Statement to the House Health and Government Operations and Judiciary Committees
Re: House Bill 961: Maryland Women’s Late-Term Pregnancy Health Act

Monday March 16, 2015
SUPPORT

What do we know about later term abortion risks?

Available data confirm that the further along in pregnancy a woman seeks an abortion, the greater the risk to her health and life.

1. At or below 8 weeks LMP: the risk is 1 woman for every one million abortions
2. From 16-20 weeks: 1 per 29,000 abortions
3. By 21 weeks: the risk of dying is 1 woman per 11,000 women. Another way of saying it: she is 91 times more likely to die from abortion than she was in the first trimester.

Gestational age is the strongest risk factor for abortion-related mortality. There are approximately 15,000 abortions annually in the U.S. past 20 weeks LMP. This means that 2-3 women die each year from complications related to later term abortions.

Cause of death in second trimester abortion¹:

• 38% hemorrhage
• 19% embolism
• 19% anesthesia
• 14% infection
• 11% other (includes cardiac and cerebrovascular)

A later term abortion is riskier than a first trimester abortion because:

• Baby larger: The cervix must be stretched open much wider because the baby is much larger. This increases the risk that the cervix will be torn and hemorrhage.
• Uterus soft and full of blood vessels: The uterus is large, soft and highly vascular, and is more at risk for being punctured by abortion instruments, which can cause massive hemorrhage—internally and externally.
• Lethal injections given to end the baby’s life to prevent a live birth could get into the mother’s bloodstream and cause complications.
• Damage to organs: A D&E abortion is a destructive procedure that involves grasping, tearing, and pulling fetal parts out through the opened cervix. Bony fragments can cut or tear maternal tissue causing damage and hemorrhage.
• Retained tissue & Infection: abortion provider keeps track of fetal parts to avoid leaving parts behind that could cause infection.
• Need for Anesthesia: increasing degrees of sedation and general anesthesia further increase the risks inherent with later term abortions.

There are additional long term risks associated with surgical abortion that increase maternal morbidity and mortality beyond any risk associated with childbirth that are not included in available databases.

There is evidence in the literature that women who undergo later term abortions experience a statistically significant increase in symptoms consistent with PTSD, such as disturbing dreams, reliving the abortion, and trouble falling asleep\(^2\).

In the National Abortion Federation approved textbook on induced abortion, “advanced stage of pregnancy” is listed as a “risk factor for negative emotional sequelae” following induced abortion\(^3\).

**Placenta previa**\(^4\), \(^5\), \(^6\), \(^7\): the risk of having a pregnancy complicated by placenta previa is higher in women who have had an induced abortion. Placenta previa occurs when the placenta covers or partially covers the cervix. This can result in unpredictable massive bleeding that threatens the life of baby and mother, especially during labor. In addition to the risk of bleeding, it is associated with the risk of preterm birth and death early in infancy.

**Preterm birth**\(^8\): it is well established in the medical literature that induced abortion increases the risk of delivering prematurely with subsequent pregnancies.

**What is the evidence for fetal perception of pain?**

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\(^2\) Coleman PK, Coyle CT, Rue VM. Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms. 2010; J of Pregnancy.


Scientists continue to debate when an unborn baby begins to feel pain. Some argue that the fetus is only capable of an involuntary reaction to pain. However, considerable research supports that not only do babies experience pain before birth, but they feel it intensely and it impacts their life after birth.\(^9\)

Fetuses possess the wiring and chemistry needed to experience pain up to the level of thalamus and subcortical plate by 20 weeks gestation along with the beginning of connections to the cerebral cortex.\(^9\)

Scientific dogma\(^10\) maintains that our ability to consciously perceive pain can only arise when the connections between the thalamus and cortex begin to function, which some say isn’t until 29-30 weeks gestation.

However, many experts in pain and consciousness research are challenging these outdated, old school ideas\(^11\) and are distressed that they have led to mistaken notions about people with impaired, immature or absent cortical function and ignore a large body of research.

Is a functioning cerebral cortex needed to consciously experience pain?

1. Penfield operated on 750 awake patients, removing large portions of the brain and cerebral cortex without the patients ever losing consciousness.\(^12\) He recognized that other subcortical structures were mediating consciousness. Consciousness can exist even when great quantities of the cortex are absent.\(^13\)

2. Studies of the hydranencephalic infants and children provide confirming evidence for this subcortical system\(^14\),\(^15\) and for the ability to experience pain in the absence of a cerebral cortex.

Children born with hydranencephaly, a rare condition where the cerebral cortex does not form, possess awareness and responded to painful and pleasurable stimuli in a coordinated manner similar to intact children, such as smiling, laughing, “fussing”, and crying, in a manner that was termed “cortex-less” children clearly possess awareness and of a variety of cognitive capacities indicative of “ordinary consciousness”. They recognize faces, have appropriate affective responses (turn and smile

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when called by name), have musical preferences (facial expressions changed to reflect the song’s mood and instruments).

2. Is the developing fetus in a coma-like state, essentially unconscious?
   - Not based upon the actions of fetal surgeons who provide sedation and pain meds to reduce fetal movement, to prevent a hormonal stress response (which is associated with poor surgical outcomes in newborns) and to prevent long term developmental problems associated with ‘remembering’ pain.\(^{17}\)
   - Putting a needle directly into the fetus’ abdomen causes it to react with vigorous body and breathing movements which doesn’t happen when the needle is placed in the umbilical cord\(^{18}\), which has no nerves. That doesn’t sound like a coma to me.
   - The idea that long term adverse effects can occur in response to painful stimuli is counter-intuitive to the notion that the unborn child is considered to be in a coma.

3. Fetuses use novel ways to process pain and are not merely “tiny adults”\(^{19}\)
   - There is substantial evidence that fetuses use different structures to process pain that differ from those of normal adults.
   - Such as the subcortical plate, are present at specific times during development and fulfill the role of pain processing without the need for the cerebral cortex\(^{20}\).
   - Connections from the thalamus to the subplate zone may be sufficient\(^{21}\).
   - If Lee’s assertions are correct, then the majority of premature babies in the NICU do not feel pain either.

5. Stimulating or removing the adult thalamus alters pain perception; not so with the cerebral cortex\(^{22}\).

Clearly, the thalamus plays a key role in pain perception of adults, adds credence to the mounting evidence that the fetus doesn’t need a fully functioning cortex to feel pain.

Substantial evidence exists that the 20 week fetus has a functioning nervous system, capable of experiencing pain.

The practice of medicine is founded on the commitment to first do no harm. On the question of fetal pain perception, unless there is unequivocal evidence that unborn children at 20 weeks from conception cannot feel pain, the default must be to err on the side that they are capable of suffering in response to painful stimuli.

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Anand, 2005, p.38, “My opinion is, based on evidence suggesting that the types of stimulation that will occur during abortion procedures, very likely most fetuses at 20 weeks after conception will be able to perceive that as painful, unpleasant, noxious stimulation.”

From the testimony of Dr. Sunny Anand, Director, Pain Neurobiology Laboratory, Arkansas Children’s Hospital Research Institute, and Professor of Pediatrics, Anesthesiology, Pharmacology, and Neurobiology, University of Arkansas College of Medicine U.S. Congress. House of Representatives. Committee on the Judiciary. Pain of the Unborn

**Does removing later term abortion access increase maternal mortality?**

A 2012 study conducted in Chile compared maternal mortality rates during two different time periods in that nation’s history: one when induced abortion was legal, and a second time frame when it was illegal. The authors found that the maternal mortality rates went DOWN when abortion was made illegal. This data convincingly demonstrates that the 1989 law prohibiting abortion has not put women’s lives at risk, effectively refuting the claims that abortion advocates routinely employ against most abortion restrictions.

**Is Induced Abortion Safer Than Childbirth?**

The answer is no, but if you believe the findings in Grimes’ 2012 article in Obstetrics & Gynecology, the answer would be a resounding yes! The authors found that childbirth was 14 times more likely to result in death than an induced abortion. A closer look at this study reveals a number of flaws which invalidate their conclusions.

The authors admit their conclusions are based on estimates and not actual data points: The total number of legal induced abortions was available or estimated from all reporting areas; however, not all of these areas collected information regarding some or all of the characteristics of women who obtained abortions.

They excluded abortion-related deaths in later term abortions, and only looked at first trimester abortion related deaths. This misses at least 12% of the data.

They used data from the Centers for Disease Control (CDC) and Guttmacher to capture the number of deaths related to childbirth and induced abortion. The CDC admits that their system under-represents abortion morbidity and mortality because:

1. CDC collects data using two systems and only 54% of data shows up in both.
2. Voluntary abortion reporting: no federal law requires reporting and many states/counties within states don’t report abortion-related deaths to the CDC. Only 26 states require providers to report.
3. CDC notes that 40% of deaths occur in the other non-live birth category. This over-inflates the maternal mortality.

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In calculating the abortion related mortality ratio, authors used CDC numbers for the abortion deaths in the numerator and Guttmacher numbers for the total number of abortions in the denominator, (which the CDC states is usually 30% more than their totals), yielding a much lower ratio (0.6 abortion deaths per 100,000) than what is actual.

The systems that the U.S. currently uses to capture maternal and abortion related mortality are woefully inadequate and are riddled with flaws.

**Death certificates** list the complication as the cause of death (i.e. infection) and NOT the procedure (i.e. abortion). Further, it is estimated that 50% of cases of maternal death certificates do not report pregnancy status. Bartlett in her 2004 paper writes: “On average, the Abortion Mortality Surveillance System reports more than twice as many deaths related to legal induced abortion than are reported on routine death-certificate data.” A Finnish study of pregnancy associated deaths reported 73% of deaths missed by relying solely on the death certificates.

**Suicide deaths** are rarely linked back to the abortion in state reporting.

Most women (2/3’s) never return to abortion clinics with complications—therefore not reported as abortion complications. Abortion clinics don’t provide emergency follow-up: women go to the hospital with their post abortion complications and frequently, these deaths are not linked to the abortion.

**What is Needed to Get Quality Data for Accurate Maternal Mortality Numbers?**

Clearly, death certificates, alone are not sufficient. Large, population-based record linkage studies containing complete reproductive history data in conjunction with data related to deaths, provide the best opportunity to bypass many of the limitations of the currently available maternal mortality data in most countries.

a. **Data from these types of studies in the U.S. and abroad clearly show a statistically significant increased risk of death associated with induced abortion, as compared to carrying to term.**

   i. Gissler, post-pregnancy death rates within one year were reported to be nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000).

   ii. Gissler and colleagues again found that mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000).

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From this information, one can conclude that reliable record-linked data supports that abortion is riskier than childbirth.

Thank you for looking through this material. I sincerely hope you will study it and allow it to inform your decision regarding this bill.

It is clear that we do not have high quality statistics in the U.S. regarding pregnancy related deaths. Based upon what is available in the medical literature, it is clear that later term abortion is decidedly NOT safer than childbirth. Later term induced abortion is associated with 91 times increased risk of death when compared to an abortion performed at or below eight weeks from a woman’s last menstrual period.

In conclusion, later term induced abortion is risky for women and likely inflicts significant pain on human fetuses. Please put an end to later term abortion in Maryland. Women in Maryland deserve better.

I respectfully ask for a favorable vote on HB 691.

Sincerely,

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