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

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Testimony of Donna J. Harrison M.D.
Abortion until Birth: The Need to Pass the
Pain Capable Unborn Child Protection Act
before the U.S. Senate Committee on the Judiciary
Position: Pass

Dear Mr. Chairman and Senate Judiciary Members,

The most vulnerable people group in the United States is unborn children in the womb. These small human beings in the womb are being pulled apart in pieces, or having their skin burned off, or partially delivered through their mother's vagina and having their brains pierced and sucked out through a suction catheter. These barbaric deaths should be stopped. The Pain Capable Unborn Child Protection Act will stop these barbaric practices from happening to unborn human beings in late pregnancy, when many of them could live outside of their mother if given a chance.

I am Dr. Donna Harrison, a board certified Obstetrician and Gynecologist, and Executive Director of the American Association of Pro-Life Obstetricians and Gynecologists. I submit this testimony on behalf of our membership of over four thousand reproductive health medical professionals across the United States.

The Pain Capable Unborn Child Protection Act will protect unborn children in Delaware from being deliberately killed inside their mother's womb. Many of the children being protected are children old enough to survive outside of their mother's womb. The fact that unborn children who are 20 weeks or older can live outside of the womb underlines the fact that these tiny human beings are separate individuals, and we as a nation have both a right and a duty to protect our most vulnerable members from being hurt or killed.

As an Ob doctor, I can tell you from my experience that it is scientific fact that 20 week babies are very sensitive to pain. They react the same way that you do: They withdraw from painful stimuli, they release stress hormones, their heart rate increases and their breathing increases.

> "The structures which transmit painful stimuli from the skin to the brain are present very early in fetal life[i] 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[ii] et Al. in 2008:
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> *He states: "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][iii] 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][ivv] 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.

A 2012 review article[vi] on fetal anesthesia agrees and 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."

When an unborn human being has to undergo surgery in the womb, the anesthesiologist gives that tiny human being separate anesthesia. Why? Because the anesthesia given to the mother is NOT sufficient for pain relief in the fetus. It is standard of medical care to give the fetus separate anesthesia when surgery is performed. It is pure pro-abortion fantasy to claim that pain relief given to the mother causes the fetus to not feel pain. Fetuses feel pain, just like you do and their body reacts to pain just like you do.

Appendix A is AAPLOG Practice Bulletin 2 Fetal Pain, a summary of the scientific literature on fetal pain up to 2018. Appendix B is the testimony of embryologist Dr. Maureen Condic before the US Judiciary Committee regarding the capacity of the unborn human being to feel pain.

Does an abortion in the second and third trimester cause the fetus pain?

The answer to this question is obvious when you actually look at the reality of what is done to these unborn human beings during an abortion. This reality is disturbing to hear, but even more disturbing is the fact that these procedures are done every day in Delaware.

Abortions done at or after 20 weeks are done by one of three procedures: 1) Dismemberment Abortion (D&E) (Appendix C), 2) Partial Birth Abortion (D&X, Intact D&E) (Appendix D). or 3) Induction (Saline or Prostaglandin) (Appendix E Saline Induction). The most common method is D&E. I would invite you to google abortionprocedures.com, narrated by AAPLOG Board member Dr. Anthony Levatino, who has performed thousands of abortions.

In a D&E abortion, the mother's womb is forced widely open to allow a grasping instrument to be inserted into the womb. The living baby is pulled apart in pieces- an arm here, a leg there,- maybe 10 to 15 pieces to get all of the baby's body out. These babies were alive when the D&E was started. Dr. Warren Hern, a Colorado abortionist who has performed numerous D&E abortions and has written a textbook on abortion procedures stated this:

"*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."*

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 unborn children are ripped apart in the D&E procedure, the outcry would be deafening.

An alternative to the D&E is partial birth abortion. If an abortionist wants the best fetal tissue specimens to sell, then rather than pulling apart the baby piece by piece, the abortionist delivers the body of the baby into the birth canal, then pierces the base of the skull with scissors and sucks out the baby's brain with a high pressure suction catheter. The advantage to doing a partial birth abortion procedure for the abortionist is that the tissue comes out whole and fresh for a better sale, and the baby is guaranteed to be born dead.

If a baby is too big for a D&E then an induction procedure can be used. In a saline induction, very concentrated salt solution is injected into the fluid surrounding the baby. The baby's skin is burned off and after hours to days, the baby dies from clotting disorders. If the abortionist doesn't want to use saline, then the abortionist can induce labor with prostaglandins. But then the abortionist has a problem…the baby will likely be born alive. This is called a "failed abortion" because the product that the abortionist is paid to produce is a dead baby. So, to make sure the baby is born dead, the abortionist can inject potassium chloride into the baby's heart, or a heart medication called digoxin into the living baby's heart or brain, to kill the baby. The baby may struggle for hours to days in his or her mother's womb until he or she dies.

There is no medical reason to intentionally kill the unborn child in order to separate the unborn child from the mother.

There is no medical reason to perform an elective abortion procedure after 20 weeks, the time when the fetus is capable of surviving outside of his or her mother's womb, in order to end a pregnancy. The unborn child could be separated from the mother by delivery, resulting in a live birth by C section or inducing labor, which is safer for the mother than the procedures used in elective abortion.

It is clear from testimony by abortion practitioners during the U.S. Supreme Court Partial Birth Abortion Ban hearings that, unlike a delivery, which separates the mother and her fetus for the purpose of life, an abortion separates the mother and the fetus with the purpose of guaranteeing that the baby is born dead. That's why a fetus who survives an abortion is called a "failed abortion". The separation did not fail to occur. What "failed" to occur in a "failed abortion" is the guarantee of a dead baby.

There are rare circumstances in which a mother's life is in jeopardy due to either pre-existing conditions or pregnancy complications. It is extremely rare for this to occur prior to the point of viability (currently 22 weeks after last menstrual period, 20 weeks after fertilization). **After 20 weeks fertilization age, it is NEVER necessary to intentionally kill the fetal human being in order to save a woman's life**.

In cases where the mother's life actually is in danger in the latter half of pregnancy, there is not time for an abortion, *because an abortion typically is a two to three-day process*.

When a mother's life is truly endangered, immediate separation and delivery is needed. The medically appropriate way to separate the mother and the baby emergently is by C-section, in a hospital where both the mother and her newborn can receive the care that they need.

There is no medical reason to intentionally kill that fetal human being through an inhumane abortion procedure, e.g. dismembering a living human being capable of feeling pain or burning off their skin, or injecting them with drugs to stop their heart. The purpose of these grotesque procedures is to kill the fetus, because that is what the abortionist is paid to guarantee, not to save a mother's life.

Obstetricians who abide by the Hippocratic oath strive, to the best of our ability, to save both lives when at all possible. There are two patients under our care. We never intentionally target the unborn child to kill the child during the separation procedure in order to guarantee that the baby is born dead. 85% of obgyns do not do abortions in their practice. Abortionist in contrast are paid to kill the baby before birth to guarantee that the baby is not born alive.

In other words, a doctor can separate a mother and baby in a way that causes them both the best chance of living. An abortionist separates a mother and baby in a way that makes sure that the baby is dead. In either case, separation would happen. ***The purpose of an elective abortion after 20 weeks is primarily to kill the child so that a live birth doesn't happen***, not to separate the mother and her unborn child.

In the Pain Capable Unborn Child Protection Act, we are **protecting the life of an unborn human being at a gestational age where that human being could live outside of** his or her mother. We have an obligation to protect the rights of these small human beings.

In the Partial Birth Abortion case, the USSC based its decision to uphold the ban 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*."[vii]

Myths and Facts about SB 21

Opponents falsely claim that determining gestational age of the fetus is ambiguous.

It is standard of care in obstetrics and gynecology to determine with as much precision as possible the gestational age of a fetus in order to provide obstetrical care appropriate to that gestational age.

Determining gestational age is routine for the obstetrician. Any obstetrician knows automatically the difference between fertilization age and gestational age by LMP. The conversion is simple: Fertilization age in weeks = LMP gestational age in weeks – 2 weeks. There is no confusion for a physician trained in obstetrics, and both fertilization age and gestational age are routinely used in the medical literature.

Opponents also falsely claim that this bill will put women's lives at risk.

Any obstetrician is routinely called on to make decisions about conditions which threaten the life of the mother, such as pre-eclampsia, chorioamnionitis, etc. Obstetricians routinely make decisions about when to separate the fetus from the mother under these circumstances. The Pain Capable Unborn Child Protection Act clearly allows the obstetrician the ability to legally provide life-saving care for the mother. In fact, in most circumstances, the quickest and safest life-saving care is cesarean section, which is also the best mode of delivery to save the life of the fetus. Cesarean sections can be completed in emergency situations in 30 minutes, under controlled circumstances of a hospital or ICU, where the emergency medical needs of the mother can be addressed. This is in contrast to the days of preparation which usually precede an elective D&E or D&X or induction abortion. Often these days of preparation before elective abortion are spent in a hotel room near the abortion clinic, with no-one to address the woman's medical needs.

Opponents also falsely claim that this bill will ban all abortions.

This bill protects the fetuses who old enough to feel excruciating pain when they are killed in the abortion. Fetuses who are at 20 weeks fertilization (22 weeks LMP) have been demonstrated in numerous research articles to be able to survive after being separated from their mother's womb.

AAPLOG urges the passage of this bill.

Respectfully submitted,

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[i] https://judiciary.house.gov/_files/hearings/113th/05232013/Condic%2005232013.pdf

[ii] 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

[iii] Boris P, Cox PBW, Gogarten W, Strumper D, Marcus MAE. Fetal surgery, anaesthesiological considerations. Curr Opin Anaesthesiol 2004; 17: 235–40

[iv] Boris P, Cox PBW, Gogarten W, Strumper D, Marcus MAE. Fetal surgery, anaesthesiological considerations. Curr Opin Anaesthesiol 2004; 17: 235–40

[v] Giannakoulopoulos X, Teixeira J, Fisk N. Human fetal and maternal noradrenaline responses to invasive procedures. Pediatr Res 1999; 45: 494–9

[vi] Van de Velde M, De Buck F. "Fetal and maternal analgesia/anesthesia for fetal procedures" Fetal Diagn Ther 2012;31:201–209.

[vii] https://www.law.cornell.edu/supct/html/05-380.ZS.html