Testimony in Support of Montana HB 136 (Pain-Capable Unborn Child Protection Act)
January 19, 2021
Katie Glenn, JD

Dear Chair Usher, Vice Chair Regier, Vice Chair Kelker, and Members of the Committee:

My name is Katie Glenn, and I serve as Government Affairs Counsel of Americans United for Life (AUL). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. Our vision at AUL is a nation where everyone is welcomed in life and protected in law.

Thank you for the opportunity to testify in support of H.B. 136, the Montana Pain-Capable Unborn Child Protection Act, a bill prohibiting abortion after the fetus reaches a gestational age of 20 weeks, except when necessary to protect the life or physical health of the mother. This bill would protect maternal health, which is increasingly at risk the later in pregnancy an abortion is performed. It also asserts Montana's legitimate interest in preventing fetal pain and affirming life.

Later-Term Abortions Carry High Risks.

In 1973, abortion was enshrined as a constitutional "right" by the U.S. Supreme Court without any real consideration of the impact of abortion on maternal health. No medical data was entered into the legal record. In fact, when *Roe v. Wade* was decided 47 years ago, there were few, if any, peer-reviewed studies related to the long-term risks of abortion.**[1]** Now the medical field paints a different picture than that before the Supreme Court in 1973. We now know what the Justices did not know (or refused to consider) then: abortion harms women, and the risk of harm increases substantially with gestational age.

It is undisputed that abortion carries a higher medical risk when performed later in pregnancy. Even Planned Parenthood, the largest abortion provider in the United States, agrees that abortion becomes riskier later in pregnancy. On its national website, Planned Parenthood states: "The chances of problems gets higher the later you get the abortion, and if you have sedation or general anesthesia. . . ," which would be necessary for an abortion at or after 20 weeks of gestation.**[2]** To put this in context, "[i]t is estimated that about 1% of all abortions in the United States are performed after 20 weeks, or approximately 10,000 to 15,000 annually."**[3]**

Gestational age is the strongest risk factor for abortion-related mortality, and the incidence of major complications is significantly higher after 20 weeks' gestation.**[4]** For example, compared to an abortion at 8 weeks' gestation, the relative risk of mortality increases exponentially (by 38 percent for each additional week) at higher gestations.**[5]** Specifically, the risk of death at 8 weeks is reported to be one death per one million abortions; at 16 to 20 weeks, that risk rises to 1 per every 29,000 abortions; and at 21 weeks or more, the risk of death is 1 per every 11,000 abortions.**[6]** In other words, a woman seeking

an abortion at 20 weeks is 35 times more likely to die from abortion than she was in the first trimester. And at 21 weeks or more, she is 91 times more likely to die from abortion than she was in the first trimester.

Further, researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."**[7]** This is because in later-term abortions there is a greater degree of cervical dilation needed, the increased blood flow predisposes to hemorrhage, and the myometrium is relaxed and more subject to perforation.

A scientific study on maternal mortality in a country that has prohibited abortion since 1989 found that making abortion illegal did not result in an increase in maternal mortality.**[8]** In fact, during the period studied (1957-2007), the overall Maternal Mortality Ratio—the number of maternal deaths related to childbearing divided by the number of live births—dramatically declined by 93.8%. This contradicts the unproven assumption advanced by many supporters of unrestricted abortion-on-demand who repeatedly assert that prohibitions on abortion will cause a rise in maternal deaths.

In addition to the mortality risks, later-term abortions also pose an increased risk for maternal health. Some immediate complications from abortion include blood clots, hemorrhage, incomplete abortions, infection, and injury to the cervix and other organs.**[9]** Immediate complications affect approximately 10% of women undergoing abortion and approximately one-fifth of these complications are life-threatening.**[10]**

Montana Has A Legitimate Interest in Preventing Fetal Pain.

Montana is permits abortion up to viability, which means current law does not protect unborn babies from abortion for several weeks when they are capable of experiencing pain. Dr. Warren Hern of Boulder, Colorado is one of the only doctors in the United States to perform abortions after 30 weeks, and he estimates that only a third of the late-term abortions he performs are because of a significant fetal health issue.**[11]** H.B. 136 would protect the remaining seventy percent of unborn babies from elective abortion.**[12]**

There is substantial medical evidence that an unborn child is capable of experiencing pain at least by 20 weeks after fertilization (22 weeks LMP), if not earlier.**[13]** In 2019, scientists found evidence of fetal pain as early as 12 weeks' gestation.**[14]** A study from 2010 found that "the earlier infants are delivered, the stronger their response to pain"**[15]** because the "neural mechanisms that inhibit pain sensations do not begin to develop until 34-36 weeks[] and are not complete until a significant time after birth."**[16]** As a result, unborn children display a "hyperresponsiveness" to pain.**[17]** According to one group of fetal surgery experts, "The administration of anesthesia directly to the fetus is critical in open fetal surgery procedures."**[18]** Current medical science has firmly established the existence of pain in preborn infants at or before 20 weeks. It is well within the legitimate interests of the state of Montana to minimize fetal pain as much as possible.**[19]** Montana should protect unborn babies by enacting the Montana Pain-Capable Unborn Child Protection Act into law.

H.B. 136 is Constitutional.

From its inception in *Roe v. Wade*, the abortion "right" has been explicitly qualified. In *Roe*, while the Court established a constitutional "right" to abortion, it simultaneously expressed that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that [ensure] maximum safety for the patient."**[20]** Affirming what is considered the essential holding of *Roe*, the U.S. Supreme Court in *Planned Parenthood v. Casey* asserted that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy. . . . The woman's liberty is not so unlimited, however, that from the outset [of pregnancy] the State cannot show its concern."**[21]** In both *Casey* and later in *Gonzales v. Carhart*, the Court continued to affirm its "essential holding" that states have "legitimate interests from the outset of the pregnancy in protecting the health of the woman."**[22]** This means the states can enact regulations aimed at protecting the health of the mother from the earliest stages of pregnancy. Thus, the medical basis for H.B. 136 supports its constitutionality.

Many states have acted on this legitimate interest of protecting both maternal health and the unborn child. Currently 20 states maintain an enforceable limitation on abortion at 20 weeks postfertilization: Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin.**[23]** By passing H.B. 136, Montana will affirm its legitimate interest in protecting life.

Today, I strongly encourage this Committee to protect maternal health and prevent fetal pain by voting in favor of H.B. 136, the Montana Pain-Capable Unborn Child Protection Act.

Respectfully Submitted,
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Government Affairs Counsel
Americans United for Life

[1] *See* Clarke D. Forsythe, Abuse of Discretion: The Inside Story of the Supreme Court's Creation of the Right to Abortion (2013) (Providing information on the legal and medical landscape in 1973).

[2] *See* Planned Parenthood, *How Safe Is An In-Clinic Abortion?*, **https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion** (last visited Jan. 14, 2021).

[3] James Studnicki, *Late-Term Abortion and Medical Necessity: A Failure of Science*, 6 Health Servs. Research and Managerial Epidemiology, 1 (2019).

[4] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 731 (2004); Janet P. Pregler & Alan H. DeCherney, Women's Health: Principles and Clinical Practice 232 (2002). *See also* Slava V. Gauferg, *Abortion Complications*, **https://emedicine.medscape.com/article/795001-overview** (updated Jun. 24, 2016) (last

visited Jan. 5, 2020) (Several large-scale studies have revealed that abortions after the first trimester pose more serious risks to women's physical health than first trimester abortions).

[5] Barlett, *supra* note 4; Professional Ethics Comm. of Am. Assoc. of Pro-Life Obstetricians & Gynecologists, *Induced Abortion & the Increased Risk of Maternal Mortality*, Comm. Op. 6 (Aug. 13, 2019).

[6] Barlett, *supra* note 4.

[7] *Id.* at 735.

[8] Elard Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, PLOS One (2012) **https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0036613**.

[9] *See* Planned Parenthood, *supra* note 2

[10] E. Shadigian, *Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion*, Testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (Sept. 21, 2005).

[11] Anna Staver, *Why a NY Woman Came to Colorado for a 32-Week Abortion*, The Denver Post (Oct. 13, 2019) **https://www.denverpost.com/2019/10/13/late-abortion-women-2020/**.

[12] In fact, Dr. Hern admits himself that around one fourth of all late-term abortions he performed were because of a Down syndrome diagnosis, which is an elective abortion; *see* Warren M. Hern, *Fetal Diagnostic Indications for Second and Third Trimester Outpatient Pregnancy Termination*, 34 Prenatal Diagnosis 438 (2014).

[13] Federal Pain Capable Act S. 160, Sec. 2(1)-(11).

[14] Stuart W.G. Derbyshire & John C. Bockmann, *Reconsidering Fetal Pain*, 46 Journal of Medical Ethics3 (2020).

[15] Lina K. Badr et al., *Determinants of Premature Infant Pain Responses to Heel Sticks*, 36 Pediatric Nursing 129 (2010).

[16] Charlotte Lozier Institute, *Fact Sheet: Science of Fetal Pain*, **https://lozierinstitute.org/fact-sheet-science-of-fetal-pain/#_ednref14** (last updated Feb. 19, 2020).

[17] Christine Greco and Soorena Khojasteh, *Pediatric, Infant, and Fetal Pain*, Case Studies in Pain Management 379 (2014).

[18] Maria J. Mayorga-Buiza et al., *Management of Fetal Pain During Invasive Fetal Procedures. Lessons Learned from a Sentinel Event*, 31 European Journal of Anaesthesiology 188 (2014).

[19] *Gonzales*, 550 U.S. 124 at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.")

[20] *Roe v. Wade*, 410 U.S. 113, 150 (1973).

[21] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 869 (1992).

[22] *Id.* at 846; *see also Gonzales v. Carhart*, 550 U.S. 124, 145 (2007).

[23] Mississippi and Utah's limitations begins two weeks earlier at 20 weeks LMP (18 weeks post-fertilization).