Written Testimony in Support of S.B. 145

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1. Good morning Chairman Bacon, Vice Chair Dolan, Ranking Member Thomas, and members of the Judiciary Committee. My sincere thanks for the opportunity to appear before this distinguished body. My name is Dr. Dennis Sullivan. I am a citizen of the state of Ohio and I reside in Beavercreek, Ohio, where I have lived since 1997. I am pleased to give my expert opinion before this committee in support of S.B. 145, and will specifically address the ethical concerns at stake in the matter of dismemberment abortion.

2. I am a physician and licensed to practice medicine since 1978. My medical degree is from Case Western Reserve University in Cleveland, Ohio, and I am board certified in the practice of general surgery. I practiced in the U.S. Army and internationally for 12 years. Since 1996, I have served on the teaching faculty of Cedarville University, teaching advanced anatomy and human embryology. During this time, I received additional graduate training in ethics and moral philosophy. Since 2006, I have directed Cedarville University's Center for Bioethics. I currently serve on the faculty of the School of Pharmacy, where I teach Pharmacy Ethics and Pharmacy Law.
3. Ladies and gentlemen, I am here to discuss a particular type of abortion procedure. It is my professional position, based on science, philosophy, and my view of human flourishing, that protectable human life begins at the moment of conception, and extends

to the grave. I am also aware that some in this hearing room may disagree with my opinion. I hope that sometime we can have a meaningful conversation about these matters, but that discussion is not for today.

4. I am also aware that the abortion debate is a highly contentious area in our civil discourse, one that causes great emotion in sorting out the rights of the unborn v. the rights of mothers. This too is a conversation for another time.

5. However, it is highly relevant to our purposes today how we will protect the most vulnerable among us, and how we will prevent abuses of our medical discretion that may amount to torture or may violate our shared human dignity. And that brings us to the matter of dilation and evacuation (D&E), a method of abortion often used between 13 and 24 weeks of pregnancy. I regret that my description of this procedure must at times be somewhat graphic.

6. After a one or two-day period of preparation by dilating the cervix, the abortionist may give the woman an anesthetic, then further open up the cervix with instruments. A suction catheter is then used to remove the amniotic fluid. The remainder of the procedure is particularly brutal:

> After the amniotic fluid is removed, the abortionist uses a sopher clamp — a grasping instrument with rows of sharp "teeth" — to grasp and pull the baby's arms and legs, tearing the limbs from the child's body. The abortionist continues to grasp intestines, spine, heart, lungs, and any other limbs or body parts. The most difficult part of the procedure is usually finding, grasping, and crushing the baby's head. After removing pieces of the child's skull, the abortionist uses a curette to scrape the uterus and remove the placenta and any remaining parts of the baby.[1]

7. Why might we describe this procedure as brutal? It all hinges, of course, on the ability of the unborn fetus to experience pain. If that is even a possibility, then compassion compels

us to reduce and mitigate such terrible stress. And there is a great deal of evidence that the unborn can indeed suffer.

8. One physician specialist has noted:

> The fetus is structurally and physiologically equipped to perceive pain at a very early age, and demonstrates physiological responses consistent with pain perception. These responses are observable at 7.5 weeks and continue to develop until birth.[2]

9. In fact, the ability to perceive pain is not dependent on the complete development of the cerebral cortex, the cognitive part of the brain in the adult. Many sensory fibers from the body travel to the reticular formation, a part of the midbrain, and from there to the thalamus. Pain sensations can travel to these structures, which are present as early as the tenth week of development, and do not need to travel to the cortex to be perceived.[3]

10. There is a common notion that neurological development is linear and progressive, such that every structure must be in place in a fully developed form prior to any function. However, that is not the way the nerves, spinal cord, and brain operate. Even when present in rudimentary form, these structures function in ways that rehearse and help to cause the more sophisticated actions of the mature baby.

11. We know this is true from the fields of perinatology and maternal-fetal medicine. Doctors now have the ability to do manipulations, even surgery, on the unborn fetus while still in the womb. When instruments are passed into the womb from outside, there is movement of the fetus away from those tools. This occurs as early as 8 weeks of gestation, and the fetus reacts to sound at 20 weeks. A direct response to painful stimuli occurs from 22 weeks onward.[4]

12. It is also well established that fetal surgery requires the entity in the womb to be anesthetized. The unborn fetus shows increased levels of stress hormones with various

manipulations, and this is distinct from any transfer of such hormones across the placenta from the mother. Mitigating the pain response of the fetus through appropriate anesthesia is an important element for the successful outcome of such procedures.[5,6] A recent review article on fetal anesthesia summarizes these concerns in the form of a recommendation:

> 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.[7]

13. Given all of this evidence, it should not be unexpected that fetal dismemberment could cause unbearable suffering. It is no surprise, therefore, that eight states have already passed bans on the dilation and evacuation procedure, and a number of other states are considering such a ban. D&E abortions on a living fetus are unnecessary, since there are other ways of accomplishing the abortion.
14. Even the U.S. Supreme Court has recognized this distinction. In 2007, the Gonzales v. Carhart decision upheld the constitutionality of a federal ban on intact dilation and extraction, otherwise known as partial-birth abortion. Justice Kennedy, writing for the majority, commented that D&E is "in some respects as brutal, if not more" than partial birth abortion itself. Evan Justice Ginsberg made this comparison in her dissent, stating that D&E "could equally be characterized as brutal."[8]
15. As I commented earlier, we are not soon likely to resolve our differences on the abortion debate in general. But when both sides of the political and moral spectrum share the same intuition about a particular procedure, this should give us pause. For the sake of compassion and human decency, the gruesome procedure of dismemberment abortion on a living fetus should be outlawed.

16. Furthermore, respect for the comfort of the unborn is not the only reason to reject dismemberment abortion. D&E is also not safe for women. Data from the CDC indicates that dismemberment abortions in the second and third trimester have a higher risk of death for the woman than carrying the pregnancy to term. The reason stems from the sharp fetal bone fragments generated by the crushing action of the forceps. These could easily perforate the womb, or if left behind could cause infection.[9]
17. In addition, D&E abortion requires significant dilation of the cervix, which increases the risk of damage to the womb. This makes it more likely that subsequent pregnancies will end in premature labor. This adverse effect continues throughout a woman's reproductive life.[10]
18. But let us not lose sight of the main reason we are here today. The bill before us, S.B. 145, does not ban the D&E abortion procedure itself; it simply prohibits electively performing that procedure on a living fetus. In other words, the unborn child must be dead before D&E can take place. This is a technique called fetocide, and is easily accomplished by injecting the fetus with potassium chloride. Another method is the use of digoxin injected into the fetus or into the amniotic fluid.[11]
19. Cutting the umbilical cord also causes fetal death within 15 minutes, and is easily done. A recent report in the journal *Contraception* supports this idea: "Umbilical cord transection immediately prior to D&E is a feasible, efficacious, and safe way to induce fetal demise without performing additional procedures."[12]
20. So does S.B. 145 place an undue burden on women seeking a legal procedure? It does not. The modest requirement of fetocide prior to D&E does not add any additional risk, and is a widely accepted technique. In the unlikely event of an imminent threat to the

woman, the bill contains an exception "to preserve the life or physical health of the mother."

21. In summary, S.B. 145 is a modest proposal to ban the brutal and gruesome practice of dismembering a live unborn fetus that may experience excruciating pain. The U.S. Supreme Court in Gonzales has already affirmed that states may place these kinds of limits, and eight other states have already established similar bans.
22. For the sake of compassion, dignity, and our shared humanity, I urge you to support and approve S.B. 145, and I thank you for the opportunity to testify before this distinguished committee.

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