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

AAPLOG Statement on Post-Viability Abortion Bans (20 weeks post fertilization)

When is a fetus capable of surviving outside of his or her mother's womb?

Survival of extremely premature infants has rapidly progressed over the last 15 years, to the point where survival of infants is possible at 22 weeks gestation (20 weeks fertilization age)[1]. The ability of extremely preterm infants to survive depends on the amount of expert care received when they are separated from their mother's womb.[2]

The fact that extremely preterm infants can in fact be separated from their mothers and survive underscores the fact that these infants are complete, separate human beings. At the moment of separation, the fetus is afforded all legal protection due to any other human being. There is no scientific or medical support for the idea that fetuses of identical gestational ages should be allowed to be killed simply because they reside within the womb.

If a mother decides that she does not want to continue to carry an unborn child after the unborn child has reached the capacity to survive outside of the womb, that mother can undergo a delivery which allows her child the optimum chances of survival. This would end the mother's pregnancy while simultaneously allowing the viable child the best chances of survival. In fact, beyond 20 weeks of gestation, the immediate risk of death to the mother from elective abortion procedures[3] exceeds the mother's risk of death from delivery.

The fact that elective abortions take place after fetal viability at 20 weeks fertilization demonstrates clearly that the "right to abortion" is in fact a claim to a "right to a dead baby". In the partial birth abortion ban hearings before the United States Supreme Court, abortionists claimed that their product was to produce a dead baby, and that banning procedures which would ensure that the baby was dead was an infringement on their trade- a telling admission about the true purpose of elective abortions after viability. This purpose is reiterated in the Royal College of Obstetricians and Gynecologists guidance document on abortion[4] :

> *"When undertaking a termination of pregnancy, the intention is that the fetus should not survive and that the process of abortion should achieve this."* [at p 29]

Thus despite the rhetoric which states that women should not be forced to carry a pregnancy, the true intent of elective abortion after viability is not separation of the mother and the fetus, but rather guaranteeing the deliberate death of the viable fetus. There is no logical, scientific or medical distinction between infanticide after the fetus has been born, and elective abortion of a viable fetus.

How are abortions done on fetuses which are 20 weeks or older?

In discussing methods of separating the mother and the fetus, it must be clearly remembered that there is an intentional difference between separating the mother and the fetus for the purpose of producing a live baby, and separating the mother and the fetus for the purpose of guaranteeing that the baby is dead. These intents correspond to different methods of separation.

Separating the fetus from the mother in order to produce a living baby (i.e. "delivery").

Separation procedures (parturitions)designed to maximize the likelihood of fetal survival are called "deliveries" and these deliveries can take place vaginally or by cesarean section. In the case of a need for emergency separation to save the life of the mother, a C-section can take place in approximately 30 minutes under emergency circumstances, in contrast to the elective abortion procedures which usually take 2-3 days or more to accomplish.[5]

Abortion procedures after viability (20 weeks post fertilization age)

After 20 weeks of gestation, the fetus must either be delivered by inducing labor, or be surgically extracted either whole ("Intact D&E", "D&X", "Partial Birth Abortion") or in pieces (Dilation and Evacuation D&E). Dr. Anthony Levatino[1] briefly and accurately describes all of the third trimester abortion procedures in an illustrated video available at http://www.abortionprocedures.com/ Some aspects of these procedures will be reviewed below:

D&E (the most common procedure after 20 weeks)

Unlike elective abortions before 14 weeks of gestation, where the fetal bones are soft enough to suck into a large bore suction catheter, fetuses older than 14 weeks are too large to fit through a catheter, and their bones have calcified, making them too firm to remove by suction alone. Thus destructive procedures are required.

During the hearings regarding the Partial Birth Abortion Ban, abortionists testified about the distinction between D&E procedures and Partial Birth Abortion procedures. In the Majority opinion, the United States Supreme Court summarized abortionists' testimonies describing D&E:

> *"In the usual second-trimester procedure, "dilation and evacuation" (D&E), the doctor dilates the cervix and then inserts surgical instruments into the uterus and maneuvers them to grab the fetus and pull it back through the cervix and vagina. The fetus is usually ripped apart as it is removed, and the doctor may take 10 to 15 passes to remove it in its entirety."*[6]

In the dissenting opinion, Justice Ginsburg recognized that the brutality inherent in performing D&E (which the court terms "non-intact D&E") on living fetuses was equal to the brutality of partial birth abortion (ie "intact D&E"):

> *"… the Court emphasizes that the Act does not proscribe the nonintact D&E procedure. See ante, at 34. But why not, one might ask. Nonintact D&E could equally be characterized as "brutal," ante, at 26, involving as it does "tear[ing] [a fetus] apart" and "ripp[ing] off" its limbs, ante, at 4, 6. "[T]he notion that either of these two equally gruesome procedures . . . is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one but not the other, is simply irrational." Stenberg, 530 U. S., at 946–947 (STEVENS, J., concurring)."*

[1] Dr. Anthony Levatino is a board certified obstetrician and gynecologist, former abortionist, and current member of the

D&X (Intact D&E, Partial Birth Abortion) (the second most common procedure after 20 weeks)

The second most common procedure is D&X (Intact D&E, Partial Birth Abortion). In this procedure the fetal legs are grasped and pulled into the vagina, and used to pull the entire body of the fetus into the vagina, trapping the head at the cervix. With the head entrapped, a scissors or other sharp object is used to puncture the base of the skull, then opened and closed to sever the brain stem from the spinal cord. (analogous to "pithing"- which is used to immobilize an animal prior to dissection) The skull is then "decompressed" by inserting a powerful suction into the brain and removing the brain tissue.

A federal ban on D&X was upheld by the Supreme Court, but these procedures continue to be the second most widely performed late term abortion procedures.

Saline induction (the third most common procedure after 20 weeks)

If a fetus is to be delivered by saline induction, the amniotic fluid surrounding the fetus is filled with a concentrated salt solution, which causes the delicate blood vessels in the fetus's skin to constrict and close. As the fetus swallows the concentrated salt solution, the delicate blood vessels inside the fetus also occlude. This constriction of blood vessels also takes place in the placenta, which provides the fetus with nourishment and oxygen. Animal models of saline abortions have demonstrated that the fetus dies from suffocation, as the oxygen supply is cut off by the constriction of the fetal blood vessels in the placenta. Usually death takes place slowly, over 24-30 hours. Sometimes death does not take place prior to delivery, and these abortions result in a severely burned living premature child. Some abortionists will kill the child in utero (feticide) to make sure the child cannot be born alive.

What does a ban on abortions after 20 fertilization weeks forbid?

Most bans after 20 fertilization weeks forbid the performance of an abortion on a living fetus of a gestational age of 20 fertilization weeks (ie 22 weeks by LMP) or more. Most bans also have an exception to the ban when a physician must perform an abortion on a living fetus in order to save the mother's life e.g. severe chorioamnionitis, and other situations which involve an immediate threat to the mother's life, or immediate threat of serious irreversible physical harm which will be alleviated by separating the mother and the fetus.

Why should a state ban abortions after 20 fertilization weeks?

Fetuses at 20 weeks post fertilization (22 weeks LMP) are human beings capable of surviving ex-utero.

Extremely premature infants at 20 weeks post fertilization (22 weeks gestation) can survive outside of the womb. They are human beings just as we all are human beings, and the principles of non-maleficence and justice requires that a civilized society care for even the smallest of its members.

Further, the procedures used for elective abortion at these gestational ages are self-evidently hideous, especially as research demonstrates that these fetuses are even more sensitive to pain than older newborns.

Fetuses at 20 weeks post fertilization (22 weeks LMP) feel and react to the pain of abortion procedures.

The structures which transmit painful stimuli from the skin to the brain are present very early in fetal life[7] and anesthesiologists for the last decade have used fetal anesthesia as standard of care for

in-utero fetal surgery, as evidenced by the review by Gupta[8] et Al. in 2008:

> *"**Fetal stress***
>
> *There is considerable evidence that the fetus may experience pain. Not only is there a moral obligation to provide fetal anaesthesia and analgesia, but it has also been shown that pain and stress may affect fetal survival and neurodevelopment.[7][9] Factors suggesting that the fetus experiences pain include the following.*
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> *i. Neural development. Peripheral nerve receptors develop between 7 and 20 weeks gestation, and afferent C fibres begin development at 8 weeks and are complete by 30 weeks gestation. Spinothalamic fibres (responsible for transmission of pain) develop between 16 and 20 weeks gestation, and thalamocortical fibres between 17 and 24 weeks gestation.*
>
> *ii. Behavioural responses. Movement of the fetus in response to external stimuli occurs as early as 8 weeks gestation, and there is reaction to sound from 20 weeks gestation. Response to painful stimuli occurs from 22 weeks gestation.*
>
> *iii. Fetal stress response. Fetal stress in response to painful stimuli is shown by increased cortisol and β-endorphin concentrations, and vigorous movements and breathing efforts.[7,9][10][11] There is no correlation between maternal and fetal norepinephrine levels, suggesting a lack of placental transfer of norepinephrine. This independent stress response in the fetus occurs from 18 weeks gestation.10 There may be long-term implications of not providing adequate fetal analgesia such as hyperalgesia, and possibly increased morbidity and mortality."*

A 2012 review article[12] on fetal anesthesia concurs, and concludes with a call for adequate fetal pain relief:

> *"Evidence is increasing that from the second trimester onwards, the fetus reacts to painful stimuli and that these painful interventions may cause long-term effects. It is therefore recommended to provide adequate pain relief during potentially painful procedures during in utero life."*

Fetuses who are victims of D&E abortions react to painful stimuli with the same physiological responses that any other human being would display: increase in heart rate, increase in stress hormones in the blood stream, and withdrawal from painful stimuli. As the science of in-utero fetal surgery has progressed, it has become clear that fetuses do better when given pain relief during the surgery.

Clearly, fetuses who are candidates for abortion by D&E (ie second and third trimester) display all the same physical reactions to those destructive procedures that any other human being would display. A living fetus will clearly suffer pain when being torn apart during a D&E or D&X procedure, or cauterized in a saline induction.

Ban on Abortions after 20 weeks Myths and FAQ's

Myth 1: A ban on abortions after 20 weeks will ban all abortions.

Fact: Bans on abortions after 20 weeks will only ban abortions at the gestational age where fetuses can survive outside of their mother's womb.

Myth 2: A ban on abortion after 20 weeks is dangerous for the mother.

Fact: Most 20 week abortion bans have an exception which allows for the physician to legally use any method of separation of the mother and fetus when the life of the mother is at stake. In these cases of a viable fetus, the most rapid and safest delivery for both the mother and the fetus is cesarean section, which can be accomplished in 30 minutes from decision to separation as standard obstetrical procedures require. In contrast, most elective abortion procedures performed after 20 weeks require days to accomplish.

In addition, the risk of immediate maternal death from elective abortion procedures done after 20 weeks[13] is greater than the risk of death from vaginal birth or cesarean section.

Late term abortions also result in greater risk of long term complications than abortions performed earlier in the pregnancy. Examples of increased risk include:

- **Increased risk of preterm birth in subsequent pregnancies,**
- **Increased risk of adverse psychological outcomes such as depression, substance abuse and suicide and**
- **Increased risk of subsequent breast cancer if the late term abortion occurs before 32 weeks, if the mother had not brought a previous pregnancy to term, and if the mother subsequently delays bringing another child to term.**

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[1] See Literature Summary 2015 to 2017 Post delivery survival of fetuses born at 20 weeks post fertilization (22 weeks LMP) attached as Appendix A

[2] Mehler K , Oberthuer A , Keller T , Becker I , Valter M , Roth B , Kribs A JAMA Pediatr. 2016 Jul 1;170(7):671-7. doi: 10.1001/jamapediatrics.2016.0207. Survival Among Infants Born at 22 or 23 Weeks' Gestation Following Active Prenatal and Postnatal Care.

[3] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. Risk factors for legal induced abortion-realted mortality in the United States. Obstet Gynecol 103(4) 2004; 729-37.

[4] Royal College of Obstetrics and Gynecology "Termination of pregnancy for fetal abnormality in England, Scotland and Wales" https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf

[5] http://www.drhern.com/en/abortion-services/second-trimester-abortion.html

[6] USSC Gonzales

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

[8] Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications Contin Educ Anaesth Crit Care Pain (2008) 8 (2): 71-75. available at https://academic.oup.com/bjaed/article/8/2/71/338464/Fetal-surgery-and-anaesthetic-implications

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

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

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

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

[13] Bartlett L, Berg C, Shulman H, Zane S, Green C, Whitehead S, Atrash H. Risk factors for legal induced abortion-realted mortality in the United States. Obstet Gynecol 103(4) 2004; 729-37.