

Courtney Slonkosky, M.D.

House Health Committee

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Chairman Merrin, Vice Chair Manning, Ranking Member Boyd, and members of the committee, thank you for allowing me to testify on Senate Bill 23.

My name is Courtney Slonkosky. I am a board-certified Ob-Gyn. Since 2010 I have been caring for Ohio's women and mothers, during and outside of pregnancy and have delivered hundreds of our new Ohioans. Thank you for the honor of sharing my experience and recommendations with you.

Identifying heartbeat is easily accomplished and reliable and that, in large part, is why this bill makes so much sense to me medically.

Our generation faces unprecedented challenges of legalized abortion. Newer technology and scientific understanding can guide us to what limitations should be implemented. I am proud and grateful to call myself an Ohioan, a resident of a state in which the majority of the citizens want to fairly protect our newest Ohioans in the womb. I congratulate and appreciate the courage of the legislators who passed legislation to support our position.

Advances in science and technology since Roe v Wade have led to our current situation, with the need to re-visit the

concept of viability, as well as capacity for independent survival, referenced in *Roe v Wade*.

Both within and outside of medicine there exist a number of different, conflicting definitions. Within medicine, an “age of viability” refers to the age at which premature infants should be resuscitated. This age of viability varies greatly between institutions, determined by the technology and medical teams available at a particular institution.

Viability has another meaning for us Ob-Gyn’s, one which we encounter much earlier in pregnancy. Most practices schedule mothers for their initial prenatal visit between 8 and 12 weeks of gestation, and the key purpose of that visit is establishing viability, by way of detecting heartbeat. An ultrasound examination is how we detect the heartbeat and confirm viability. This ultrasound exam is routine and non-invasive. Mothers greatly enjoy the ultrasound- seeing their baby and hearing the heartbeat is the highlight of their visit. Once the heartbeat is detected, we confidently determine that this mother has a viable baby within her womb.

Rarely, at this first visit, particularly if it is earlier in the first trimester, between 6 and 8 weeks gestation, we encounter a more difficult situation when a single ultrasound examination can not determine conclusively whether the pregnancy is viable or non-viable. In these infrequent cases, a follow-up ultrasound exam, typically a few days to a week later, often accompanied by blood tests, provides definitive confirmation of viability or non-viability.

At some point in time during the 7 to 12 week gestation interval, certainty is reached regarding viability. Either by use of internal, trans-vaginal, or external, trans-abdominal ultrasound exams (both of which are routine and not painful), we are able to definitively reassure the mother of viability. Once viability is established by detecting the heartbeat, statistics suggest a 95-98% certainty that this new life will go full-term and join the other citizens of Ohio.

Detection of heartbeat is a reliable and logical point for determining viability, and thereby the right to legal protection. Once the heartbeat is documented, we have definitively identified a living human being, and that living human being will almost certainly be born and grow into a child, and eventually an adult citizen, and, therefore, deserves legal protection.

Utilizing the point of “viability” with respect to when the fetus or infant can survive independently outside the mother’s womb is problematic, medically, ethically, and thereby legally.

It is problematic due to inconsistency. The age of viability, in the context of resuscitation for newborns, varies between institutions, due to policy choices and available technology. It has changed over time, and will continue to do so as medical technology and capabilities continue to advance, likely equipping teams to perform successful resuscitation of infants at progressively earlier gestational ages.

Establishing law based upon this definition of viability is problematic medically because of the following limitations.

Due to varying intrinsic factors, some babies are capable of sustaining life outside their mother's womb at very different gestational ages than others. Some full-term babies suffer birth defects – at times discovered during pregnancy and anticipated, but other times not encountered until after delivery – which lead to a need for significant resuscitation or a very short lifespan despite resuscitation. Many babies born preterm, but by only 4 weeks, require no medical support to easily sustain their lives. Some babies born very preterm – 6 or 8 weeks- surprisingly, require very little, brief support. Of course we're all aware that every baby requires nurturing and feeding by her mother or a caregiver in order to survive outside the womb. No baby, at any gestational age, can survive outside the womb independent of a caregiver.

As medical professionals we frequently are incorrect in our predictions of which babies will require medical support for survival versus those who will require only routine nurturing and feeding. If we establish our laws based upon medical teams' predictions, they will be unjust due to inaccurately judging many babies' capacity for survival and health status.

It is urgent that we acknowledge and discuss these very sensitive and real situations: women who conceived when raped, due to incest, and women who are carrying a baby with a birth defect suspected to be fatal to the baby. These are tragic and difficult situations. Thankfully, they are not common, but the anguish is very real and intense for the women and families involved. I urge you to recognize that firstly, the babies who are born and survive these situations are often heard to testify most passionately that they are grateful

for their gift of life. Secondly, that women who conceived after being sexually assaulted – whose pregnancies stem from acts of the most extreme degradation and violence – and abort, experience a second act of violence when they abort. They suffer far more, due to the physical difficulties of the abortion procedure or process and the emotional harm beyond that of the trauma of being rape survivors. Those who choose to carry the pregnancy and give the child up to loving couples who long for a child to raise, share testimonies of many lives greatly improved through one choice of pregnancy and birth, rather than abortion. The medical and emotional trauma of abortion are well documented. Though an abortion seems to bring more rapid resolution and relief, many women later bitterly regret this choice, mourning for their lost baby. Many women share testimonies of the healing they experience through carrying the baby to term and giving the baby up for adoption or raising the child. The same is true in cases of incest.

Surprising to some, the same is true for mothers carrying babies who are likely or virtually certain to die soon after birth. Most medical professionals and even ethicists consider a lethal anomaly a medical justification for an abortion, or induction of labor at a preterm gestation age. It should be acknowledged that some situations exist in which a mother can ethically be offered a “compassionate induction”. Equally important to recognize is that testimonies, and even scientific studies, suggest that life, however brief, is a healthier alternative. Mothers who opt to carry the baby to term and deliver, overwhelmingly report tremendous physical and

psychological benefits and a healthy closure to the pregnancy. They vehemently testify of their delight in holding and loving their baby for whatever length of time the child lives, in many cases only minutes or hours. In some cases, mothers and medical teams are surprised and the child lives for days, months, or even years. Regardless of how short or long the time frame, mothers unanimously express their gratitude at the choice to enjoy holding their baby for any length of time.

Abortion not only harms the baby within the womb but also our Ohio women. Statistics confirm that risk to the mother is considerable, not only during or immediately following an abortion, but also long-term – conferring risk of infertility, complications with future pregnancy, and significant risk of mental health disorders. Carrying a pregnancy and putting the baby up for adoption is a much safer option for our mothers.

I urge you to support this Bill which establishes a consistent, logical definition for viability and provides the legal protection deserved by our Ohioans within the womb, protecting them and their mothers from undue harm. Thank you for your thoughtful consideration.