

Testimony before the Senate Committee on the Judiciary
“The Assault on Reproductive Rights in a Post-Dobbs America”

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Chair Durbin, Ranking Member Graham, and members of the Committee:

Thank you for the opportunity to testify at this hearing. My name is Dr. Monique Wubbenhorst, and I am a practicing board-certified obstetrician-gynecologist with more than 30 years’ experience in patient care, teaching, research, health policy and global health. In my clinical career, I have focused on providing obstetric and gynecological care for underserved and disadvantaged populations in both domestic and international settings. For example, I have cared for women in such places as rural North Carolina, inner city Boston, Native American reservations, as well as women in India, Nepal, the Philippines, Kazakhstan, Ghana, Cameroon, South Sudan and most recently Kenya. I have chaired the Women and Special Populations Committee for the American Heart Association and worked as a senior consultant to the United States Veterans Administration, and was on the faculty of Duke University School of Medicine. Subsequently I was recruited by the United States Agency for International Development to a senior executive position focusing on global health programs and policy, prior to assuming my current role at the de Nicola Center for Ethics and Culture at the University of Notre Dame. I have authored over twenty peer-reviewed publications and been a member of review boards for several peer-reviewed journals, including *The British Journal of Obstetrics and Gynecology*, *Public Health*, *The Journal of Medical Ethics*, *PLOS 1*, *Journal of General Internal Medicine*, *Issues in Law and Medicine*, *Journal of Medical Ethics*, and *The North Carolina Medical Journal*. My research interests include the epidemiology of adverse pregnancy outcomes and long-term cardiovascular health; the molecular biology of adverse pregnancy outcomes; reproductive health; health services research; racial-ethnic disparities in women’s health; women veteran’s health; and ethics in reproductive health.

Abortion is associated with harms to women and children. The *Dobbs* decision, which returns decision-making on abortion legislation to the states, and federal elected officials, presents an opportunity to

mitigate abortion's many harms to women, unborn human beings and communities. Abortion not only poses risks to the mother, it is always lethal to an unborn child.

Abortion is not healthcare. Abortion is defined by CDC as “an intervention...that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth”. The goal of any abortion is therefore to kill the embryo or fetus. The embryo or fetus—the unborn child—is a human being. That is, he or she is a member of the human family, a unique living being with human DNA distinct from his or her parent. He or she is not a “clump of cells” or a “potential child” but an unborn child, a child assuming the human form. Since the goal of an abortion is to cause the death of the unborn child, and the unborn child is a human being, abortion causes the death of a human being. Abortion neither prevents, treats, or palliates any disease. Instead, it has as its goal the death of a human being. Abortion is therefore not health care, for either the mother or her fetus.

The majority of OB/GYNs do not perform abortions. Research shows that not only do the majority of OB/GYNs not perform abortions, but the percentage that do is declining and has been for decades. For example, in 1985, 40% of OB/GYNs surveyed performed abortions (Margaret Terry Orr and Jacqueline Darroch Forrest. The Availability of Reproductive Health Services from U.S. Private Physicians. *Family Planning Perspectives*, Mar. - Apr., 1985, Vol. 17, No. 2, pp. 63-69).

In 1986, 46.5% of OB/GYNs surveyed performed abortions (Weisman C., Nathanson C, Martha Ann Teitelbaum, Gary A. Chase and Theodore M. King. Abortion Attitudes and Performance Among Male and Female Obstetrician-Gynecologists. *Family Planning Perspectives*, Mar. - Apr., 1986, Vol. 18, No. 2 (Mar. - Apr.,1986), pp. 67-73).

In 2008, 22% of OB/GYNs surveyed performed abortions (Steinauer J, Landy U, Filippone H, Laube D, Darney P, Jackson RA. Predictors of abortion provision among practicing obstetrician-gynecologists: A national survey. *Am J Obstet Gynecol* 2008;198:39.e1-39.e6).

In 2011, 14% of OB/GYNs surveyed performed abortions (Debra B. Stulberg, Annie M. Dude, Irma Dahlquist, Farr A. Curlin. Abortion Provision Among Practicing Obstetrician–Gynecologists. *Obstet Gynecol*. 2011 September; 118(3): 609–614. doi:10.1097).

In a 2018 survey, 7% of OB/GYNs in private practice settings performed abortions (Sheila Desai, Rachel K. Jones, Kate Castle. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. *Contraception* 97 (2018) 297–302).

In a 2019 survey of OB/GYNs, 23.8% of OB/GYNs performed abortions. However, among a subset of study participants who provided more detailed information, 33% performed a median of 6 abortions per year, and 48% performed a median of 8 abortions per year (Grossman D, MD, Grindlay K, Altshuler A, Schulkin J. Induced Abortion Provision Among a National Sample of Obstetrician–Gynecologists. *Obstet Gynecol* 2019;133:477–83).

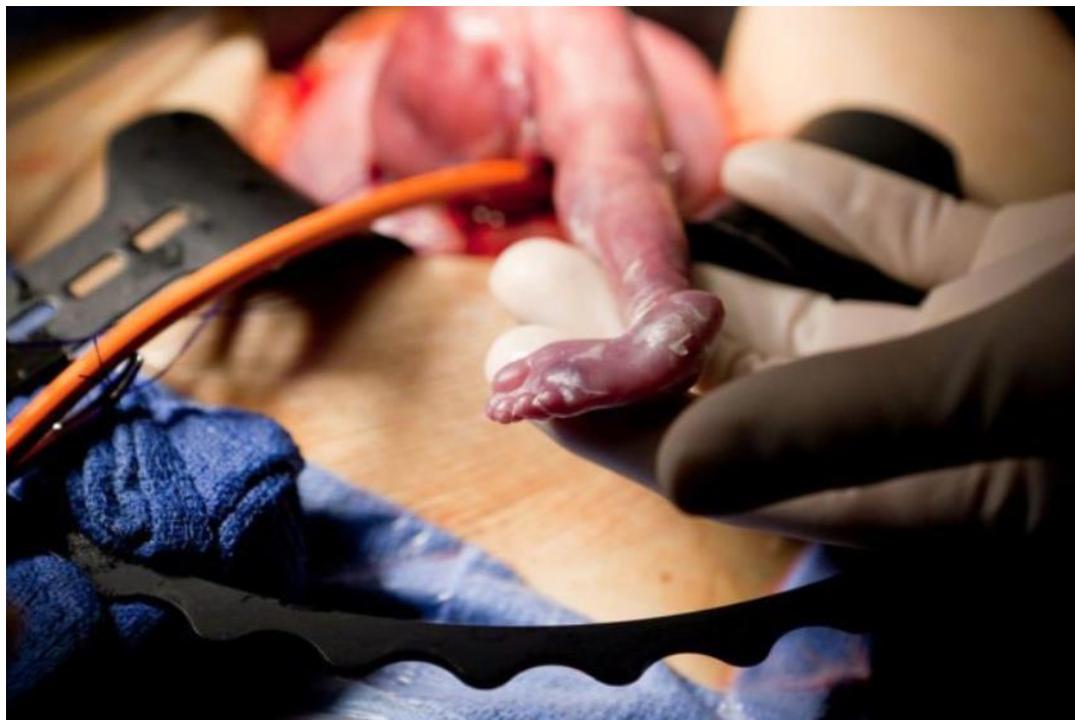
Given that a small and decreasing percentage of OB/GYNs perform abortions, abortion cannot be considered “essential healthcare for women”.

The fetus is a patient. Clinicians caring for pregnant women have two patients: the mother and her unborn child. The fetus is a patient. Advancements in technology have led to recognition of the fetus as a patient by mainstream medicine. Science has not only plainly revealed the human form of the unborn child. It has led to the recognition of the fetus as a patient in his or her own right – the “patient within the patient” (Choolani, M. and A. Biswas, Fetal diagnosis and therapy. Preface. *Best Pract Res Clin Obstet Gynaecol*, 2012. 26(5): p. 515-6). Obstetricians have long viewed the unborn child as a patient along with the mother. But there was a limit to what doctors could do to diagnose or treat an ill fetus until recently. Sophisticated imaging, genetics, and the exploding field of fetal therapy have increased our knowledge of fetal life. Mainstream medicine now treats the fetus as a patient, capable of being treated and worthy of care. With these realizations has come a revolution in care for mothers and their babies. Advancements in technology have led to recognition of the fetus as a patient by mainstream medicine as science has not only plainly revealed the human form of the unborn child but led to the recognition of the fetus as a patient in his or her own right. Clinicians also recognize that the fetus’ environment in the womb can have an impact on the rest of his or her life.

In 1973 when *Roe* was decided, perinatal medicine was a brand-new field. The development of diagnostic technology like ultrasound and MRI, which allowed physicians to safely visualize the living fetus in real time throughout pregnancy, ‘shifted the focus from the newborn, with a severe disorder that could not be corrected after birth, to the possibility of prenatal medical or surgical intervention that could help ameliorate the clinical manifestations of disease ... these diagnostic capabilities led to further research ... and the realization that the fetus was, and is, a patient’.” (C. Malloy, M. Chireau Wubbenhorst, T. Sander Lee, The Perinatal Revolution, *Issues in L. & Med.* 26 Vol. 34 no. 1 (2019).

One of the most common interventions is the preventative treatment of neural-tube defects. Doctors routinely advise women to take folic acid starting before conception and throughout their pregnancy, as it reduces risk for neural-tube defects like spina bifida. Magnesium sulfate has been examined extensively as a means to reduce the risk of cerebral palsy. Congenital adrenal hyperplasia can be diagnosed very early in pregnancy and treated, starting at 7-9 weeks' gestation. Other fetal problems that can be medically prevented or treated are HIV infection and thyroid disease.

Improved diagnostic capability has allowed for many conditions to be treated medically while the fetus is still *in utero*. Advancing technology also allows doctors to perform open fetal surgery as early as 15 weeks' gestation, including heart surgery. During these surgeries, physicians will open the uterus and operate directly on the fetus, producing images like those below, which reinforce the human form of the child in the womb (Shawn Shinneman, *The Surgeon Who Works On Babies Before They're Born*, *Dallas Magazine*, Oct. 2018, <https://www.dmagazine.com/publications/d-magazine/2018/october/timothy-crombleholme-works-on-babies-before-theyre-born/>; [Vanderbilt-pioneered fetal surgery procedure yields positive results | Vanderbilt University](#)).





Over the last decade, the number of fetal surgeries has “soared as never before” (Carlo V. Bellieni, Analgesia for fetal pain during prenatal surgery: 10 years of progress, *Pediatric Res.* 1612-18, 1 & Fig. 1 (Sept. 24, 2020), <https://www.nature.com/articles/s41390-020-01170-2>.) The rapidly developing field of fetal therapies and surgery is significant for purposes of considering the fetus as a patient. These new technologies have confirmed that in the view of mainstream medicine, “the fetus has truly become a patient” (Moise, K.J., Jr., The history of fetal therapy. *Am J Perinatol*, 2014. 31(7): p. 557-66).”. If the unborn child was not a human being, or a patient, the tremendous investment in research and clinical care to treat them would not have occurred. This investment only came about because it was recognized that the unborn child is human and a patient, and worthy of intervention to save his or her life, or improve its quality.

The view that the fetus is a patient only changes, however, if the same child is unwanted by its mother and slated for abortion. Thill notes that “abortion rights advocates and abortion providers preferentially avoid terminology such as ‘baby’ and ‘fetus’ (Andaya and Campo-Engelstein 2021)” or images of the fetus because of “not wanting to give the fetus human status”. This denies or ignores an overwhelming amount of data and scientific consensus. It is morally inconsistent to choose to treat some fetuses and to abort others, to withhold medical treatment from some and not from others. Human dignity is not

dependent on whether that human is slated to die. “By protecting even those convicted of heinous crimes, the Eighth Amendment reaffirms the duty of the government to respect the dignity of all persons” (McCorvey v. Hill, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring). It is my professional opinion that the same ethical principles governing the medical treatment of the fetus should govern elective abortion of the fetus. This includes restrictions on abortion, including for eugenic reasons; recognition of the fact that the fetus experiences pain at earlier gestational ages than previously thought, with avoidance of procedures which likely cause pain to the fetus at early gestational ages; and recognition of the fact that the fetus is a human being with human dignity, and who experiences pain at earlier gestational ages than previously thought.

The fetus feels pain. Science shows that an unborn child is able to perceive pain much earlier than previously thought. “[N]eonatal and medical science ... now graphically portrays, as science was unable to do, how a baby develops sensitivity to external stimuli and to pain much earlier than was then believed.” McCorvey v. Hill, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring). With the development of fetal surgery, it was necessary for physicians to consider fetal pain, and anesthesia to prevent it, to ensure treatment is done humanely. After reviewing scientific evidence from the last decade, researchers have now concluded that “the human fetus can feel pain when it undergoes surgical interventions and direct analgesia must be provided to it” (Bellieni). Not only do physicians prevent and treat fetal pain, insurance companies reimburse the cost of doing so.

Thill (Thill B. Fetal pain in the first trimester. *The Linacre Quarterly* 2022, vol. 89(1), pages 73-100) notes that “In the field of fetal medicine...fetal surgeons and anesthesiologists, routinely administer fetal analgesia at increasingly earlier gestations in the second trimester (> 14 weeks) to ameliorate pain and improve outcome. Consideration of fetal pain capacity and negative long-term neuroadaptive phenomena have prompted anesthesiologists to recommend fetal analgesia from the second trimester onwards (Gupta, Wimalasundera and Moore, 2021, , *Anaesthetic Considerations in Fetal Therapy*. In: Goudra, B.G., Singh, P.M., Green, M.S. (eds) *Anaesthesia for Uncommon and Emerging Procedures*. Springer, Cham. https://doi.org/10.1007/978-3-030-64739-1_28).). Some prominent researchers, likewise, propose fetal pain capacity beginning as early as 12 weeks gestation via the cortical subplate... The fetal pain debate is also complicated by political and legal issues regarding abortion and feticide. Recognition of fetal pain capability at 12 weeks gestation, for example, has the potential to impact second- and third trimester abortions...”.

Generally, pain is perceived after receptors transmit the pain message to the spinal cord, which carries the message into the deeper parts of the brain—the thalamus and cortex—for processing. These structures are developing in the baby well before “viability.” Thill notes that

“Fetal pain perception requires that the pathways for pain signal transmission are present and functioning, at least at an immature level. The sensory systems for both tactile and nociceptive stimuli develop early in embryologic development, preceding the development of the olfactory, vestibular, auditory, and visual systems (Borsani et al. 2019). Noxious stimuli are first sensed by peripheral nociceptors in the perioral area at 7.5 weeks gestation, the hands (10 weeks), and most areas of the body by 14 weeks gestation (Humphrey 1964). Nerve fibers from these peripheral receptors reach the spinal cord beginning at 7–8 weeks gestation (Okado and Kojima 1984). Projections from the spinal cord reach the brainstem and thalamus beginning at 7 weeks gestation (Derbyshire 2006, 2008). Nerve fibers from the thalamus then project to the cortical subplate, a structure in the fetus, discovered in 1974, which is a waiting compartment for neurons which later migrate to the fetal cortex (Judas, Sedmak, and Pletikos 2010). The first thalamocortical nerve fibers from the thalamus project to the cortical subplate beginning at 12–15 weeks gestation (Bystron et al. 2008; Kostović and Judas 2002; RCOG 2010), earlier than the 20–22 weeks that has been reported in previous studies (Hevner 2000; Kostovic and Rakic 1990; Lee et al. 2005). Thalamocortical fibers are then noted to “massively invade the subplate zone” between 15–26 weeks gestation (Kostovic and Judas 2002, 146)”³¹.

The fact that the fetus lacks a fully functional cortex before 24 weeks’ gestation had previously led some scientists to believe that fetal pain perception was impossible before then, despite evidence showing that the fetus will respond to noxious stimuli much earlier (V. Glover & N. Fisk, Fetal pain: implications for research and practice. *Brit. J. Obstet. Gyn.* Vol. 106, 881–86, 882(Sept. 1999), <https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/j.1471-0528.1999.tb08424.x>). More recent research “call[s] into question the necessity of the cortex for pain and demonstrat[es] functional thalamic connectivity into the subplate.” Further, “even if the cortex is deemed necessary for pain experience, there is now good evidence that thalamic projections into the subplate, which emerge around 12 weeks’ gestation, are functional and equivalent to thalamocortical projections that emerge around 24 weeks’ gestation.” Researchers now believe that “current neuroscientific evidence undermines the necessity of the cortex for the experience of pain and supports the possibility of fetal pain before 24 weeks” (Bellieni).

Review of the last decade's research shows that science has also disproved other theories arguing that fetal pain is impossible before 24 weeks. "[O]ne of the most prominent researchers" in the field of fetal pain, "who had always excluded" its eventuality, "has changed his conclusions, due to the new evidence". He now concludes that "[o]verall, the evidence, and a balanced reading of that evidence, points towards an immediate and unreflective pain experience mediated by the developing function of the nervous system from as early as 12 weeks. That moment is not categorical, fetal development is continuous and not an event, and we recognise that some evidence points towards an immediate and unreflective pain not being possible until later. Nevertheless, we no longer view fetal pain (as a core, immediate, sensation) in a gestational window of 12–24 weeks as impossible based on the neuroscience"(Derbyshire SWG, Bockmann JC. Reconsidering fetal pain. *J Med Ethics* 2020;46:3–6. doi:10.1136/medethics-2019-105701).

The relevance to abortion was not lost on the prominent researcher who reconsidered his views due to new science. Even though he is pro-choice, he and his co-author (who is pro-life) noted that "The two authors of this paper have very different views on the morality of abortion. One of us believes that abortion is necessary for women's health and autonomy, while the other believes that abortion violates the ethical principle of non-maleficence and ought to be restricted and discouraged. Regardless of our stark differences on this question, we both believe that our moral views on abortion should not interfere with discussion of whether fetal pain is possible and whether the science of fetal development can rule out the possibility of fetal pain. We also agree that if fetal pain is likely then that has ethical and clinical significance independent of any views on the morality of abortion per se. That said, it is also clear to us that the issue of fetal pain has ethical significance because of abortion practices and not because of other surgical or therapeutic fetal procedures" (Derbyshire).

There are limited data on how the fetus responds to noxious stimuli before 15 weeks' gestation. Thill notes that "Physician testimony offered during state legislative hearings, however, has reported fetal withdrawal and flailing during feticide *prior* to 18 weeks gestation" (Ohio Senate Bill 2019).

It is still unknown exactly how the fetus experiences pain. But even if it does not experience pain in the same way as an adult with a fully formed cortex, fetal pain is still worthy of consideration. In fact, evidence suggests that the unborn child, like infants, may even experience pain more severely than mature humans. Glover and Fisk note "The last pathways in the nociceptive system ... do not form until

after birth, raising the possibility that the fetus may actually be more sensitive to noxious stimuli than the older child, and may explain why the newborn shows exaggerated behavioural responses to sensory provocation.”.

Physicians already recognize this and as noted avoid suffering in even very pre-viable fetuses. Fetal anesthesia is the standard of care for any fetal procedure. Derbyshire and Bockmann (S. Derbyshire & J. Bockmann, Reconsidering fetal pain, *J. Med. Ethics* Vol. 46, no. 1, 3–6, 4 (2020), <https://jme.bmj.com/content/46/1/3>) note “[W]hile all the evidence suggests that surgeons performing therapeutic fetal interventions routinely consider pain relief for the fetus, surgeons performing abortions have their focus on the pregnant woman as their patient. Consequently they more rarely consider fetal pain relief during the preparation and execution of abortion. Whether or not the fetus feels pain, therefore, is relevant to current medical practice surrounding abortion and could motivate changes in practice.” They also note “Currently ... we are not aware of any procedures where invasive fetal intervention proceeds without anaesthesia or analgesia, except for abortion.”

The possibility of fetal pain warrants the same consideration given in the context of medical treatment as it does in the context of abortion. Yet when those same babies are subjected to abortion, their suffering is deemed irrelevant because they are destined to die. As noted above, medicine has developed new ways to treat the fetus as a patient and is addressing the impact those treatments have on the fetus with respect to pain. However, over the same period, abortion providers have increasingly employed brutal abortion methods, such as dilation and evacuation (D&E), in the second trimester.

Second and third trimester abortion. Because abortion kills a human being, as we have seen, elective abortion is not healthcare. The term “therapeutic abortion” is a misnomer, since pregnancy is not a disease. Such abortions not only destroy human life in a gruesome and painful way, they are associated with significant risks to women (see below).

In addition to demonstrating the humanity of the fetus, advancing technology also provides more information about how the fetus experiences the brutal second or third trimester abortion procedure that ends its life. Dilation and evacuation (D&E) is the procedure currently used after 15 weeks’ gestation. The Supreme Court of the United States has previously described D&E based on the testimony of late-term abortionist Dr. Leroy Carhart in gruesome “technical detail” in *Stenberg v. Carhart*, acknowledging that its description “may seem clinically cold or callous to some, perhaps horrifying to others.” As the Supreme Court explained,

The Supreme Court described the D&E procedure in gruesome “technical detail” in *Stenberg v. Carhart*, acknowledging that its description “may seem clinically cold or callous to some, perhaps horrifying to others.” As the Supreme Court explained, abortion doctors use D&E in the second trimester because at that stage of fetal development, “the fetus is larger”—“particularly the head”—and the “bones are more rigid,” meaning “dismemberment or other destructive procedures” are required. . . . A physician extracts from the womb what moments before had been a living “unborn child”—using forceps, scissors, or a similar instrument that “slices, crushes, or grasps” fetal body parts one at a time. Piece by piece. Arm by arm. Leg by leg. And as the abortion doctor “cut[s] or rip[s] the piece from the body”—a torso, a spine, a rib cage—he places each body part on a tray (or in a dish) 87 to keep inventory and ensure that nothing is left behind. Sometimes the heart is still beating on the tray. The fetus dies just as an adult experiencing corporal dismemberment would—by bleeding to death as his or her body is torn apart.⁴¹

“As one bioethicist testified, it’s ‘self-evident that it’s brutal and inhumane to tear a living organism limb from limb alive’”⁴². And “[n]o one would dispute that, for many, D&E is a procedure itself laden with the power to devalue human life” (*Gonzales*, 550 U.S. at 158.89).

Given the recent evidence showing the fetus may experience pain as early as 12 weeks, researchers have directly concluded that “a D&E procedure will deliver repeated nociceptive events that may involve fetal pain before fetal death”. Fetal pain is so likely that the same researchers advocate for fetal analgesia to be used in abortions, even before less outwardly brutal procedures causing fetal death, such as feticidal injections (injections into the heart of the fetus to kill him or her before D&E). But the D&E procedure is inherently brutal and inhumane regardless of whether the fetus can feel it. We would never countenance dismembering a person (or even an animal) as a means of causing death, even if the person were anesthetized first.

This was acknowledged in the recent United States Supreme Court case *Dobbs*, where the justices noted more than once the problematic nature of D&E. Quoting *Gonzales v Carhart*, the court noted that that case found “most abortions after 15 weeks employ ‘dilation and evacuation procedures which involve the use of surgical instruments to crush and tear the unborn child,’ and it concluded that the “intentional commitment of such acts for nontherapeutic or elective reasons is a barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession”. Abortion destroys what those decisions call “potential life” and the life of an unborn human being. Current science strengthens these interests.

Nevertheless, considerations of fetal pain are often excluded from the abortion informed consent process. As Thill notes,

This dichotomy in terminology and the shielding of the pregnant woman from medical information may unduly influence the patient's decision-making process, particularly in a time of crisis when reliance on medical counsel is high. Reports over the past 20 years show that fetal pain is a concern of women considering abortion (Andaya and Campo-Engelstein 2021; Furedi 2001; RCOG 2010). Research, however, notes a reluctance among providers to discuss fetal pain due to concerns of causing emotional distress for the pregnant woman (Andaya and Campo-Engelstein 2021). This has raised the issue of medical paternalism potentially precluding appropriate patient counseling, education, and informed consent. In *Gonzales v. Carhart* (2007), abortion providers noted that pertinent medical information about the abortion procedures was not typically disclosed to patients. In the majority opinion, Justice Kennedy noted that the omission of information necessitates government involvement: "It is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State...The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know... (IV.A)" (quoting *Gonzales v. Carhart*, 550 U. S. 124, 160 (2007)).

Abortion is associated with risks to the mother. But it is not only the unborn child who faces risk of death and serious injury from a second or third trimester abortion. The mother who undergoes these procedures is at high risk for serious complications, including death. Abortion in the second and third trimesters is significantly more dangerous than in the first trimester. And it does not appear to be the case that abortion is safer than childbirth.

Most abortions are elective. Because elective abortions are not performed out of medical necessity, the bar for safety should be very high. There is evidence that the safety of both surgical and medical abortion is overstated.

Risks of medication abortion. First trimester medication abortion carries substantial risks to the mother. A study by Niimaki et al used data from Finland's health service administrative database, which included all women in Finland undergoing abortion from 2000 to 2006 (42,619 women) and collected follow up data for 42 days post abortion (Niinimäki M, Pouta A, MD, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. *Obstet Gynecol* 2009;114:795–804). This study design captured all outcomes for all women undergoing abortion in an entire country over a longer period of time than most studies of abortion complications. As a result, it is free of methodological problems and bias that plague other studies of abortion, including those conducted in the United States.

In the study by Niimaki et al, 20% of women underwent medical abortion, and 5.6% underwent surgical abortion. The authors note that “The overall incidence of adverse events was fourfold higher in the medical compared with the surgical abortion cohort. The risk of hemorrhage with medical abortion was 15.6%, and 2.1% with surgical abortion. The risk of incomplete abortion with medical abortion was 6.7%, and 1.6% with surgical abortion. The risk of emergency surgery with medical abortion was 5.9% with medical abortion, and 1.8% with surgical abortion”.

Therefore, in this study, women undergoing medical abortion had 8 times the risk for hemorrhage compared to those undergoing surgical abortion. They had 5 times the risk of needing a curettage to remove retained placenta or fetal parts, and 4.2 times the risk for an adverse event compared to those undergoing surgical abortion. These findings have significant implications given the increased use of medical abortion.

As noted, the strength of this study was its ability to completely ascertain all abortions and all associated complications. In contrast, other studies attempting to answer questions about the safety of abortion have methodological problems, which are due to the study design. For example, a study by Upadhyay et al (Ushma D. Upadhyay, Sheila Desai, Vera Zlidar, Tracy A. Weitz, Daniel Grossman, Patricia Anderson, Diana Taylor. Incidence of Emergency Department Visits and Complications After Abortion. *Obstet Gynecol* 2015;125:175–83), though well designed, has many limitations, similar to other retrospective administrative database research studies. These include potential confounding associated with inaccurate coding; the absence of clinical data, especially on gestational age at the time of abortion and method of abortion; and the likelihood that patients with complications did not engage with the medical system. As with many studies of this type, no charts were reviewed. There was very limited follow up. The authors acknowledge some of these issues and note as well that, for example, second trimester abortion complications in their study are lower than in other studies, suggesting that their population may not be representative, or that cases were incompletely ascertained.

First trimester surgical abortion carries immediate risks of hemorrhage, infection, continuing pregnancy, death, perforation of the uterus, damage to organs including hysterectomy. These complications, and the need to discuss them in counseling for informed consent, are described in the *National Abortion Federation 2020 Clinical Policy Guidelines for Abortion Care*.

Future pregnancy complications may be caused by surgical abortion-related uterine damage. This may lead to an abnormal placental attachment, causing premature separation (abruption) or invasion (accreta); both have been associated with catastrophic hemorrhage at delivery.

Additionally, cervical incompetence caused by abortion-related damage may lead to preterm delivery, potentially harming the mother from aggressive medical interventions, and the sibling from complications of prematurity. Large meta-analyses have shown a dose-dependent increase in this risk, with women obtaining multiple abortions at even higher risk of delivering a subsequent child prematurely.

Longer-term risks may include infertility. In one of the few long-term studies of infertility in women with a history of abortion, Wang et al (2017) evaluated 454 patients with a history of induced abortion and 1078 without. They found that the miscarriage rate was significantly higher, and the lining of the uterus was significantly thinner, among patients with a history of surgical abortion. Women who had a history of more than two surgical abortions had lower live delivery and clinical pregnancy rates.

Out of all abortions reported by state-level and CDC data in 2018, nearly 40,000 of them, or 7.8%, of all abortions were performed at or after 14 weeks gestation. Many of the harms to women from mid-trimester abortions are discussed in a paper at <https://lozierinstitute.org/midtrimester-abortion-epidemiology-indications-and-mortality/>. Morbidity and mortality cluster in second and third trimester procedures (Grimes 1985; Bartlett et al 2004; Lohr et al 2010).

Analyzing the CDC's abortion surveillance data from 2018 by age group reveals that most second trimester abortions are performed in women who are 20-29 years old – in every gestational age band from 14 weeks to 21 weeks and greater, the 20-29 year old group has the largest amount of abortions.

Analyzing the CDC's abortion surveillance data from 2018 by ethnicity also reveals that most second trimester abortions – 38.6% of them – are performed in Black women; in every gestational age band up to 21 weeks gestation, more abortions are performed in African American women than any other ethnicity. These statistics likely underestimate abortion rates and ratios and hence the impact of abortion on the African American population, given that data from states with large populations (such as California and New York) are not included in the CDC dataset.

In the U.S. 96.9% of abortions at or after 13 weeks' gestation are performed surgically using dilation and evacuation (D&E), suction procedures, and hysterotomy (incision into the uterus) or hysterectomy (removal of the uterus). 3.1% of second-trimester abortions are performed using medical methods; that

is, mostly with orally or vaginally administered prostaglandins with or without mifepristone to induce labor. A small percentage of medical abortions are still being performed by instillation (or injection) of prostaglandins, saline, or urea into the amniotic cavity in the late second or third trimester, which usually but not always kills the fetus. Despite the notably increased risks for complications and death associated with the procedures, 2018 CDC data for a limited number of states indicates that at least 219 abortions were performed with this method. Again, this dataset likely underestimates the number of instillation abortions performed since states with large populations are not included.

As Turok et al (2008) note, "The risk of death from abortion increases with gestational age, and these procedures are potentially more morbid because of the increased size of fetal and placental tissue, increased blood volumes and a distended uterus...". Cates and Grimes (1981) used data from approximately 243,000 D&E procedures from 1972-1978 and noted that for women undergoing D&E the mortality rate was 5.6 per 100,000 at 13-15 weeks' gestation and 14.0 per 100,000 at > 16 weeks'. In comparison, the mortality rate for dilation and curettage procedures at < 12 weeks' was 1 per 100,000; for instillation procedures at > 13 weeks' it was 13.9 per 100,000 for saline and 9 per 100,000 for prostaglandin and other agents; and for hysterectomy and hysterotomy 42.8 per 100,000. The authors note that 'because the risk of death from D&E is directly related to gestational age, the death:case rate [or ratio of deaths per 100,00 procedures] in the 13-15 week interval (5.6/100,000) is significantly...less than at 16 weeks' or later (14/100,000).'"

Many studies have quantified the association between increasing gestational age and increasing risk for maternal mortality, specifically in second trimester abortions. A study by Cates and Grimes using abortion data from 1972-1978 shows that D&E procedures performed at 16 weeks gestation were nearly 3 times more dangerous than those performed from 13-15 weeks, with the risk of a woman dying from a second trimester abortion increasing 50% for each additional gestational week.

Similarly, Zane et al reported using CDC and AGI abortion data from 1998-2010 that the mortality rate for women having second trimester abortions increases with gestational age, from 2.4 deaths per 100,000 abortions at 14-17 weeks gestation to 6.7 deaths per 100,000 at or after 18 weeks gestation.

Rates of complications associated with second trimester abortion are higher than for first trimester abortion. For example, Turok et al (Turok D, Gurtcheff SE, Esplina MS, Shahb M, Simonsena SE, Trausch-Van Horn J, Silvera RM. Second trimester termination of pregnancy: a review by site and procedure type. *Contraception* 77 (2008), pp. 155–161) studied differences in complications between second trimester

abortions performed in 475 women, in hospitals vs. free-standing clinics. The authors found that major complications (defined as death, uterine perforation, hysterectomy, transfusion, clotting disorders, deep venous thrombosis, pulmonary embolus, stroke or heart attack, need for exploratory surgery, and prolonged hospitalization) occurred in 1-11% of women undergoing D&E, depending on the site where the procedure was performed.

Other complications included: need for readmission, need for curettage after abortion for retained placenta and/or fetal parts, infection of the fetal membranes after initiation of the procedure, and uterine infection. The authors also note that complications may have been underreported due to loss to follow-up.

Edlow et al. (Edlow AG, Hour MY, Maurer R, Benson C, Delli-Bovi L, Goldberg A. Uterine evacuation for second-trimester fetal death and maternal morbidity. *Obstetrics and Gynecology* 2011;117:307–16) noted that “[higher] gestational age was significantly associated with maternal morbidity”, with women undergoing abortion at > 20 weeks’ being 2 ½ times more likely to suffer a complication than women undergoing abortion at < 20 weeks’ gestation.

Lederle et al. (Lederle L, Steinauer JE, Montgomery A, Aksel S, Drey E, Kerns JL. Obesity as a Risk Factor for Complication After Second-Trimester Abortion by Dilation and Evacuation. *Obstetrics and Gynecology* 2015 September; 126(3): 585–592) found a 30% increased risk for complications with each additional week of gestation. In my opinion, the above data support the assertion that the safety of abortion, especially in the second trimester, is overestimated.

Relatively few second trimester abortions are performed for the health of the mother (with 2018 CDC data showing the highest percentage for life of the mother abortions was 7.1%) or fetal anomalies (highest percentage is was 2.3% among states reporting). Rather, most second trimester abortions are performed in a healthy women carrying a normal fetus who desires to end her pregnancy. Overall, common exceptions to abortion restrictions are estimated to account for less than five percent of all abortions meaning that 95 percent of abortions are for elective or unspecified reasons.

Another harm to women from abortion is the facilitation of sex trafficking. The link between child sex trafficking and abortion has been documented. Child sex trafficking is a prevalent problem in the United States. For example, a local study in Minneapolis, which has an active anti-trafficking program, found over 34,000 advertisements posted online for sex in the Twin Cities in a six-month period

<https://alphanews.org/minneapolis-in-top-cities-for-child-sex-trafficking-mn-attorney-general/>.

Abortion is used to cover up child sexual abuse and sex trafficking.

In a review of 13 federal sex trafficking cases that focused on trafficking in minors in Minnesota, Floro C. Balato, an attorney and anti-trafficking advocate, noted that a “total of twenty-five (25) female victims were identified. None of the victims were males. All victims were recruited, transported, advertised online and sold for commercial sexual exploitation by the defendants. Out of this number, twenty-one (21) were minors and four (4) were eighteen (18) years old and above, showing that most of the victims in the sex trafficking cases reviewed were minors...The large number of minor victims highlight the vulnerability of this age group to sex trafficking. From the actual cases reviewed, it appeared that sex traffickers may be more likely to recruit minor women to their operations. In this review, 84% of the trafficked individuals were minor females.

Research on survivors of sex trafficking indicates that pimps and traffickers force exploited teenagers to undergo abortions when they become pregnant. In Laura Lederer and Christopher Wetzel’s 2014 study of trafficked women , 71% of trafficked women reported at least one pregnancy while being trafficked. 21% reported having 5 or more pregnancies. 55% reported at least one abortion and 30% reported multiple abortions. 66 of the women surveyed, who responded to abortion questions, stated that 114 abortions were reportedly performed on them during their trafficked state. One young woman had 17 abortions. Based on these findings, sadly, abortion may be enabling sex traffickers to exploit children and adolescents.

Lederer states “Notably, the phenomenon of forced abortion as it occurs in sex trafficking transcends the political boundaries of the abortion debate, violating both the pro-life belief that abortion takes innocent life and the pro-choice ideal of women’s freedom to make their own reproductive choices”. It also violates the innocence of children and adolescents, as well as adult women caught in prostitution.

Abortion does not appear to be safer than childbirth. The assertion that “abortion is safer than childbirth” has been used to defend the so-called right to abortion in virtually every abortion-related legal case over the last 20 years or more. This assertion can be traced to papers by Grimes and colleagues (2006 and 2012) which were published in leading OB/GYN journals and which reiterated earlier, similar claims. These studies mix different types of data, from different sources, with different denominators and definitions. Grimes’ 2012 paper notes these serious problems and limitations, stating that “weaknesses include the

likely underreporting of deaths, possibly differential by pregnancy outcome (abortion or childbirth)". This claim also does not acknowledge the flaws in abortion data collection for both numbers of abortions and deaths from abortion, and ignores differences in the biology and physiology of pregnancy at different stages.

U.S. abortion data are incomplete. The collection of abortion statistics is widely acknowledged to be severely flawed. CDC's collection of data is voluntary, not mandatory. Starting in 1998, multiple states did not report their abortion data or provided incomplete data. Per CDC's 2019 Abortion Surveillance, "Data from 24 reporting areas excludes 17 states that did not report, did not report by race/ethnicity or did not meet reporting standards," including Alabama, Arizona, California, Delaware, District of Columbia, Florida, Hawaii, Illinois, Louisiana, Maine, Maryland, New Hampshire, New Mexico, Tennessee, Vermont, Wisconsin, and Wyoming.

California, Maryland, and New Hampshire do not report any official data, and many states submit incomplete data lacking information on gestational age, race-ethnicity and gestational age. The lack of abortion reporting from some of the most populous states makes it difficult to arrive at accurate estimates of the number of abortions performed in the United States.

In 2019, CDC's Abortion Surveillance report stated that "Because reporting to CDC is voluntary and reporting requirements vary by the individual reporting areas, **CDC is unable to report the total number of abortions performed in the United States** [emphasis added]." Data collected by the Alan Guttmacher Institute (AGI) are also limited because AGI relies on surveys rather than collection of case data. According to AGI's own description of their methodology, see <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>. Both CDC and AGI data acknowledge the limitations of their data and their quality. Their reports are estimates and cannot be used to precisely assess the total number of abortions performed in the United States.

Estimates of abortion related mortality are likewise inaccurate because deaths from abortion appear to be underreported (see David C. Reardon, Thomas W. Strahan, John M. Thorp, Jr. & Martha W. Shuping, Deaths Associated with Abortion Compared with Childbirth – A Review of New and Old Data and the Medical and Legal Implications, 20 J. Contemp. Health Law & Policy 279, 286-91 (2004); Byron Calhoun, Systematic Review: The maternal mortality myth in the context of legalized abortion, *The Linacre Quarterly*, 264 (2013).

The problem of inadequate data collection and analysis is not limited to abortion mortality. It is far greater for abortion complications. CDC does not systematically collect and report data on abortion complications, nor do many abortion providers. In some states, abortion providers are required to report immediate complications. However, there are very few studies on longer-term follow up. The American College of Obstetrician-Gynecologists Current Commentary: Routine Follow up Visits After First-Trimester Induced Abortion (2004) noted that "In practice, attendance at abortion follow up visits is usually low, generally about 50%. Studies of first trimester aspiration abortion complications observing consecutive series of patients show follow-up proportions from 35% to 60%, although a few series report proportions as high as 80-90%". Most women with complications from abortion seek help at emergency departments. This is especially true of abortions performed by non-physicians, who by definition cannot manage abortion complications. Therefore, the true risks of abortion to women and the frequency of abortion-related complications remain unknown. The need for accurate statistics on abortion is a public safety issue, not a pro-life or pro-choice issue..

As a result of these flaws, it is not possible to accurately estimate the risks of abortion, including abortion mortality. It is my opinion that without an accurate estimate of the number of abortions performed in the United States or the number of maternal deaths from abortion, it is impossible to estimate abortion related morbidity or mortality with any precision.

U.S. maternal mortality data are incomplete. Maternal deaths use a denominator of 100,000 live births, even though it is acknowledged that only two-thirds of maternal deaths are associated with a live birth. This is because many reported deaths occur while a woman is pregnant, but not near term. It is estimated that 39-93% of maternal deaths are not reported on death certificates, which also skews maternal mortality statistics.

Maternal death reporting associated with early losses is even more compromised, with international records-linkage studies documenting that less than a quarter of deaths following induced abortion are reported on death certificates. Because of these severe data deficiencies, the U.S. did not report a maternal mortality ratio to the world from 2007-2016.

Even now, researchers are aware that U.S. statistics continue to be flawed and many deaths go underreported. Calculations of abortion related mortality and maternal mortality not only overlap, they also use different denominators. Some studies use the number of maternal deaths per 100,000 abortions. Some use the number of deaths per 100,000 live births. In fact, it is very difficult to accurately estimate

the true denominator of all pregnancies. Many pregnancies miscarry before detection, or are only briefly detected using a pregnancy test (“chemical pregnancies”), or their outcomes are not reported (a woman is never seen by a physician, miscarries at home, etc.). Many pregnancy outcomes are never reported. For these reasons it would be impossible to count all pregnancies occurring in all women in a given year (the denominator for estimates of maternal mortality). Maternal mortality data as noted are compromised due to many data deficiencies. The numbers of miscarriages and induced abortions occurring annually in the United States is not known, nor is there mandated reporting of their complications and deaths, so we lack knowledge about the adverse outcomes of most early pregnancy events (Stuart M. Berman, H. Trent MacKay, David A. Grimes, Nancy J. Binkin. Deaths From Spontaneous Abortion in the United States. *JAMA* 1985;253:3119-3123); Hani K. Atrash, H. Trent MacKay, Nancy J. Binkin, Carol J. R. Hogue. Legal abortion mortality in the United States: 1972 to 1982. *Am J Obstet Gynecol* 1987;156:605-12; Herschel W. Lawson, Alice Frye, Hani K. Atrash, Jack C. Smith, Holly B. Shulman, Merrell Ramick. Abortion mortality, United States, 1972 through 1987. *Am J Obstet Gynecol* 1994; 171:1365-72; Mona Saraiya, Clarice A. Green, Cynthia J. Berg, Frederick W. Hopkins, Lisa M. Koonin, Hani K. Atrash. Spontaneous Abortion–Related Deaths Among Women in the United States—1981–1991. *Obstet Gynecol* 1999;94:172–6; Suzanne Zane, Andreea A. Creanga, Cynthia J. Berg, Karen Pazol, Danielle B. Suchdev, Denise J. Jamieson, William M. Callaghan. *Obstet Gynecol*. 2015 August ; 126(2): 258–265. doi:10.1097/AOG.0000000000000945; CDC Abortion Surveillance 2018 available at <https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm>).

In 2004, Dr. Julie Gerberding, then head of the CDC, noted that maternal mortality rates and abortion mortality rates “are conceptually different and are used by the CDC for different public health purposes.” Julie Louise Gerberding, M.D., to Walter Weber, American Center for Law & Justice, July 20, 2004, <http://afterabortion.org/pdf/CDCResponsetoWeberReAbortionStats-Gerberding%20Reply.pdf>, responding to Weber's April 30, 2004, letter to Tommy G. Thompson, U.S. Department of Health and Human Services, requesting a reassessment of pertinent statistical measures of mortality rates associated with pregnancy outcome, <http://afterabortion.org/pdf/WeberLettertoThompson&CDCReAbortionStats.pdf>.

Given these limitations it is scientifically inaccurate to claim any connection between high maternal mortality rates and state abortion legislation, or between maternal mortality rates and access to abortion. Variations in abortion reporting produce unstable estimates which make it impossible to calculate the true maternal mortality rate in the United States, let alone make comparisons between states.

Assertions that abortion is safer than childbirth also do not take into consideration the biology of fetal and uterine development and adaptation, or the epidemiology of spontaneous abortion, induced abortion, and term delivery. At 8 weeks, the fetus is 1.22 inches long and weighs 0.71 ounces. At 20 weeks, the fetus is 12.7 inches long and weighs 11.7 ounces. At term the average fetus is 21 inches long and weighs 8 lbs. Uterine size increases from approximately the size of an orange late in the first trimester to almost the size of a watermelon in the late third trimester. Uterine blood flow increases from 200 cc/minute in the nonpregnant state to almost 1 liter per minute at term. An abortion done in the first trimester is therefore vastly different from childbirth. It is my opinion, supported by scientific evidence, that the two procedures (first trimester abortion and childbirth) are not comparable due to these changes.

In 2019 most abortions (79%) were performed at less than or equal to 9 weeks, and 92.7% were performed at less than or equal to 13 weeks. But mortality from abortion mostly occurs in the smaller number of abortions performed at later gestational ages. If abortion maternal mortality estimates combine deaths at all gestational ages, the estimates will be skewed toward the lower mortality rates at lower gestational ages due to the much larger number of abortions done at lower gestational ages. This “needle in a haystack” effect contributes false support to the conclusion that abortion is safer than childbirth. It is illogical to conflate abortion mortality risk with that from childbirth at term. A more accurate comparison would be between abortions vs. miscarriages early in pregnancy, and late abortions and childbirth. Data show that abortion is riskier at equivalent gestational ages compared with miscarriage or birth.

Bartlett et al (2004) used abortion mortality data to estimate abortion mortality as gestational age increases. They noted that “currently, the risk of death [from abortion] increases exponentially at all gestational ages...the risk of death at later gestational ages may be less amenable to reduction because of the inherently greater technical complexity of later abortions related to the anatomical and physiologic changes that occur as pregnancy advances [emphasis added].” These authors found that the risk of a woman dying from abortion increased 38% for each week of gestational age. Abortions performed past 21 weeks had a mortality rate 76 times greater than abortions done in the first trimester. Based on their data, the estimated maternal mortality rate for abortions done at 28 weeks would be 62/100K, at 30 weeks 225/100K, and at 36 weeks 818/100K. These estimates are astronomically higher than the maternal mortality rate at term.

Even compared with cesarean delivery, surgical abortion done using a hysterotomy (an abortion technique that uses an incision in the uterus to remove the fetus) carries a markedly higher maternal mortality. Epner et al (1998) noted a maternal mortality rate of 274 per 100,000 hysterotomy or hysterectomy procedures, a rate much higher than for contemporaneous cesarean delivery, again suggesting that even for these surgical procedures, the assertion that abortion is safer than childbirth is incorrect.

Abortion does not prevent pregnancy complications or maternal death. A woman's individual risk for pregnancy complications such as diabetes, high blood pressure in pregnancy, or even death, can be estimated but not predicted with certainty. There is no way to predict whether an individual woman will suffer a pregnancy complication, and therefore any presumed effect of abortion on maternal mortality is speculative and based on statistical sleight-of-hand.

Abortion does not prevent pregnancy complications or maternal death. It merely ends a pregnancy during which a woman may or may not have had a complication. A woman's individual risk for pregnancy complications can be estimated but not predicted with certainty, because there is no way to predict whether an individual woman will suffer a pregnancy complication. Any statement that an abortion can reduce a woman's risk for maternal morbidity and mortality in the absence of signs of life-threatening illness is speculative at best and inaccurate at worse, and in this case the procedure is not an abortion if done for this reason (see below). All risk is based on estimates, and when estimating complications from a disease, some individuals will develop them and some will not. This cannot be predicted with complete certainty. Good maternal care during pregnancy markedly reduces the risk of complications from many diseases.

For any pregnancies where serious complications occur, early delivery of the unborn child may be necessary, but such a delivery is not an abortion because its goal is to save the life of the mother, and the life of the fetus, if possible. As in law, in medicine the intent of the procedure is paramount. The intent of the procedure done to save the life of the mother prior to viability of the fetus is not to kill the fetus, and in fact the procedure is done in such a way as to attempt to save the life of the unborn child. The intent of the procedure is not to kill the child, but to save the life of the mother. "Premature delivery is not induced abortion...the Dublin Declaration upholds that 'there is a fundamental difference between abortion and necessary medical treatments that are carried out to save the life of the mother, even if such treatments results in the loss of life of her unborn child". In those tragic cases, if possible, an attempt will

be made to preserve the life of the baby and if not possible, the body of the unborn child is treated with respect, recognizing the humanity of the life which is lost in the separation” (AAPLOG). Treating the body of the child with respect means not using a destructive dismemberment procedure, such as D&E.

There are times when separating the mother and her unborn child (that is, performing delivery of the fetus) is necessary to save the life of the mother, even if the unborn child is too premature to live. The death of the fetus may be a tragic outcome of early delivery, but it is not the goal, as it is in abortion, and especially abortions where destructive dismemberment procedures are used, such as D&E. Performing a procedure to save the life of the mother while acknowledging that the procedure may result in the death of the unborn child is a standard ethical framework which has been used as part of reasonable medical judgment in obstetrics and gynecology for more than a century. Such a delivery is not technically an abortion and therefore ethically permissible because its goal is to save the life of the mother, and the life of the fetus, if possible.

“In contrast, the purpose of an induced abortion is to produce a dead baby. The Centers for Disease Control and Prevention defined legal induced abortion as an ‘intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate a suspected or known ongoing intrauterine pregnancy and produce a non-viable fetus at any gestational age’...the focus of the abortion procedure is on killing the unborn child, and the purpose of the abortion is to produce a dead baby”⁵⁶.

Importantly, in the standard ethical framework used by obstetrician-gynecologists in performing a procedure to save the life of the mother and if possible the life of the baby, if the unborn child does not die, the procedure is still considered a success. This is in contrast to a “failed abortion”, where the goal of the procedure is to kill the fetus, and the procedure is considered a failure if he or she survives. In this case, fetal survival is considered a complication of the procedure.

Regardless of whether some women undergo abortion, the risk of pregnancy-related complications for any woman is the same because the root causes of maternal morbidity and mortality – cardiovascular disease, hemorrhage, infection, blood clots, etc. – are unchanged. Abortion does nothing to address these causes.

Abortion decreases the number of pregnancies that may be at risk by ending pregnancies, whether they are at risk or not (decreasing the numerator of potentially at-risk pregnancies) and killing unborn

children. This is a eugenic argument: that by preventing the “fit” – those women at highest risk for adverse pregnancy outcomes (most of whom are older women, and/or, not incidentally, African American) – from reproducing, society’s goals of better statistics can be met. The early eugenicists made this argument, proposing contraception and sterilization as solutions to medical and public health problems such as pellagra, and malnutrition. By reducing the number of the “unfit”, they claimed, the health of the American population would be improved.

Similar arguments are made today related to abortion and maternal mortality. But abortion does not increase the safety of other pregnancies that carry to term. It does not address the patient, community or health systems factors associated with maternal mortality. Many pregnancy complications can be prevented in many cases with patient education, lifestyle modification and medical treatment. Others can be managed with proper medical care.

There is hope for parents whose unborn children have disabilities, or who are premature. Abortion is used to end the lives of disabled children. This is modern eugenics. As noted above, second and third trimester abortion using D&E is the preferred technique for aborting unborn children with anomalies, including those with anencephaly (eugenic termination). In this context, eugenics has as its goal the “weeding out” of the unfit by killing those individuals who are deformed, weak, unwanted or considered less than human. Justice Thomas recently explained abortion’s ties to the eugenics movement, noting that “technological advances have only heightened the eugenic potential for abortion”...Thus, there is a “compelling interest in preventing abortion from becoming a tool of modern-day eugenics”. As was found in *Dobbs*, states have a legitimate, if not compelling interest in preventing discrimination on the basis of race, sex or disability. These interests should be considered in limiting abortion, since many abortions performed in the second trimester are for fetal anomalies.

For many families there are other options than abortion for unborn children with disabilities. Advanced perinatology, neonatology and pediatrics allow our medical system to safely care for high-risk women and their unborn children facing fetal abnormalities. Advancements in science and medicine, especially over the past 50 years, have paved the way for the significant growth in maternal fetal medicine (MFM) and fetal care centers in the U.S., and for perinatal hospice.

Today, we have an unobstructed view inside the womb of the developing unborn child, which not only unveils the humanity of every life but allows physicians to diagnose conditions and manage life-saving care with greater precision and confidence. As noted above, birth defects once considered life-threatening, and debilitating are now identified much earlier in gestation, and many can be corrected via in utero surgery at major medical institutions throughout the United States. Such innovations have resulted in increased fetal survival, improved quality of life, and a significant reduction in the standard age of viability. For those who are unlikely to survive, the standard of care for babies born alive that are too young to be resuscitated still includes palliative care: pain medication, warmth and swaddling for comfort.

Extremely premature babies are now surviving at new records of 21-weeks' gestation—a little over halfway through a standard 40-week pregnancy duration. Infant mortality has declined and neurodevelopmental impairment among surviving infants has been reduced. Medical teams work to save children at 21-22 weeks gestation and have found that survival rates for babies born 22 to 23 weeks' gestation are significantly higher in hospitals with maternal-fetal medicine physicians and specialized equipment. There are currently over 80 hospitals in the United States reported to assist babies born at 22 weeks gestation.

Today, there are 1,587 MFM subspecialists in the United States, a 17% increase over 12 years, with one MFM specialist for every 14 general obstetrician-gynecologists and one MFM for every 2,277 births. Some states have shown tremendous growth from 2010 -2022 in the number of MFM specialists, with Virginia showing 600% growth. And the highest number of MFM specialists are in some of the most populous states including California (179), New York (140), Texas (137), Florida (80), and Pennsylvania (68).

For families facing fetal anomalies, such as spina bifida and twin-to-twin transfusion syndrome, some conditions are now treatable with modern surgical interventions before birth, some as early at 15 weeks gestation. Today, there are over 35 medical centers in the United States that perform advanced in-utero fetal therapeutic procedures. There are centers located across 21 states and 31 cities.

For parents facing possible life-limiting conditions such as Trisomy 13 or Trisomy 18, studies show that significant long-term survival is possible for selected patients after receiving interventions for congenital heart disease. Patients on a corrective treatment pathway demonstrated median survival of 32 years

(ranging from 11-53 years), while patients on a palliative treatment pathway demonstrated shorter median survival of 10 years.

For conditions that are currently untreatable before birth, there are 125 perinatal hospice programs, a subspecialty within MFM in the United States, with more than 70% of total programs being less than 10 years old. Several studies show improved psychological outcomes for families who carried their affected children to term and then cared for them through the end of their children's lives in the neonatal period. It is imperative that these options be presented to parents struggling with a prenatal diagnosis for their children.

Since *Roe v Wade*, an estimated 17 million unborn African Americans have been aborted in the United States. That's more than the populations of the countries of Senegal and Cambodia, respectively, and slightly less than the entire population of the Netherlands. This means the deaths of not only the 17 million black people who were aborted, but all of their descendants and, families and their hopes, dreams and contributions to our society. We must ask ourselves, is this justice? How does one defend the deliberate killing of the most vulnerable members of a minority group, especially when births to that group have been and continue to be in decline?

There are substantial racial disparities in abortion rates, abortion mortality and non-abortion related maternal mortality between black women and white women. The abortion rate for African American women is 2-3 times higher than for white women. African American women also have 2-3 times higher mortality rate from abortion compared with white women. Bartlett et al found that "The second most significant risk factor for death [from abortion, after gestational age] overall was race. Women of black and other races were 2.4 times as likely as white women to die of complications of abortion...At all gestational ages, women of black and other races had higher case mortality rates than white women".

Zane et al (2015) also reported that the abortion "mortality rate was 0.4 for non-Hispanic white women, 0.5 for Hispanic women, 1.1 for black women and 0.7 for women of all other races...Black women have a risk of abortion-related death that is three times greater than that for white women".

Black women therefore have higher rates of abortion, higher rates of abortion-related mortality, and higher rates of maternal mortality compared with white or Hispanic women. Black women undergo approximately 200-300,000 abortions annually, CDC 2019 estimates 132,878 abortions in African American women, or 38.4% of the total, based on data from 30 states. Using the total # of abortions

(629,898) as the denominator, the estimated total number of abortions in African American women was 292,675. This is true even though African Americans (population 42,000,000) comprise only 12-14% of the total population. An estimated 684 African American unborn children are aborted every day, at an average rate of 28 every minute, or 1680 per hour.

The most recent CDC statistics (from 2021) show that the maternal mortality rate among African American women is more than double that of white or Hispanic women. While these mortality statistics are highly aggregated, it is difficult or impossible to reconcile them with the assertion that abortion reduces maternal mortality. Black women have the highest rates of abortion, and the highest rates of maternal mortality. Both of these facts cannot be true if abortion reduces maternal mortality.

In conclusion, the societal landscape post-*Dobbs* offers many opportunities to help women carry their unborn children to term. The pro-life message is one of hope and healing, and of love, of walking with women and parents through often difficult circumstances, of helping families to thrive, and working to avoid abortion's harms to women and children. Thank you.