psychological Consequences. *J. Youth Adolesc.* 2006;35:903-911; Coleman, P. K. Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. *Br. J. Psychiatry* 2011;199:180-186; Coleman, P. K., Coyle, C. T., and Rue, V. M. Late-term elective abortion and susceptibility to posttraumatic stress symptoms. *J. Pregnancy* 2010:130519; Coleman, P. K., and Nelson, E. S. The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion

A woman and her unborn child are not natural enemies-most pregnancies end in delivery of a healthy child to a healthy mother. It is misleading to say that elective abortion is healthcare. Healthcare is defined as “maintenance and restoration of the health of the body or mind”. Prenatal care and delivery of babies is healthcare. Disrupting the normal physiologic process of pregnancy and ending the life of an unborn human being by induced abortion is the very antithesis of healthcare. Only 7-14% of obstetricians say they will perform an abortion when requested by their patient.⁷² If abortion was necessary for a woman’s health, every obstetrician would be willing to perform that intervention.

Many media sources have erroneously suggested that laws limiting elective abortion prevent physicians from providing medical care—including abortion—when a patient’s life is threatened. Yet, every pro-life law in effect allows an exclusion for a "medical emergency" usually defined as “a condition that, in reasonable medical judgment, so complicates the medical condition of a pregnant woman that it necessitates (abortion) in order to avert the woman's death or prevent a serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions”.

However, it is unusual for a physician to need to resort to an abortion when complications arise during pregnancy. A cesarean section or labor induction are readily available when a woman experiences a complication with her pregnancy that requires separation of mother and baby. Indeed, for nearly any serious pregnancy complication that arises after the point of viability, a cesarean section or labor induction will be the most effective remedy. If the pregnancy is causing a serious health concern for the mother, delivering the baby will address the underlying health issue, while also providing the baby with the best opportunity for survival. Delivery is also far preferable to a dilation and evacuation abortion because it is faster and more widely available and shows respect for the unborn human life. Once a physician determines that separation of mother and baby is necessary, a cesarean section can usually be performed within 30 minutes. If the

attitudes. *J. Soc. Clin. Psychol.* 1998;17:425–442; Coleman, P. K., Reardon, D. C., Rue, V. M., and Cogle, J. A history of induced abortion in relation to substance use during subsequent pregnancies carried to term. *Am. J. Obstet. Gynecol.* 2002;187:1673–1678; Coleman, P. K., Reardon, D. C., Rue, V. M., and Cogle, J. State-funded abortions versus deliveries: a comparison of outpatient mental health claims over 4 years. *Am. J. Orthopsychiatry* 2002;72:141–152; Coleman, P. K., Reardon, D. C., Strahan, T., and Cogle, J. R. The psychology of abortion: A review and suggestions for future research. *Psychol. Health* 2005;20:237–271; Cogle, J. R., Reardon, D. C., and Coleman, P. K. Depression associated with abortion and childbirth: a long-term analysis of the NLSY cohort. *Med. Sci. Monit.* 2003;9:Cr105–Cr112.

⁷² Desai S, Jones R, Castle K. Estimating abortion provision and abortion referrals among United States obstetricians and gynecologists in private practice. *Contraception* 2018;97:297-302; Stuhlberg DB, Dude AM, Dahlquist I, Curlin FA. Abortion provision among practicing obstetrician-gynecologists. *Obstet Gynecol* 2011;118(3):609-614.

situation is less immediately urgent, labor induction is also an option.⁷³ Both interventions can be performed in any hospital environment providing obstetric care, as all ob/gyns are trained to perform these procedures. In fact, cesarean sections account for nearly a third of all U.S. deliveries currently.⁷⁴

To be sure, even in these scenarios, it may not always be possible to save the baby's life. But taking steps like labor induction or cesarean section will give the baby the best opportunity for survival, whereas resorting to abortion eliminates any opportunity for the baby's survival. Perinatal hospice services are also available in many hospital systems, whereby a multidisciplinary team comforts and supports the fragile child and his family, even if he is too young or sick to survive.⁷⁵ Consistent evidence supports improved mental health outcomes for women and families following this more caring approach.⁷⁶

Such pre-viability deliveries are rare. Deliveries between 20 and 26 weeks, either due to spontaneous labor or medical intervention for serious maternal complications are estimated to comprise only 0.5% of all births.⁷⁷ Moreover, often when life-threatening situations arise before the point of viability, temporary medical interventions, such as antihypertensive treatments, antibiotics, bedrest and other measures may allow delay of delivery until viability has been reached, and then delivery can occur through standard obstetric interventions as mentioned above.

The American College of Obstetrics and Gynecology (ACOG) has created comprehensive guidance for management of many obstetric and gynecologic conditions, and I will discuss how this guidance may be applied in some life-threatening conditions below.

It should not be necessary to address miscarriage management because a straightforward reading of laws limiting abortion of a living fetus provide clear evidence that treatment of miscarriage is not prohibited by law (as the intent is to remove a deceased fetus); nonetheless, widespread confusion and anecdotes of

⁷³ Defining the end of pregnancy. American Association of Pro-Life Obstetricians and Gynecologists. Practice Bulletin 10. <https://aaplog.org/resources/practice-guidelines/>, Accessed June 17, 2022.

⁷⁴ Births – Method of Delivery, Centers for Disease Control & Prevention, <https://www.cdc.gov/nchs/fastats/delivery.htm>.

⁷⁵ Perinatal Palliative Care. American Association of Pro-Life Obstetricians and Gynecologists. Practice Bulletin 1. <https://aaplog.org/resources/practice-guidelines/>, Accessed December 14, 2022; Premature Delivery is Not Induced Abortion. American Association of Pro-Life Obstetricians and Gynecologists. <https://aaplog.org/premature-delivery-is-not-induced-abortion/>. Accessed December 14, 2022.

⁷⁶ Korenromp MJ, Page-Christiaens gCML, Van den Bout J, Mulder EJH, Visser GHA. Adjustment to termination of pregnancy for fetal anomaly: a longitudinal study in women at 4, 8, & 16 months. *Am J Obstet Gynecol* 2009;201:160.e1-7; Janssen HJ, Cuisinier MC, Hoogduin KA, de Graauw KP. Controlled prospective study on the mental health of women following pregnancy loss. *Am J Psychiatry* 1996;153:226-230.

⁷⁷ ACOG Obstetric Care Consensus: Periviable Birth. *Obstet Gynecol.* 2017;130(4):e187-e199.

denied care necessitate discussion of miscarriage treatment, which can be similar to interventions used to provide elective abortion.

For management of a miscarriage, ACOG recommends, “Accepted treatment options for early pregnancy loss include expectant management, medical treatment, or surgical evacuation” (p. 198). “Patients should be counseled about the risks and benefits of each option...Because of a lack of safety studies of expectant management in the second trimester and concerns about hemorrhage, expectant management generally should be limited to gestations within the first trimester” (p. 199). “Women who present with hemorrhage, hemodynamic instability, or signs of infection should be treated urgently with surgical uterine evacuation” (p. 201). “In patients for whom medical management of early pregnancy loss is indicated, initial treatment using 800 micrograms of vaginal misoprostol is recommended, with a repeat dose as needed. The addition of a dose of mifepristone (200 mg orally) 24 hours before misoprostol administration may significantly improve treatment efficacy and should be considered when mifepristone is available” (p. 203).⁷⁸

Additionally, treatment of an ectopic pregnancy should not cause confusion. While not all state laws explicitly exclude the treatment of ectopic pregnancy from the definition of abortion, its treatment is otherwise covered in any “life of the mother” exception. A failure to treat an ectopic pregnancy will inevitably lead to the death of the baby and possibly the death of the mother and has therefore never been considered abortion.

“Ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity” (p. 91). “In clinically stable women in whom a nonruptured ectopic pregnancy has been diagnosed, laparoscopic surgery or intramuscular methotrexate administration are safe and effective treatments. The decision for surgical or medical management of ectopic pregnancy should be guided by the initial clinical, laboratory and radiologic data as well as patient-informed choice based on a discussion of the benefits and risks of each approach. Surgical management of ectopic pregnancy is required when a patient is exhibiting any of the following: hemodynamic instability, symptoms of an ongoing ruptured ectopic mass (such as pelvic pain) or signs of intraperitoneal bleeding” (p. 99).⁷⁹

Hypertension: Some women experience severe hypertensive emergencies during pregnancy (preeclampsia/eclampsia), which can lead to severe maternal complications such as hematologic abnormalities, seizures, stroke, and liver rupture, although these events rarely occur before fetal viability (and by definition are not considered to be preeclampsia unless they occur after twenty weeks). This condition can usually be treated without abortion. As ACOG recognizes, “[d]elivery

⁷⁸ ACOG Practice Bulletin 200: Early Pregnancy Loss. *Obstet Gynecol.* 2018;132(5):197-207.

⁷⁹ ACOG Practice Bulletin 193: Tubal Ectopic Pregnancy. *Obstet Gynecol.* 2018;131(3):91-103.

is recommended when gestational hypertension or preeclampsia with severe features is diagnosed at or beyond 34 0/7 weeks of gestation, after maternal stabilization or with labor or prelabor rupture of membranes... The expectant management of preeclampsia with severe features before 34 0/7 weeks of gestation is based on strict selection criteria of those appropriate candidates and is best accomplished in a setting with resources appropriate for maternal and neonatal care. Because expectant management is intended to provide neonatal benefit at the expense of maternal risk, expectant management is not advised when neonatal survival is not anticipated” (p. 252). In other words, ACOG supports maternal fetal separation (which can be done by abortion or labor induction) if this crisis occurs before the fetus can survive. After viability, ACOG agrees that delivery, not abortion is the appropriate treatment.⁸⁰

Periviable Premature Rupture of Membranes (“PPROM”). Some women also experience PPROM, which occurs when the amniotic membrane ruptures in the absence of labor but before the fetus can survive if delivered. This is a severe complication, which can pose serious health risks to the mother and child. Again, however, it is very rare. My 20-physician group practice cares for a woman in such a situation perhaps 2-4 times in a year.

ACOG advises, “Women presenting with PROM before neonatal viability should be counseled regarding the risks and benefits of expectant management versus immediate delivery. Counseling should include a realistic appraisal of neonatal outcomes. Immediate delivery (termination of pregnancy by induction of labor or dilation and evacuation) and expectant management should be offered. Physicians should provide patients with the most current and accurate information possible” (p. 88).⁸¹

PPROM is a complicated situation. The prognosis for the fetus is poor: the risk of stillbirth is 36% and about 46% of liveborn babies will die within the first month.⁸² Even if he reaches the point of viability, the lack of amniotic fluid may cause his lungs to fail to mature, leaving him unable to breathe when delivered. Additionally, the risk of infection (chorioamnionitis) for the mother is very high. Even if she does not show obvious evidence of infection, it is likely that a subclinical infection is already present, and may have been the event that caused the membranes to rupture. Microscopic examination documents evidence of infection in 94% of

⁸⁰ ACOG Practice Bulletin 222: Gestational Hypertension and Preeclampsia. *Obstet Gynecol* 2020;135(6):237-260; ACOG Practice Bulletin 203: Chronic Hypertension in Pregnancy. *Obstet Gynecol* 2019;133(1):26-50.

⁸¹ ACOG Practice Bulletin 217: Prelabor Rupture of Membranes. *Obstet Gynecol* 2020;135(3):80-97.

⁸² Sim WH, et al. Maternal and neonatal outcomes following expectant management of of preterm prelabor rupture of membranes before viability. *J Perinat Med.* 2017;45(1):29-44; Kibel M, et al. Outcomes of pregnancies complicated by preterm premature rupture of membranes between 20 and 24 weeks gestation. *Obstet Gynecol.* 2016;128(2):313-320.

placentas in the setting of PPROM between 21-24 weeks gestation.⁸³ The risk to the mother of developing a more serious infection, if the pregnancy continues, is high (up to 71%), and may progress to sepsis (overwhelming blood infection) or even maternal death.⁸⁴

To be clear, because the likelihood for progression to life-threatening sepsis for the mother is high, and the prognosis for continued extra-uterine life for the fetus is poor, the law allows an exception where an abortion is necessary to preserve the “life of the mother”. Offering immediate delivery by induction or by induced abortion is supported by ACOG’s medical guidance. In this rare situation, abortion is permissible by state law, as necessary to prevent the mother’s death.

Occasionally women will choose expectant management—i.e., no intervention except watchful waiting and antibiotics—in hopes of reaching delivery at a viable age, and this option is also supported by ACOG guidance if clinical infection is not present. But, refusing to offer the option of intervention in this circumstance is not supported by this law, which would permit intervention because of the likelihood it that PPROM could become life-threatening for the mother. Physicians at Southwestern Medical School demonstrated this reality recently, when they misinterpreted Texas law and declined to offer 26 women with PPROM immediate intervention. The results were predictably poor: 57% of the women experienced serious morbidity and only one of the babies remains alive.⁸⁵

Maternal heart disease. Some mothers experience complications from heart disease, which may vary from mild to life-threatening. ACOG documents what constitutes “Life-threatening Maternal Heart Disease”, advising, “[p]Patients should be counseled to avoid pregnancy or consider induced abortion if they have severe heart disease, including an ejection fraction below 30% or class III/IV heart failure, severe valvular stenosis, Marfan Syndrome with aortic diameter more than 45 mm, bicuspid aortic valve with aortic diameter more than 50 mm, or pulmonary arterial hypertension”. Consistent with this law, these patients may be offered immediate abortion when their pregnancy is diagnosed due to the high likelihood of death as the physiologic changes of pregnancy progress. In such rare cases, an abortion may be necessary to prevent the death of the pregnant woman, and thus would fall within this law’s exception.

⁸³ Kim JC, et al. Acute chorioamnionitis and funisitis: definition, pathologic features, and clinical significance. *Am J Obstet Gynecol.* 2015;213(40):S29-S52.

⁸⁴ Margato MF, et al. Prevalable preterm rupture of membranes: gestational and neonatal outcomes. *Arch Gynecol Obstet.* 2012;285(6):1529-1534.

⁸⁵ Nambiar A, et al. Maternal morbidity and fetal outcomes among pregnant women at 22 weeks gestation or less with complications in two Texas hospitals after legislation on abortion. *Am J Obstet Gynecol.* 2022; doi: <https://doi.org/10.1016/j.ajog.2022.06.060>.

ACOG continues, “[p]atients with moderate and high risk cardiovascular disease should be managed during the pregnancy, delivery and the postpartum period in medical centers with a multidisciplinary Pregnancy Heart Team that includes obstetric providers, maternal fetal medicine subspecialists, cardiologists, and an anesthesiologist at a minimum...A personalized approach estimating the maternal and fetal hazards related to the patient’s specific cardiac disorder and the patient’s pregnancy plans can provide anticipatory guidance to help support her decision making” (p. 346). In other words, in serious but not life-threatening cardiac conditions, careful multidisciplinary care should be provided, and the fetus a woman can be delivered or aborted if the care team agrees that pregnancy has begun to pose a risk to a woman’s life. And again, consistent with this law, the fetus can be aborted in this situation if necessary to save the woman’s life. Still, it should be noted that medical or procedural treatments are available in many instances to improve cardiac function, allowing a woman to continue her pregnancy until childbirth.⁸⁶

Placenta accreta spectrum. Women may also experience Placenta Accreta Spectrum, when the placenta becomes abnormally invasive, extending into the uterine musculature, cervix, or surrounding organs. When this occurs and the woman desires to continue her pregnancy to birth, she is followed closely by high-risk obstetric specialists and delivery is arranged in a tertiary medical center where a multidisciplinary team and well-stocked blood bank are immediately available if catastrophic bleeding occurs. ACOG similarly provides guidance for dealing with Placenta Accreta Spectrum, “When the diagnosis of placenta accreta spectrum is made in the previable period, it is important to include counseling about the possibility of pregnancy termination for maternal indications given the significant risk of maternal morbidity and mortality. However, there are currently no data to support the magnitude of risk reduction, if any. Further, pregnancy termination in the setting of placenta accreta spectrum also carries risk, and the complexities of counseling should be undertaken by health care providers who are experienced in these procedures” (p. 263-264). This extremely high-risk condition is associated with frequent hysterectomies if the fetus is carried to childbirth, but as ACOG notes, there is no data to support the magnitude of risk reduction afforded by abortion versus continuing the pregnancy. Introducing surgical instruments through a placenta previa (which covers the cervical opening) to perform a D&E abortion may itself cause immediate and catastrophic hemorrhage. Of course, if active catastrophic bleeding is occurring, a cesarean section delivery is the quickest and most effective way to immediately control the bleeding.⁸⁷

⁸⁶ ACOG Practice Bulletin 212: Pregnancy and Heart Disease. *Obstet Gynecol* 2019;133(5):320-356.

⁸⁷ ACOG Obstetric Care Consensus 7. Placenta Accreta Spectrum. *Obstet Gynecol* 2018;132:259-275.

Critically ill patients. There are sometimes situations when a mother will experience a serious illness during pregnancy that is not itself caused by the pregnancy but nonetheless threatens her life. This may require treatment in an Intensive Care Unit (ICU). But once again, this does not mean that abortion is the necessary treatment. Rather, the treatment options will vary depending on the illness and organ systems affected. Most of the time, care for the ill mother through circulatory, respiratory, renal dialysis or other organ system support will protect her life and allow recovery from the initiating illness without ever resorting to delivery, much less abortion. In these circumstances, ACOG advises: “[b]ecause the risk benefit considerations for continued pregnancy versus delivery are likely to change as the pregnancy and critical illness progress, the care plan must be reevaluated regularly. In situations when there is an acute deterioration in the patient’s clinical condition, immediate reassessment of continuing the pregnancy versus delivery should be undertaken” (p 308). “When obstetric patients are transferred to the ICU, patient care decisions including mode, location and timing of delivery ideally should be made collaboratively between the intensivist, obstetrician-gynecologist, and neonatologist, and should involve the patient and her family when possible” (p. 314). Doctors can confidently rely on standard evaluations of medical necessity when such a risk arises to determine if an abortion is necessary in compliance with the law. But as noted, ACOG agrees that early delivery rather than abortion will often be a method of responding in such circumstances if separation becomes necessary, where the child and his mother are both given the best opportunity for survival.⁸⁸

Cancer treatment. If maternal cancer is diagnosed during pregnancy, treatment considerations and concerns for maternal and fetal health can vary depending on the type of cancer, the degree of spread, the likelihood of recurrence, the proximity of the cancer to the uterus, the possibility of cancer promotion due to pregnancy hormones, and the toxicity of treatment options for the unborn child (which may include surgery, radiation and chemotherapy), so there is not a standard recommendation on how cancer treatment should be addressed in pregnancy. However, if a multidisciplinary team—which should be standard in such a situation—concludes that ending the pregnancy would be necessary to prevent the woman’s death, an abortion in this situation benefit a woman undergoing cancer treatment, this management would also fall under the statutory exemption for the “life of the mother.”⁸⁹

⁸⁸ ACOG Practice Bulletin 211. Critical Care in Pregnancy. *Obstet Gynecol* 2019;133:303-319.

⁸⁹ New Drugs Raise Old Questions about Treating Cancer during Pregnancy, Nat’l Inst. Of Health (May 25, 2022), <https://www.cancer.gov/news-events/cancer-currents-blog/2022/treating-cancer-pregnancy-new-drugs>.

It is scientifically undeniable that abortion ends the life of a preborn human. This decision should be undertaken with a great deal of consideration to the gravity of the action weighed against the reasons for ending this fetal life.

Abortion advocates often claim that women obtaining late abortions have compelling reasons for obtaining abortions at those late gestational ages. Of the many abortions performed in the United States each year, only one to two percent are for danger to the mother's life, which is an exception to all pro-life legislation. Most of the rest are for financial, social or other undefined reasons. Three quarters of women who obtain an abortion say they cannot afford a child or that having a baby would interfere with school, work, or the ability to care for dependents; 86 percent are unmarried.⁹⁰

It appears many abortions are not freely "chosen." Often the decision to terminate a pregnancy is influenced by partner abandonment, family pressure, or outright coercion. Lack of resources and family support seem to encourage many women to choose abortion. In a survey of post-abortive women, 58 percent said that they had their abortions in order to "make others happy," with over 28 percent saying they had the abortion because "they feared their partner would leave them" if they did not. 66 percent of women "said they knew in their hearts that they were making a mistake when they underwent the abortion."⁹¹

Studies confirm that most late abortions are obtained for the very same elective reasons as earlier abortions, and most of those aborted are healthy babies being carried by healthy women. Reasons given for late abortions are: "not knowing about the pregnancy," "trouble deciding about the abortion," and "disagreeing about the abortion with the man involved."⁹² Fifty percent of women having second trimester abortions delayed the procedure due to indecision, and 33 percent due to the difficulty of the decision.⁹³ A study in England and Wales found similar reasons for later abortions: 41 percent indecision, 30 percent procrastination and 23 percent relationship changed.⁹⁴ Nine months is a long time for a woman who desires her child to say "no" to a coercive partner. Decisional uncertainty leaves a woman likely to regret aborting a baby whose kicks she can feel and with whom she has begun to

⁹⁰ Jenna Jerman, Rachel K. Jones and Tsuyoshi Onda. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. Guttmacher Institute, May 2016. Available at <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>, accessed June 21, 2022.

⁹¹ Priscilla K. Coleman, et al. Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences. *Journal of American Physicians and Surgeons* 2017;22:4.

⁹² Rachel K. Jones and Lawrence B. Finer. Who Has Second Trimester Abortions in the United States? *Contraception* 2012;85 (2012): :544-551

⁹³ Finer, et al. Timing of steps and reasons for delays in obtaining abortions in the United States. *Contraception* 2006;74:334-344.

⁹⁴ Roger Ingham, et al. Reasons for Second Trimester Abortions in England and Wales. *Reproductive Health Matters* 2008;16:18-29.

bond. These studies did not report the number of “hard cases,” because apparently there were so few.

The State of Florida keeps statistics on the reasons for all abortions in the state, and from 2020 to 2022, they found incest accounted for only 0.002 percent of all abortions, rape 0.02 percent, health of mother 2 percent, life of mother 0.03 percent, and serious fetal anomalies 2 percent, further confirming that most abortions are for elective reasons.⁹⁵

A 15-week gestational age limitation does not prevent a woman from obtaining an abortion. It merely requires a physician to perform that action before a gestational age when the fetus has attained the attributes of pain capability and before the procedure becomes significantly more dangerous for a woman. It provides ample time for most women to obtain an abortion. Clinical recognition of pregnancy can be detected by readily available over the counter urine pregnancy tests when BHCG levels range from 6.5-100 miu/ml which occurs by 3-4 weeks gestational age.⁹⁶ Serum BHCG levels can be detected at > 5 miu/ml, which occurs by 5-8 days after fertilization, almost immediately after uterine implantation.⁹⁷ Thus, for a woman who discovers a pregnancy early, the law allows a window of up to twelve weeks for the woman to decide on and procure an abortion. Indeed, two thirds of abortions nationally (65.4 percent) are obtained by 8 weeks gestation.⁹⁸ 7.2 percent of U.S. abortions are performed after the first trimester: 2.9 percent between 14-15 weeks, 3 percent between 16-20 weeks, and one percent after viability.⁹⁹ This limitation would impact very few abortions.

Upon implementation of a 15-week gestational age limitation, women in the United States will be encouraged to obtain abortions at earlier gestational ages, which will improve the safety of the procedure. The risks of abortion procedures greatly increase with the duration of pregnancy, largely due to the growth of the fetus requiring more technically difficult procedures. Even abortion advocates acknowledge that obtaining an earlier abortion is far safer for a woman.¹⁰⁰

Fetal neurologic research documents that the pathways required for pain perception are in place by 15 weeks gestation, and during an abortion the fetus displays all the

⁹⁵ Agency for Health Care Administration, “Reported Induced terminations of Pregnancy (ITOP) by Reason, by Trimester, 2021 - Year to Date,” [https://ahca.myflorida.com/MCHQ/Central Services/Training Support/docs/TrimesterByReason 2021.pdf](https://ahca.myflorida.com/MCHQ/Central%20Services/Training%20Support/docs/TrimesterByReason%202021.pdf).

⁹⁶ “The best pregnancy tests” <https://www.cbsnews.com/news/the-best-pregnancy-tests/>, accessed June 17, 2022.

⁹⁷ Montagnana M, Trenti T, Aloe R, Cervellin G, Lippe G. Human chorionic gonadotropin in pregnancy diagnostics. *Clin Chim Acta* 2011;412(17):1515-1520.

⁹⁸ Induced abortion in the United States. Available at <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>, accessed December 14, 2022.

⁹⁹ Kortsmid K, Mandel MG, Reeves JA, et al. Abortion Surveillance — United States, 2019. *MMWR Surveill Summ* 2021;70(No. SS-9):1–29. DOI: <http://dx.doi.org/10.15585/mmwr.ss7009a1>.

¹⁰⁰ Practice Bulletin 135: Second Trimester Abortion: Obstetrics & Gynecology. 2013;121(6):1394-1406.

responses we would exhibit if we were torn limb from limb. I have cared for many tiny babies, delivered at the edge of viability, around 22 weeks. Their precious faces express pain when their fragile bodies undergo therapeutic procedures. Amazing medical technology can keep these babies alive and allow fetal surgery as early as 15 weeks to heal neurologic and cardiac conditions before birth. Of course, these babies are always offered pain relief. How can we, as a supposedly moral society, justify painful dismemberment of unborn babies at similar gestational ages, just because we cannot hear their cries?

Many abortion advocates argue that fetal pain does not exist until after 24-28 weeks gestation, but they base this assertion on an extreme interpretation of what constitutes pain. Some even inexplicably argue that a fetus remains in a persistent sleep state in utero, and thus cannot feel pain until after birth, but this theory has been debunked.¹⁰¹ Of course, we should all recognize even if that were the case, having his limbs pulled off in a D&E abortion would undoubtedly wake him up!

The first requirement for fetal pain perception is the presence of sensory receptors in the skin, which begin to develop around the mouth at seven weeks, spread to the hands and feet by eleven weeks, to trunk and limbs by fifteen weeks, and are present throughout the fetus's entire body by twenty weeks.¹⁰² The part of the central nervous system leading from these peripheral nerves to the brain begins developing in the spinal cord at thirteen weeks.¹⁰³ Connections are made from the spinal cord to the thalamus (midbrain) between fourteen to twenty weeks, allowing pain from the extremities to be transmitted to the brain.¹⁰⁴

The neurons of the cerebral cortex begin development at eight weeks and are complete by twenty weeks.¹⁰⁵ Neural connections between the thalamus and the cerebral cortex are made starting at seventeen weeks and are fully functional by twenty-six to thirty weeks, which allows a higher order reflection on the pain.¹⁰⁶ Studies of individuals born without a cerebral cortex (anencephalic and hydranencephalic) demonstrate that the cortex is not necessary to experience pain.¹⁰⁷ Animals lacking higher cortical structures obviously feel pain. The neural

¹⁰¹ Brusseau R, Developmental Perspectives: Is the Fetus Conscious?, *International Anesthesiology Clinics* 2011;46:11.

¹⁰² Anand KJ and Hickey PR. Pain and Its Effects in the Human Neonate and Fetus. *New England Journal of Medicine* 1987;317(21):1321-1329.

¹⁰³ Gupta R, et al. Fetal Surgery and Anesthetic Implications. *Continuing Education in Anesthesia, Critical Care and Pain* 2008;8(2):71-75.

¹⁰⁴ Chien JH et al., Human Thalamic Somatosensory Nucleus (Ventral Caudal, Vc) as a Locus for Stimulation by INPUTS from Tactile, Noxious and Thermal Sensors on an Active Prosthesis. *Sensors (Basel)*. 2017;17.

¹⁰⁵ Bystron I et al., The first neurons of the human cerebral cortex, *Nature Neuroscience* 2006;9:880.

¹⁰⁶ Glover V and Fisk NM, Fetal Pain: Implications for Research and Practice. *British Journal of Obstetrics and Gynecology* 1999;106:881-886.

¹⁰⁷ Slater R et al., Cortical Pain Response in Human Infants, *J Neuroscience* 2006;25:3662.

mechanisms that inhibit pain sensations do not develop until 34-36 weeks, so it is likely that the pain sensation is even more intense in babies (born or unborn) prior to that gestational age and these babies show “hyperresponsiveness” to pain.¹⁰⁸

Early in the second trimester, the fetus reacts to stimuli that an adult would find painful, in much the same ways as an adult.¹⁰⁹ Fetuses can be seen reacting to a needle insertion in the intra-hepatic vein with recoil from the needle, vigorous body and breathing movements, increased heart rate, and increased blood flow to the brain. A similar reaction does not occur when needling the umbilical vein, which does not have fetal sensory nerves.¹¹⁰ Additionally, increases in stress hormones and endogenous opioids can be measured in the fetal blood.¹¹¹

Anesthesiologists routinely provide specific anesthesia and analgesia to a fetus undergoing intrauterine surgery because of the potential for fetal pain as early as 15-18 weeks gestation.¹¹² A leading children’s hospital performed nearly 1,600 fetal surgeries between 1995 and June 2017 during which pain medication for the unborn patient was routinely administered as standard medical practice.¹¹³ One fetal surgery team stated, “The administration of anesthesia directly to the fetus is critical in open fetal surgery procedures.”¹¹⁴ The leading textbook on clinical

¹⁰⁸ Badr LK et al., Determinants of Premature Infant Pain Responses to Heel Sticks, *Pediatric Nursing* 2010;36:129; Brusseau R and Bulich LA, Anesthesia for fetal intervention, in *Essential Clinical Anesthesia*, Charles Vacanti, Pankaj Sikka, Richard Urman, Mark Dershwitz, B. Scott Segal, Eds., Cambridge University Press, NY; July 2011; 772-776; Greco C and Khojasteh S, Pediatric, Infant and Fetal Pain, *Case Studies in Pain Management*, Alan David Kaye and Rinoo V. Shah, Eds., (Cambridge: Cambridge University Press, 2014), 379; Goksan S et al., fMRI reveals neural activity overlap between adult and infant pain, *eLife* 2015;4:e06356; Sekulic S et al., Appearance of fetal pain could be associated with maturation of the mesodiencephalic structures. *J Pain Res.* 2016;9:1031.

¹⁰⁹ Lowery CL, et al. Neurodevelopmental Changes of Fetal Pain. *Seminars in Perinatology* 2007;31:275-282.

¹¹⁰ Giannakouloupoulos X, et al. Fetal Plasma Cortisol and B-Endorphin Response to Intrauterine Needling. *Lancet* 1994;344:77-81.

¹¹¹ Gita R, et al. Fetal Hypothalamic-Pituitary-Adrenal Stress Responses to Invasive Procedures are Independent of Maternal Responses. *Journal of Clinical Endocrinology and Metabolism* 2001;86:x.

¹¹² Myers LB, et al. Fetal Endoscopic Surgery: Indications and Anesthetic Management. *Best Practices and Research Clinical Anesthesiology* 2004;18(2):231-258; Sekulic S et al., Appearance of fetal pain could be associated with maturation of the mesodiencephalic structures. *J Pain Res.* 2016;9:1031; Bellieni CV, Analgesia for Fetal Pain During Prenatal Surgery: 10 Years of Progress, *Pediatric Research* 2020;89:1612; Gupta, R., Wimalasundera, R., Moore, P. (2021). Anaesthetic Considerations in Fetal Therapy. In: Goudra, B.G., Singh, P.M., Green, M.S. (eds) *Anaesthesia for Uncommon and Emerging Procedures*. Springer, Cham. https://doi.org/10.1007/978-3-030-64739-1_28.

¹¹³ “Volumes and Outcomes: Fetal Anomalies,” Children’s Hospital of Philadelphia, 2017, <http://www.chop.edu/centersprograms/>

center-fetal-diagnosis-and-treatment/volumes-outcomes#.VLbMhCvF8T-. See also, “Fetal Family Reunion,” Children’s Hospital of Philadelphia, 2017, <http://www.chop.edu/events/fetal-family-reunion>; See, e.g., Ramirez MV, Anesthesia for fetal surgery, *Colombian Journal of Anesthesiology* 2012;40:268; Tran KM, Anesthesia for fetal surgery, *Seminars in Fetal & Neonatal Medicine* 2010;15:40; Schwarz U and Galinkin JL, Anesthesia for fetal surgery, *Semin Pediatr Surg* 2003;12:196; Anand KJS and Hickey PR, Pain and Its Effects in the Human Neonate and Fetus, *N Engl J Med* 1987;317:132; Adzick NS, Prospects for fetal surgery, *Early Human Development* 2013;89:881.

¹¹⁴ Mayorga-Buiza MJ et al., Management of fetal pain during invasive fetal procedures. Lessons learned from a sentinel event, *European Journal of Anaesthesiology* 2014;31:88.

anesthesia says: “It is clear that the fetus is capable of mounting a physiochemical stress response to noxious stimuli as early as 18 weeks.”¹¹⁵

A 2020 comprehensive review of the fetal pain literature concluded that unborn babies may experience pain as early as 12 weeks and the neural connections from periphery to brain are functionally complete after 18 weeks. These noted researchers, one of whom is ideologically pro-choice, reversed their previous opinion from 2010, concluding, “Nevertheless, we no longer view fetal pain (as a core, immediate, sensation) in a gestational window of 12–24 weeks as impossible based on the neuroscience.” They conclude that although the fetus may not experience pain in the same way as an adult, he does experience pain as a real sensation, and this pain has moral implications. Additionally, they wrote, “The two authors came together to write this paper through a shared sense that the neuroscientific data, especially more recent data, could not support a categorical rejection of fetal pain.”¹¹⁶

Rejecting this recent evidence, abortion advocates often argue that the fetal responses noted above do not qualify as pain because the fetus cannot yet experience an emotional response to the pain in the cerebral cortex. They support their position by referencing a biased study which states: “Pain is an emotional and psychological experience that requires conscious recognition of noxious stimulus.” Study authors included a former NARAL Pro-choice America attorney, and the medical director of an abortion clinic at the University of California, San Francisco. The intent of the study is readily apparent from the first paragraph, where the authors discuss legislative limitations on mid-trimester abortions and discount any concern for the fetus. They address all of the observed fetal physiologic responses and attempt to explain how that does not actually represent pain as we know it.¹¹⁷

This approach to fetal pain has been widely criticized.¹¹⁸ A natural extension of this premise would lead to a neonatologist’s failure to treat pain in infants born at the threshold of viability (previously documented around 22 weeks’ gestation). Anyone who has ever observed these babies in a NICU would confirm that they appear to experience pain and are deserving of compassionate treatment of this pain.¹¹⁹ Besides, there are many other instances in our society in which we take extra precautions to prevent pain even though we do not know whether the recipient is

¹¹⁵ Brusseau R and Bulich LA, Anesthesia for fetal intervention, in *Essential Clinical Anesthesia*, Charles Vacanti, Pankaj Sikka, Richard Urman, Mark Dershwitz, B. Scott Segal, Eds., Cambridge University Press, NY; July 2011; 772-776.

¹¹⁶ Derbyshire SW. Foetal Pain? Best Practices and Research. *Clinical Obstetrics & Gynecology* 2010;24(5):647-655; Derbyshire SWG and Bockmann JC, Reconsidering fetal pain, *J Med Ethics* 2020;46:3-6.

¹¹⁷ Lee SL, et al. Fetal Pain: A Systematic, Multidisciplinary Review of the Evidence. *JAMA* 2005;294(8):947-954.

¹¹⁸ Platt MW. Fetal awareness and fetal pain: the emperor's new clothes. *Arch Dis Child Fetal Neonatal Ed.* 2011 Jul;96(4):F236-7.

¹¹⁹ Bellieni CV. New insights into fetal pain. *Semin Fetal Neonatal Med.* 2019 Aug;24(4):101001.

capable of fully experiencing pain. When organs are harvested from a person who has experienced brain death, we administer anesthesia. Prior to undergoing a painful procedure, a person in a persistent vegetative state is given anesthesia. When a convicted murderer is given the death penalty, there is a long list of safeguards to make sure that he dies as quickly and painlessly as possible. We have many laws that monitor how animals raised to provide meat should be treated when they are butchered, and many more laws to tell us how we should interact with pets so that they do not experience pain. A conference on pain in laboratory animals noted that “it is imperative to acknowledge that unless it is established to the contrary, we should assume that those procedures that produce pain in us might also produce pain in animals,” and proposes preemptive analgesia in those situations.¹²⁰ Why are abortion proponents not willing to give the benefit of the doubt to the fetus when we are willing to do so for lab rats?

Conclusion: For these reasons and many more, a proposed 15-week gestational age limit on elective abortion would greatly improve safety for women and would protect their mental health by preventing coerced late abortions. The Women’s Health Protection Act, by allowing unsupervised abortion at any gestational age in pregnancy, would place women at increased risk of coercion and physical and mental health complications. Legislation allowing abortion up to birth for any reason prioritizes ending unborn human life over the health and well-being of women.

¹²⁰ Gebhart GF. Definition of Pain and Distress and Reporting Requirements for Laboratory Animals: Proceedings of the Workshop Held June 22, 2000, available at <https://www.ncbi.nlm.nih.gov/books/NBK99547/>, accessed December 9, 2022.