ProLife OB|GYNS
AAPLOG American Association of Pro-life Obstetricians & Gynecologists

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Ohio Senate Bill 145
Dismemberment Abortion Ban
Senate Judiciary Committee

June 20, 2017

Chairman Bacon, Vice Chair Dolan, Ranking Member Thomas, and members of the committee,

Thank you for allowing me to address this committee. I am Dr. Donna Harrison, a board certified Obstetrician and Gynecologist, and Executive Director of the American Association of Pro-Life Obstetricians and Gynecologists, representing over 4,500 medical professionals across the U.S.

Attached as Appendix A is the AAPLOG Fact Sheet on D&E Abortion Bans like SB 145.

Appendix B summarizes the medical literature documenting that fetuses react to painful stimuli, beginning at the second and third trimesters, when D&E abortions are performed.

The AAPLOG Fact Sheet on D&E Abortion Bans states the following:

> "The structures which transmit painful stimuli from the skin to the brain are present very early in fetal life[1] and anesthesiologists for the last decade have used fetal anesthesia as standard of care for in utero fetal surgery, as evidenced by the review by Gupta[2] et Al. in 2008:
>
> *"**Fetal stress***
>
> *There is considerable evidence that the fetus may experience pain. Not only is there a moral obligation to provide fetal anaesthesia and analgesia, but it has also been shown that pain and stress may affect fetal survival and neurodevelopment.[7][3] Factors suggesting that the fetus experiences pain include the following.*
>
> *i. Neural development. Peripheral nerve receptors develop between 7 and 20 weeks gestation, and afferent C fibres begin development at 8 weeks and are complete by 30 weeks gestation. Spinothalamic fibres (responsible for transmission of pain) develop between 16 and 20 weeks gestation, and thalamocortical fibres between 17 and 24 weeks gestation.*
>
> *ii. Behavioural responses. Movement of the fetus in response to external stimuli occurs as early as 8 weeks gestation, and there is reaction to sound from 20 weeks gestation. Response to painful stimuli occurs from 22 weeks gestation.*
>
> *iii. Fetal stress response. Fetal stress in response to painful stimuli is shown by increased cortisol and β-endorphin concentrations, and vigorous movements and breathing efforts.[7,9][45] There is no correlation between maternal and fetal norepinephrine levels, suggesting a lack of placental transfer of norepinephrine. This independent stress response in the fetus occurs from*

18 weeks gestation.10 There may be long-term implications of not providing adequate fetal analgesia such as hyperalgesia, and possibly increased morbidity and mortality."

A 2012 review article[6] on fetal anesthesia concurs, and concludes with a call for adequate fetal pain relief:

"Evidence is increasing that from the second trimester onwards, the fetus reacts to painful stimuli and that these painful interventions may cause long-term effects. It is therefore recommended to provide adequate pain relief during potentially painful procedures during in utero life."

Fetuses who are victims of D&E abortions react to painful stimuli with the same physiological responses that any other human being would display: increase in heart rate, increase in stress hormones in the blood stream, and withdrawal from painful stimuli. As the science of in-utero fetal surgery has progressed, it has become clear that fetuses do better when given pain relief during the surgery.

It is also very clear that fetuses who are candidates for abortion by D&E (ie second and third trimester) display all the same physical reactions to pain that any other human being would display. A living fetus will clearly suffer pain when being torn apart during a D&E procedure.

There are few procedures which could be as painful as tearing apart a living fetus, limb by limb. Civilized societies which continue to permit elective abortion by D&E should at least ensure that the unborn victim of the elective abortion is dead prior to being torn limb from limb."

To talk about D&E requires that you leave the sterility of political bantering, and enter the reality of what a D&E actually consists of, as seen in Appendix C attached.

Dr. Warren Hern, a Colorado abortionist who has performed numerous D&E abortions and has written a textbook on abortion procedures, has stated "there is no possibility of denial of an act of destruction by the operator [of a D&E abortion]. It is before one's eyes. The sensations of dismemberment flow through the forceps like an electric current."[7] A D&E procedure is accurately described in video by Dr. Tony Levatino, former abortionist, and current AAPLOG Board member.[8]

It is hard to imagine a more gruesome way to die. If veterinarians ripped apart living dogs or cats to kill them in the same way that living human fetuses are ripped apart in the D&E procedure, the outcry would be deafening.

The U.S. Supreme Court decision on Partial Birth Abortion[9] states:

"In the usual second-trimester procedure, "dilation and evacuation" (D&E), the doctor dilates the cervix and then inserts surgical instruments into the uterus and maneuvers them to grab the fetus and pull it back through the cervix and vagina. The fetus is usually ripped apart as it is removed, and the doctor may take 10 to 15 passes to remove it in its entirety."…" The main difference between the two procedures is that in intact D&E [i.e. partial birth abortion] *a doctor extracts the fetus intact or largely intact with only a few passes, pulling out its entire body*

instead of ripping it apart. In order to allow the head to pass through the cervix, the doctor typically pierces or crushes the skull.

Justice Ginsberg states in her dissent:

> *"… the Court emphasizes that the Act does not proscribe the nonintact D&E procedure. See ante, at 34. But why not, one might ask. Nonintact D&E could equally be characterized as "brutal," ante, at 26, involving as it does "tear[ing] [a fetus] apart" and "ripp[ing] off" its limbs, ante, at 4, 6. "[T]he notion that either of these two equally gruesome procedures . . . is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one but not the other, is simply irrational." Stenberg, 530 U. S., at 946–947 (STEVENS, J., concurring)."*

The Partial Birth Abortion Ban did not ban a procedure. The court banned the use of a certain procedure, the partial birth abortion procedure, on ***living*** fetuses. Yet even Justice Ginsberg, in her dissent above, recognized that the performing a D&E on a ***living*** fetus is equivalently gruesome to performing a partial birth abortion procedure on a living fetus. To have one's limbs ripped off is a horrible and painful way to die. And, it is completely medically unnecessary to perform an elective D&E on a ***living*** fetus, when a feticide procedure could kill the fetus before dismemberment.

In the Partial Birth Abortion Ban case, the USSC based its decision in part on the "*premise…that the State, from the inception of the pregnancy, maintains its own regulatory interest in protecting the life of the fetus that may become a child…. Where it has a rational basis to act, and does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including the life of the unborn*."[10]

The Supreme Court not only recognized the brutality of both partial birth abortion and D&E on the fetus, but also gave consideration to the effects on the medical profession. In *Gonzales,* the USSC justified the federal law protecting unborn children from partial birth abortions based on the government's "*interest in protecting the integrity and ethics of the medical profession*."[11]

Opponents of SB 145 falsely claim that banning D&E on ***living*** fetuses will somehow put a mother's life at risk. This assertion is false, as any physician can clearly read. Under SB 145, a D&E can be done legally on a living fetus if there is a "*serious health risk to the pregnant woman*". This risk is clearly defined in the text of the bill at section 20-217 (G) (1) line 30 :

> " '*Serious health risk to the pregnant woman' means that, in the reasonable medical judgement of a physician, the pregnant woman has a condition that so complicates her medical condition that it necessitates the abortion of her pregnancy to avert her death or to avert a serious risk of substantial and irreversible physical impairment of a major bodily function*".

Any physician can clearly read this and understand it. This wording clearly gives a physician the freedom to legally exercise their medical judgement and legally perform whatever procedure is necessary to save the life of the woman, or to avert serious risk of substantial physical harm.

Opponents SB 145 also falsely claim that SB 145 will ban all D&E abortions. This assertion is also false. SB 145 ***only bans elective D&E abortions on living fetuses***, in cases where there is no risk to the mother's life. Under SB 145, elective D&E abortions can be legally done if the fetus has been killed first, (ie a feticide procedure performed) prior to beginning the D&E procedure. SB 145 clearly states at section 2919.15 (A) (2) that this ban does not apply to procedures used to remove the remains of a dead unborn child.

SB 145 also reiterates this fact at section 2919.15 (A) (2) where it states "…*to dismember a* ***living*** *unborn child…*" [emphasis mine]. It is exquisitely clear that SB 145 will only ban those dismemberment procedures which involve tearing a ***living*** unborn child limb from limb.

If SB 145 is in effect, any abortionist who wants to perform an elective D&E procedure must first perform a feticide procedure. Killing the fetus in utero is called feticide.

An abortionist would perform a "feticide" procedure (kill the fetus) prior to beginning the D&E. In the first trimester, feticide procedures are called "selective reduction". In the second and third trimester, feticide is usually accomplished with injection of potassium chloride, injection of digoxin, or by cord transection which result in death within 15 minutes or less. The 2010 Society for Family Planning review article[12] states:

"*For decades, the induction of fetal demise has been used before both surgical and medical second trimester abortion. Intra-cardiac potassium chloride and intra-fetal or intra-amniotic digoxin injections are the pharmacological agents used most often to induce fetal demise."*

Major abortion proponents in Europe, including the Royal College of Obstetricians and Gynecologists (RCOG) and the British Pregnancy Advisory Service (BPAS), the leading abortion provider in the UK, routinely use feticide prior to abortion for abortions over 22 weeks[13] [14]

Many studies have reported that inducing feticide prior to starting the D&E does not pose major risks to the mother. [See Appendix D: Summary of Feticide Studies] One study reported that mothers preferred to have feticide performed prior to the abortion. [15]

Inserting a needle into the fetus is associated with a measurable[16] pain response. Feticide procedures are in and of themselves painful, but less than the horrible pain of being dismembered while still alive.

In summary:

- SB 145 will not ban all abortions. **SB 145 only bans elective D&E's done on *living* fetuses.**
- SB 145 will not ban all D&E's, **SB 145 only bans elective D&E's done on *living* fetuses**.
- SB 145 does ***NOT*** ban D&E abortions when the fetus has been killed before starting the D&E abortion. **SB 145 only bans elective D&E's done on *living* fetuses.**
- **SB 145 does NOT ban D&E abortions on living fetuses when the D&E is necessary to save the life of the mother or avert major physical harm.**
- **SB 145 only bans D&E abortions in which the fetus is *alive* when being torn apart.**

If SB 145 passes, the abortionist will need to perform a feticide procedure on the fetus before tearing him or her apart limb from limb. The U.S. Supreme Court Partial Birth Abortion Ban made clear that states can ban barbaric procedures done in the name of elective abortion, especially those procedures which cause excruciating pain to living fetuses. AAPLOG urges the passage of SB 145.

Respectfully submitted,

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Life. It's why we are here.

[1] https://judiciary.house.gov/_files/hearings/113th/05232013/Condic%2005232013.pdf
[2] Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications Contin Educ Anaesth Crit Care Pain (2008) 8 (2): 71-75. available at https://academic.oup.com/bjaed/article/8/2/71/338464/Fetal-surgery-and-anaesthetic-implications
[3] Boris P, Cox PBW, Gogarten W, Strumper D, Marcus MAE. Fetal surgery, anaesthesiological considerations. Curr Opin Anaesthesiol 2004; 17: 235–40
[4] Boris P, Cox PBW, Gogarten W, Strumper D, Marcus MAE. Fetal surgery, anaesthesiological considerations. Curr Opin Anaesthesiol 2004; 17: 235–40
[5] Giannakoulopoulos X, Teixeira J, Fisk N. Human fetal and maternal noradrenaline responses to invasive procedures. Pediatr Res 1999; 45: 494–9
[6] Van de Velde M, De Buck F. "Fetal and maternal analgesia/anesthesia for fetal procedures" Fetal Diagn Ther 2012;31:201–209.

[7] Warren M. Hern, M.D., and Billie Corrigan, R.N., *What About Us? Staff Reactions to the D & E Procedure, paper presented at the Annual Meeting of the Association of Planned Parenthood Physicians,* San Diego, California, (October 26, 1978).

[8] http://www.abortionprocedures.com/
[9] https://www.law.cornell.edu/supct/html/05-380.ZS.html
[10] https://www.law.cornell.edu/supct/html/05-380.ZS.html
[11] https://www.law.cornell.edu/supct/html/05-380.ZS.html
[12] Diedrich J, Drey E; Society of Family Planning."Induction of fetal demise before abortion"Contraception. 2010 Jun;81(6):462-73. doi: 10.1016/j.contraception.2010.01.018.
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[14] Lohr P. BPAS Clinical update 19 Jan 2012 http://www.reproductivereview.org/index.php/site/article/1093/
[15] Jackson RA, , Teplin VL, Drey EA, Thomas LJ, Darney PD. Digoxin to facilitate late second-trimester abortion: a randomized, masked, placebo-controlled trial. Obstetrics and Gynecology. 2001;97:471–476
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