Survival of extremely premature infants has rapidly progressed over the last 15 years, to the point where infant survival ex-utero is possible at 22 weeks gestation (20 weeks fertilization age). 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.

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 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:

“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.

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.

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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 or less 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 M.D., J.D. briefly and accurately describes all of the third trimester abortion procedures in an illustrated video available at [http://www.abortionprocedures.com/](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 opinion6, the United States Supreme Court summarized abortionists’ testimonies describing D&E:

“"The surgical procedure referred to as "dilation and evacuation" or "D&E" is the usual abortion method in this trimester. Planned Parenthood, 320 F. Supp. 2d, at 960–961. Although individual techniques for performing D&E differ, the general steps are the same. A doctor must first dilate the cervix at least to the extent needed to insert surgical instruments into the uterus and to maneuver them to evacuate the fetus. Nat. Abortion Federation, supra, at 465; App. in No. 05–1382, at 61. The steps taken to cause dilation differ by physician and gestational age of the fetus. See, e.g., Carhart, 331 F. Supp. 2d, at 852, 856, 859, 862–865, 868, 870, 873–874, 876–877, 880, 883, 886. A doctor often begins the dilation process by inserting osmotic dilators, such as laminaria (sticks of seaweed), into the cervix. The dilators can be used in combination with drugs, such as misoprostol, that increase dilation. The resulting amount of dilation is not uniform, and a doctor does not know in advance how an individual patient will respond. In general the longer dilators remain in the cervix, the more it will dilate. Yet the length of time doctors employ osmotic dilators varies. Some may keep dilators in the cervix for two days, while others use dilators for a day or less. Nat. Abortion Federation, supra, at 464–465; Planned Parenthood, supra, at 961. After sufficient dilation the surgical operation can commence. The woman is placed under general anesthesia or conscious sedation. The doctor, often guided by ultrasound, inserts grasping forceps through the woman’s cervix and into the uterus to grab the fetus. The doctor grips a fetal part with the forceps and pulls it back through the cervix and vagina, continuing to pull even after meeting resistance from the cervix. The friction causes the

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fetus to tear apart. For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman. The process of evacuating the fetus piece by piece continues until it has been completely removed. A doctor may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes. Once the fetus has been evacuated, the placenta and any remaining fetal material are suctioned or scraped out of the uterus. The doctor examines the different parts to ensure the entire fetal body has been removed. See, e.g., Nat. Abortion Federation, supra, at 465; Planned Parenthood, supra, at 962.”

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).”

**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 Court⁸, 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?

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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 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 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]11 *Factors suggesting that the fetus experiences pain include the following.*

i. **Neural development.** Peripheral nerve receptors develop between 7 and 20 weeks gestation, and afferent C fibres begin development at 8 weeks and are complete by 30 weeks gestation. Spinothalamic fibres (responsible for transmission of pain) develop between 16 and 20 weeks gestation, and thalamocortical fibres between 17 and 24 weeks gestation.

ii. **Behavioural responses.** Movement of the fetus in response to external stimuli occurs as early as 8 weeks gestation, and there is reaction to sound from 20 weeks gestation. Response to painful stimuli occurs from 22 weeks gestation.

iii. **Fetal stress response.** Fetal stress in response to painful stimuli is shown by increased cortisol and 8-endorphin concentrations, and vigorous movements and breathing efforts.[7,9]1213 *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*
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providing adequate fetal analgesia such as hyperalgesia, and possibly increased morbidity and mortality.”

A 2012 review article 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.

Post-Viability Abortion Bans
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 is greater than the risk of death from vaginal birth or cesarean section. Induction abortions are riskier than D&E abortions.

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.

Appendix A

Post-delivery Survival of Fetuses at 20 weeks post fertilization (22 weeks LMP)
Selected publications 2015 to 2017

   Survival and Neurodevelopmental Outcomes among Perivable Infants. Younge N, Goldstein RF,
   Bann CM, Hintz SR, Patel RM, Smith PB, Bell EF, Rysavy MA, Duncan AF, Vohr BR, Das A,
   Goldberg RN, Higgins RD, Cotten CM; Eunice Kennedy Shriver National Institute of Child
   Health and Human Development Neonatal Research Network.

“Methods:
We compared survival and neurodevelopmental outcomes among infants born at 22 to 24 weeks of
gestation, as assessed at 18 to 22 months of corrected age, across three consecutive birth-year
epochs (2000-2003 [epoch 1], 2004-2007 [epoch 2], and 2008-2011 [epoch 3]).

Results:
Data on the primary
outcome were available for 4274 of 4458 infants (96%) born at the 11 centers. The percentage of
infants who survived increased from 30% (424 of 1391 infants) in epoch 1 to 36% (487 of 1348
infants) in epoch 3 (P<0.001). The percentage of infants who survived without neurodevelopmental
impairment increased from 16% (217 of 1391) in epoch 1 to 20% (276 of 1348) in epoch 3
(P=0.001), whereas the percentage of infants who survived with neurodevelopmental impairment did
not change significantly (15% [207 of 1391] in epoch 1 and 16% [211 of 1348] in epoch 3, P=0.29).
After adjustment for changes in the baseline characteristics of the infants over time, both the rate of
survival with neurodevelopmental impairment (as compared with death) and the rate of survival
without neurodevelopmental impairment (as compared with death) increased over time (adjusted
relative risks, 1.27 [95% confidence interval {CI}, 1.01 to 1.59] and 1.59 [95% CI, 1.28 to 1.99],
respectively). Conclusions The rate of survival without neurodevelopmental impairment increased
between 2000 and 2011 in this large cohort of perivable infants. (Funded by the National Institutes of
Health and others; ClinicalTrials.gov numbers, NCT00063063 and NCT00009633 ).

   Maternal Outcomesamong Women with Prolapsed Membranes Admitted before 29 Weeks Gestation.
   PLoS ONE 11(12): e0168285.doi:10.1371/journal.pone.0168285

“Results: 129 women at 22–25 weeks gestation and 65 women at 26–28 weeks gestation were
admitted to hospital and the median time-to-delivery was 4 days in both groups. Stillbirth rates were
12.4% vs 4.6% among women admitted at earlier vs later gestation (AOR 2.8, 95% CI 0.5–14.8), while
perinatal death rates were 38.0% vs 6.1% (AOR 14.1, 95% CI 3.5–59.0), respectively.”
Comment: 38% perinatal death rate means that 62% of the group between 22 and 25 weeks gestation
by LMP (ie 20-23 weeks fertilization age) survived.

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Survival Among Infants Born at 22 or 23 Weeks' Gestation Following Active Prenatal and Postnatal Care. Mehler K, Oberthuer A, Keller T, Becker I, Valter M, Roth B, Kribs A

“Results: Of 106 liveborn infants (45 born at 22 weeks and 61 born at 23 weeks and 6 days), 20 (19%) received palliative care (17 born at 22 weeks and 3 born at 23 weeks), and 86 (81%) received active care (28 born at 22 weeks and 58 born at 23 weeks). Of the 86 infants who received active care (mean [SD] maternal age, 32 [6] years), 58 (67%) survived until hospital discharge (17 born at 22 weeks and 41 born at 23 weeks). Eighty-five infants survived without severe complications, with 1 infant born at 22 weeks excluded because of missing data (6 of 27 [22%] born at 22 weeks, and 16 of 58 [28%] born at 23 weeks). Survival was predicted by the Apgar score after 5 minutes (odds ratio, 0.62 [95% CI, 0.46-0.84]) and birth weight (odds ratio, 0.001 [95% CI, 0.00-0.40]).

Conclusions and Relevance: One in 4 infants born at the border of viability and offered active care survived without severe complications. …”


“Results: A total of 3,371 patients were born alive, 3,236 of whom were admitted to the neonatal intensive care unit (NICU). Survival without MBD was 44.4% among patients admitted to the NICU, increasing from 12.5% at 22 weeks to 57.9% at 26 weeks' GA. The proportion of survivors without MBD relative to the total number of survivors was 81.1%

Conclusions: The proportion of survivors without MBD, when referred to the total number of survivors, is relatively high and is independent of GA. EoL decisions after the occurrence of MBD seem to play an important role in this respect. These results support the attitude of "giving an opportunity" even to the most immature patients, if this is in accordance with the parents' wishes.”


Association of Neurodevelopmental Outcomes and Neonatal Morbidities of Extremely Premature Infants With Differential Exposure to Antenatal Steroids

Sanjay Chawla, MD, Girija Natarajan, MD, Seetha Shankaran, MD, Athina Pappas, MD, Barbara J. Stoll, MD, Waldemar A. Carlo, MD, Shampa Saha, PhD, Abhik Das, PhD, Abbot R. Laptook, MD, and Rosemary D. Higgins, MD for the National Institute of Child Health and Human Development Neonatal Research Network

“All neonates born with a birth weight of 401 to 1000 g and/or a GA of 22 to 27 weeks as determined by early ultrasonography or last menstrual period…. Of 6121 eligible infants, 4284 (70.0%) survived to 18- to 22-month follow-up.”

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**Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants**

“Overall rates of survival, survival without severe impairment, and survival without moderate or severe impairment were 5.1% (interquartile range, 0 to 10.6), 3.4% (interquartile range, 0 to 6.9), and 2.0% (interquartile range, 0 to 0.7), respectively, among children born at 22 weeks of gestation and were 23.1% (interquartile range, 0 to 50.0), 15.4% (interquartile range, 0 to 33.3), and 9.0% (interquartile range, 0 to 14.6), respectively, among those born at 22 weeks of gestation who received active treatment.” [underline mine]

“CONCLUSIONS—Differences in hospital practices regarding the initiation of active treatment in infants born at 22, 23, or 24 weeks of gestation explain some of the between-hospital variation in survival and survival without impairment among such patients. (Funded by the National Institutes of Health.)”


**Improving survival of extremely preterm infants born between 22 and 25 weeks of gestation.**

Kyser KL, Morriss FH Jr, Bell EF, Klein JM, Dagle JM

"Results: Survival rates for the decade by gestational age (compared with predicted rates) were: 22 weeks, 33% (compared with 19%); 23 weeks, 58% (compared with 38%); 24 weeks, 87% (compared with 58%); and 25 weeks, 85% (compared with 70%). Antenatal corticosteroids were administered in 96% of pregnancies. Variables that significantly predicted survival and their odds ratios (OR) with 95% confidence intervals (CI) are: antenatal corticosteroid administration (OR 5.27, CI 1.26­22.08); female sex (OR 3.21, CI 1.42­7.26); gestational age (OR 1.89, CI 1.27-2.81); 1minute Apgar score (OR 1.39, CI 1.15-1.69); and birth year (OR 1.17, CI 1.02­1.34). The number needed to treat with any antenatal corticosteroid therapy to prevent one death was 2.4.

Conclusion: In this single-institution cohort treated aggressively (antenatal corticosteroid administration [even if less than 24 weeks], tocolysis until steroid course complete, cesarean for fetal distress) by perinatologists and neonatologists, survival rates at 22-25 weeks of gestation age for inborn infants during the 2000s exceeded predicted rates, with increasing odds of survival during the decade. Antenatal corticosteroid administration had a significant effect on survival.

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