HB 69, Heartbeat Bill PROPONENT TESTIMONY by Dr. Carmen Doty-Armstrong

Mr. Chairman and Members of the Committee:

My name is Dr. Carmen Doty-Armstrong. I am an obstetrician and gynecologist from Findlay, OH where I have had been practicing medicine for 13 years. We are one of the largest private OBGYN practices in northwest Ohio, with 6 providers in two locations. On average, we do approximately 60 deliveries a month.

I support HB 69 because the presence of a fetal heartbeat is the undeniable existence of a unique and distinctive life and the heartbeat is an accepted indicator of life acknowledged by medical professionals worldwide.

I had the privilege of being contacted by the Heartbeat Bill team as they were initially developing this bill. I participated in several conference calls with other physicians to give input as they were determining the Heart Beat Bill verbiage.

From a physician's perspective, the verbiage of the Heartbeat Bill makes perfect sense. A detectable heartbeat is the critical parameter that signifies life for every patient encountered, both moms and babies. It is the first vital sign that can be documented for a fetus and standard medical practice is to document a fetal heartbeat at every prenatal appointment.

I rely on a detectable heartbeat to discern whether a pregnancy is viable or not. I confirm a heartbeat by ultrasound or doppler at every prenatal visit as the fetal heartbeat identifies life. Once there is a heartbeat I know that statistically there is a 90-95 percent chance that the pregnancy will proceed to a live birth.

I believe that a detectable heartbeat is the indicator of life that we cannot ignore. It is an unequivocal sign of viability. It is the vital sign of an unborn child who deserves your consideration and protection.

Carmen Doty-Armstrong, DO, FACOOG
Findlay Women's Care LLC **[Answers to questions below & on Pg 2]**

Using abortion in the case of physical or mental disability:

Genetic testing now provides patients with a great deal of information that was not available in the past. We offer genetic testing to our patients if they request it. In our experience, our patients are interested in the results, not to be able to determine whether or not they should abort their child, but rather to have advanced knowledge

about what special needs their child might have or what preparations they might need to make in advance of his/her birth. We do not perform abortions in our practice when test show that the child will be either physically deformed or mentally handicapped. Given the number of deliveries we do in our practice, this is an issue we deal with occasionally. If the deformity is not conducive with life, the baby will not live after birth. If it is conducive with life, the baby will live. Aborting a child that will, or will not, live after birth is nothing more than a convenience for the mother. Over the past 10 years, we have had many examples of patients that carried their babies to full term even though they were aware that the child would have physical and/or mental disabilities or would not live long after birth.

Medical risk for the mother when her water breaks early in her pregnancy:

It is true that a woman's water can break early in pregnancy before the baby is viable. It is also true that there is risk of serious infection for the mother. It is also likely that the infection was preexisting and was the cause of the rupture in the first place. In our practice, when a patient ruptures early in the pregnancy (before the baby is viable), she is immediately put on antibiotics and blood tests are done to determine whether or not she has an infection. In most cases the mother will go into labor and deliver the baby within 24 hours of the rupture (water breaking). If she does not go into labor we will continue to monitor her (test for infection, continued antibiotics and vital signs). It's possible that the mother might even be sent home (returning for testing and monitoring) until she goes into labor. If she does not deliver and tests show that she develops an infection, we then would consider inducing labor to protect the life of the mother. There are cases where the mother ruptured early in the pregnancy and she still carried the baby to full term or until it could survive outside of the womb. This is unlikely, but possible. Again, in most cases, the mother will deliver the baby within 24 hours of the rupture without intervention. Without details of the case you cited in Ireland, it is impossible to know whether or not the ruptured membrane led to an infection that caused the woman's death or if the infection was even related to the her pregnancy. The infection could've come from a kidney infection or even appendicitis. Did they test her for infection? Did they give her antibiotics? It is possible that her death was simply due to poor medical treatment, nothing to do with the fact that she didn't get an abortion.

Complications due to mother and baby not sharing the same blood type:

I do not agree that abortion will ensure there are no future complications for the mother. Fetal blood cells are in maternal circulation as early as the 1st trimester. When the mother and the baby do not have the same blood type, the patient is given Rhogam. Rhogam is a treatment that binds to the fetal red blood cells to prevent the mother from making antibodies against an RH positive blood type (baby). Once the fetal blood cells cross over into the mother's blood (as early as the 1st trimester), an abortion will not reverse the effect. The mother will still need to take Rhogam in any future pregnancy.