Oral Testimony of Monique C. Wubbenhorst, M.D., M.P.H., F.A.C.O.G., F.A.H.A.

Senior Research Associate, de Nicola Center for Ethics and Culture, University of Notre Dame

U.S. House of Representatives Committee on Oversight and Reform

"Examining the harm to patients from abortion restrictions and the threat of a national abortion ban"

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Chair Maloney, Ranking Member Comer, 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 board-certified obstetrician-gynecologist. I have over 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, including patients in both domestic and international settings, including those with limited access to care. For example, I have cared for women in rural North Carolina, inner city Boston, Native American reservations, as well as women in India, Nepal, the Philippines, Kazakhstan, Ghana, Cameroon, and South Sudan. I 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 at Duke University School of Medicine. I worked at the United States Agency for International Development prior to assuming my current role at the de Nicola Center for Ethics and Culture at the University of Notre Dame.

Abortion's harms to women.

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 and communities, and to unborn human beings. Abortion not only poses risks to the mother, it is always lethal to an unborn child.

2. Abortion is not health care. Abortion (legal abortion) is defined by CDC as "an intervention performed by a licensed clinician…within the limits of state regulations, 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.

3. 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.

4. 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.

5. There are, of course, different types of healthcare. Preventive healthcare, or prophylaxis, consists of measures taken for the purposes of disease prevention, defined by Leavell and Clark (Hugh R. Leavell and E. Gurney Clark. The science and art of preventing disease, prolonging life, and promoting physical and mental health and efficiency. Leavell, H. R., & Clark, E. G. (1979). *Preventive Medicine for the Doctor in his Community* (3rd ed.). Huntington, NY: Robert E. Krieger Publishing Company). Treatment, or therapeutic healthcare, is defined as "relating to the curing of a disease or medical condition (Cambridge Dictionary, https://dictionary.cambridge.org/dictionary/english/therapeutic). Palliative healthcare is defined as "specialized medical care for people living with a serious illness, such as cancer or heart failure."

6. It is my opinion that abortion neither prevents, treats, or palliates any disease. Instead, it has as its goal the death of a human being. It is therefore not health care, for either the mother or her fetus.

7. 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.

8. 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).

9. In 1986, 46.5% of OB/GYNs surveyed performed abortions (Carol S. Weisman, Constance A. Nathanson, 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).

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

11. 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).

15. 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).

16. 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 (Daniel Grossman, Kate Grindlay, Anna L. Altshuler, Jay Schulkin. Induced Abortion Provision Among a National Sample of Obstetrician–Gynecologists*. Obstet Gynecol* 2019;133:477–83).

17. It is my opinion, supported by these facts, that abortion is not healthcare, and is not essential healthcare, given that a small and decreasing percentage of OB/GYNs perform this procedure.

Clinicians caring for pregnant women have two patients: the mother and her unborn child.

18. 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 baby 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.

19. Clinicians also recognizes that the fetus' environment in the womb can have an impact on the rest of his or her life.

26. 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).

27. Improved diagnostic capability has allowed for many conditions to be treated medically while the fetus is still in utero. 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.

28. Aside from diagnosis of the fetus, imaging has also made it possible for interventional surgical procedures to be performed in utero. Using ultrasound for guidance, doctors can safely perform amniocentesis, biopsies, surgery and sampling on the fetus, including blood transfusion for severely anemic fetuses. Fetal hemolytic disease, for example, often fatal if untreated, may be treated in utero using fetal blood transfusions. As imaging technology has advanced, better visualization has led to "drastically improved" screening for certain conditions and an explosion in possible treatments.

29. Laparoscopic-type techniques, known as fetoscopy, have "revolutionized" procedures performed on the fetus. These procedures use endoscopes (small, fiber-optic guided instruments) within the uterus. Using ultrasound guidance, fetoscopy enables doctors to place shunts (to treat problems like bladder obstruction), as well as to correct blood vessel abnormalities.

30. Life-saving interventions are now available for fetuses diagnosed with congenital heart disease.

31. Advancing technology also allows doctors to perform open fetal surgery as early as 15 weeks' gestation. Over the last decade, the number of fetal surgeries has "soared as never before." During these surgeries, physicians will open the uterus and operate directly on the fetus. 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)

32. The view that the fetus is a patient only changes if the same child is unwanted by its mother and slated for abortion.

33. It is my professional opinion that at minimum, the same ethical principles governing the medical treatment of the fetus should govern elective abortion of the fetus. This includes restrictions on abortions performed past the second trimester, and recognition of the fact that the fetus experiences pain at earlier gestational ages than previously thought.

The fetus feels pain at earlier gestational ages than previously thought

34. Science shows that an unborn child is pain-capable much earlier than previously thought. "[N]eonatal and medical science … now graphically portrays, as science was unable to do [at the time of Roe], 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" (Malloy et al).

35. Not only do physicians prevent and treat fetal pain, insurance companies reimburse the cost of doing so.

35. Advancing technology also provides more information about how the fetus experiences brutal abortion procedures, such as D&E, that ends his or her life. The possibility of fetal pain warrants the same consideration given in the context of medical treatment as it does in the context of abortion.

36. 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." Cutaneous sensory receptors (nociceptors) appear as early as 6 weeks' gestation when face skin receptors appear. These receptors spread to the palms and soles of the feet by 11 weeks, and to the trunk and proximal limbs by 15 weeks. By 12 weeks' gestation, sensory fibers have grown into the spinal cord and connected with the thalamic portion of the brain. The thalamus is the "essential organ of the affective side of our sensation, especially pain," and has "pivotal importance" for "fetal pain." Also by 12 weeks, the first projections from the thalamus connect with the cortical subplate. The subplate is a transient developmental structure that forms underneath the cortical plate proper. Neurons first migrate into the subplate until the cortical plate above is sufficiently mature; the neurons then migrate to the cortex. The subplate gradually becomes white matter.

37. 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. 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."

38. "[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."

39. 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.

40. Physicians already recognize this and avoid suffering in even very pre-viable fetuses. Fetal anesthesia is the standard of care for any fetal procedure. And 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.

The epidemiology of abortion

41. The collection of abortion statistics is widely acknowledged to be severely flawed. The collection of data on the numbers of abortions performed in the United States 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.

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 data quality. Their reports are estimates and cannot be used to precisely assess the total 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."

Estimates of abortion related mortality are 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 death certificate may not state abortion as the cause of death. This was seen in the case of Keisha Atkins, who died in New Mexico as a result of a late third trimester abortion. The cause of death was listed as "Natural".

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.

42. 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.

43. It is not possible to estimate the risks of abortion, including abortion mortality, based on statistical data because these statistics are flawed. 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 mortality with any precision.

44. 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.

45. 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 abortion providers.

46. 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%". Therefore, the true risks of abortion to women and the frequency of abortion-related complications remain unknown.

The collection of accurate statistics on abortion is a public safety issue, not a pro-life or pro-choice issue.

Maternal mortality

50. The assertion that "abortion is safer than childbirth" has been used to defend the right to abortion in virtually every abortion-related legal case over the last 20 years or more.

51. 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)". It also does not acknowledge the flaws in abortion data collection for both numbers of abortions and deaths from abortion.

52. U.S. maternal mortality data is incomplete, so it is scientifically inaccurate to claim any connection between high maternal mortality rates and states that restrict or ban abortion. Variations in abortion reporting produces unstable estimates and makes it impossible to calculate the true maternal mortality rate in the United States, let alone make comparisons between states. Maternal mortality is compromised due to many data deficiencies. The numbers of miscarriages and induced abortions are 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.

Maternal deaths are compared to 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 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 our statistics continue to be flawed and many deaths underreported.

52. 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.

53. 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.

54. An abortion done in the first trimester is vastly different from childbirth. It is my opinion, supported by scientific evidence, that the two procedures are not comparable due to these changes.

55. 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 large 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.

56. It is therefore 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.

57. 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]."

58. Bartlett *et al* 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.

59. 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.

60. Abortion does not prevent pregnancy complications or maternal death. 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.

61. Abortion does not decrease pregnancy-related health risks and it cannot prevent pregnancy complications. A woman's individual risk for pregnancy complications such as diabetes or high blood pressure in pregnancy, or even death, can be estimated but not predicted with certainty. Regardless of whether some women undergo abortion, the risk of complications for any woman is the same because the root causes of maternal mortality – cardiovascular disease, hemorrhage, infection, and blood clots – are unchanged. Abortion does nothing to address these causes.

62. 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). Abortion does not increase the safety of other pregnancies that carry to term. It also does not address the patient or health systems factors associated with maternal mortality. Many pregnancy complications can be prevented in many cases with lifestyle modification and medical treatment. Others can be managed with proper medical care.

63. For other 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. The intent of the procedure is not to kill the fetus, and the procedure is done in such a way as to attempt to save the life of the unborn child. The death of the fetus may be a tragic outcome of early delivery, but it is not the goal. If the unborn child dies, the procedure is still considered a success. This is in contrast to a "failed abortion", which is a failure because the fetus is not killed and the pregnancy continues.

References: 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.

Abortion safety

67. 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.

Risks of surgical abortion.

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.

Risks of second trimester and later abortions. I have discussed the harms to women from mid-trimester abortions in a paper at https://lozierinstitute.org/midtrimester-abortion-epidemiology-indications-and-mortality/

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.

Most abortion-related adverse events and outcomes occur with abortions performed in the second-trimester or later (Grimes 1985; Bartlett et al 2004; Lohr et al 2010). Morbidity and mortality cluster in second and third trimester procedures.

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.

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.

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.

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 medical and surgical abortion is overstated.

Most abortions are elective in nature.

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

Only two states, Florida and Utah, reported reasons by week of gestation. The data from those two states show that abortions occurring after 15 weeks gestation, when babies can feel pain, are performed for the same reasons as earlier abortions. In Florida and Utah, abortions for common exceptions made up only an estimated 12% of second trimester abortions, meaning that 88% of the second trimester abortions in these two states were performed for elective reasons.

These statements are not rhetoric. In 2013, a study published by the Guttmacher Institute noted that "data suggests that most women seeking later terminations are not doing so for reasons of fetal anomaly or life endangerment." 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.

For many families there are other options than abortion for unborn children with disabilities

Maternal fetal medicine allows our advanced 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. 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.

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 at the end of their lives in the neonatal period.

Of note, several recent reports have exposed the unacceptably high rate of false positives from prenatal screens, which may mislead anxious parents to abort a perfectly healthy child, especially when screening for rare disorders and more common disorders such as Down syndrome, among low-risk women (e.g., less than 35 years of age). Autopsy studies have confirmed a higher-than-expected rate of false positive screening results for anomalies.

The fetal heartbeat is an important and useful measure of fetal health. In my experience, physicians use either transvaginal or abdominal ultrasound, or fetal doppler, to detect the fetal heartbeat, depending on the situation or gestational age of the fetus. The fetal doppler device is an ultrasound device that uses sound waves to detect the fetal heartbeat. It typically cannot detect a heartbeat until between 8-10 weeks' gestation, sometimes not until about 12 weeks depending on the patient's body habitus, fetal activity, and fetal position.

In early pregnancy it may be necessary to use transvaginal ultrasonography to visualize the embryo or fetus within the uterus. This is not required, however, and clinicians always discuss the use of transvaginal ultrasound and obtain patient consent for its use. And any patient who does not wish to undergo transvaginal ultrasound can (and does) opt out of its use.

From approximately 3-8 weeks' gestation, the developing baby is considered an embryo. The word "embryo," which is derived from Greek and Latin words meaning "young one," is the early stage of a developing human being, a multicellular organism. In humans, the embryonic stage of development lasts until about 8-9 weeks' gestation, at which point the baby becomes known in medical terms as a "fetus." The fetal stage lasts until birth. The rate of embryonic and fetal development is specific to each

unborn child and can vary, just as developmental and physical characteristics of humans outside of the womb can vary.

15. The baby's circulatory system is one of the first systems to develop and mature. At around 4 weeks' gestation, the primordial circulation has begun to develop from blood vessels which circulate blood from the umbilical vein and the placenta. At only about 4-5 weeks' gestation, the embryo develops a primitive circulatory system. Special cells that will become heart cells (cardiomyocytes) begin to align and beat in sync around 22-23 days' gestation, and a primitive heart structure, which resembles a tube, forms. The forerunners of the atria and ventricles (or heart chambers) are in place around 6 weeks' gestation, and some movement of valves is present. At about 7 weeks' gestation, the atria and ventricles are more developed. At about 8 weeks' gestation, the valves mature, and by 9-10 weeks' gestation, the aorta and pulmonary veins form. At this point, the final pattern of the baby's heart is laid down and it functions similarly to an adult's heart.

The unborn child's heart pumps blood around the baby's body as it will for the rest of his or her life, with the exception of the ductus arteriosus, a vessel present in fetal life which connects the pulmonary artery and the aorta, bypassing the fetal lungs in utero. As noted above, at this point (around 9 weeks), the baby is called a "fetus" in medical terminology and remains classified as such until birth. Thus, the fetal heart is functional by about 9-10 weeks' gestation—when the baby is considered a "fetus," and when the heart is fully formed. See the below chart for a summary of this process.

https://www.medicalnewstoday.com/articles/when-does-a-fetus-have-a-heartbeat#detection-tools.

Week of pregnancy	Level of heart development
5th week	The developing heart is made up of two tubes that have fused in the middle, creating a trunk with four tubes branching off. The heart begins to beat, and it may be possible to detect it using vaginal ultrasound.
6th week	The heart of the embryo has changed dramatically — the basic heart tube has looped, forming an S-shape and creating an area for the ventricles.
7th week	The ventricles and atria of the heart begin to separate and develop.
8th week	The valves between the atria and ventricles of the heart form.
9th and 10th weeks	The aorta and pulmonary vein form. By the 10th week, the fetal heart will have developed fully.

Note: the fetal heart begins to beat at approximately 5 weeks + 1 day, which is considered the 5th to 6th week.

At about 5 weeks, the yolk sac may be visible on ultrasound, and it is the first structure visible by ultrasound during pregnancy. Around 5-6 weeks' gestation, it may be possible to see the gestational sac via transvaginal ultrasound. At about 6 weeks, 2 days' gestation using transvaginal ultrasound, and 6 weeks, 4 days' gestation using transabdominal ultrasound, "the embryo appears, which has also been designated as the embryonic pole or embryonic disc." Hamza et al., 2016, Diagnostic Methods of Ectopic Pregnancy and Early Pregnancy Loss: a Review of the Literature, *Geburtshilfe Frauenheilkd* 2016 Apr.; 76(4): 377-382.

The embryo, sometimes referred to as the fetal pole, does not appear as a "dot". The "fetal pole" is the earliest sonographic manifestation of the developing embryo and refers to the body of the unborn child, although it may not be seen until 9 weeks in some cases. (Radiopaedia, https://radiopaedia.org/articles/fetal-pole). A certain percentage of even viable pregnancies are unable to be detected on ultrasound until later in the pregnancy (Infante, F., et al. Rationalising the change in defining non-viability in the first trimester, *AJUM* Aug. 2013; 16(3), 114-117).

18. Pregnancy may be confirmed before ultrasound visualization of the embryo by testing a woman's blood or urine for levels of beta human chorionic gonadotropin (βhCG), a hormone produced by the placenta. Very sensitive blood tests can detect a pregnancy within days of conception. As urine pregnancy test technology has progressed, most home urine pregnancy tests are now sensitive enough to detect a pregnancy at about 4 weeks' gestation (i.e., an average βhCG level of 100 mIU/mL) and some can potentially detect pregnancy earlier. For example, a review of over-the-counter home pregnancy tests showed a range of sensitivities from 2.8 mIU/mL to 25.7 mIU/mL (Minkin, M., Embryonic development and pregnancy test sensitivity: the importance of earlier pregnancy detection, *Women's Health* 2009; 5(6), 659-667).

Cardiac activity on ultrasound is present in the embryo before the pregnancy can even be detected by ultrasound imaging, as the cardiomyocytes develop. In my experience, it is possible to detect cardiac activity as early as 5 weeks' gestation. But successful detection between 5-7 weeks' gestation depends on a number of factors: the skill of the sonographer, the route (abdominal versus transvaginal), the woman's weight and anatomy, the presence or absence of fibroids or adenomyosis, and individual variation in a woman's tissue characteristics (see for example Fu, A., et al., A noninferiority randomized controlled trial to compare transabdominal and transvaginal sonography for eligibility assessment prior to medical abortion. *Contraception* 2018; 98, 199-204; and Lohr, P., et al., A comparison of transabdominal and transvaginal ultrasonography for determination of gestational age and clinical outcomes in women undergoing early medical abortion, *Contraception* 2010; 81, 240-244). Hamza notes "Despite technical advances and sonographer training, human error and physical variation can result in over- and underestimates of the gestational age". On ultrasound at that stage, fetal cardiac activity looks like a faint twinkle within the embryo (see https://informedconsent.health.utah.gov/information-module/childbirth/fetus-heart-development/

20. By the time a woman is 8 weeks pregnant, a heartbeat should be reliably detectable in most cases. In my career, however, I have treated patients without a detectable heartbeat at that stage who still had a viable pregnancy. In one notable case, I treated a pregnant woman for whom there was concern for ectopic pregnancy. Even with the aid of a skilled sonographer and a radiologist, we were unable to detect a heartbeat until around 12 weeks' gestation and a βhCG value > 5200 mIUs/mL be-cause of her unique anatomy and tissue characteristics. This has been substantiated in the radiologic and obstetric literature.

21. While I have used precise medical and scientific terminology above, when treating my patients and in general parlance with non-physicians and physicians alike, I may refer to the baby‘s “heartbeat” even before the heart is fully formed, and most physicians do as well (see Hamza, 2016, using term "heartbeat" and "embryo"; Bourne, T. and Bottomley, C., When is a pregnancy nonviable and what criteria should be used to define miscarriage?, *Fertil Steril* 2012; 98: 1091-6, using the terms "baby," "embryo," and "heartbeat" describing early pregnancy). Whether we hear the heartbeat or not, it is there. We only use ultrasound and microphones to amplify the sounds. But listening to, or seeing the baby’s heartbeat for the first time is an emotional moment for most parents, and hearing the heartbeat remains significant to patients (and physicians) throughout the pregnancy.

For women who are worried about their babies, hearing the heartbeat is extremely reassuring. It also has medical significance. Several studies have estimated the likelihood of a pregnancy’s viability, or the likelihood that that pregnancy would proceed to term (or a predetermined gestational age cutoff for research studies), if a heartbeat is detected on ultrasound. Tannirandorn (Tannirandorn, Y., et al., Fetal loss in threatened abortion after embryonic/fetal heart activity, *Int'l J Gynecol Obstet* 2003; 81, 263-266) noted that after heart activity is detected, fetal loss (miscarriage) occurs in approximately 2-5% of pregnancies. Makrydimas (Makrydimas, G., et al., Fetal loss following ultrasound diagnosis of a live fetus at 6-10 weeks of gestation. *Ultrasound Obstet Gynecol* 2003; 22, 368-372) noted that the risk of fetal loss in women decreases with gestational age; for those women whose baby had a visible heartbeat at 6 weeks the risk of fetal loss was 10%, and for those with a heartbeat at 10 weeks the rate was 3%. The heartbeat is therefore a powerful predictor of whether the child in the womb will one day see the world outside the womb.

Racial disparities

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 families and descendants, and their hopes, dreams and contributions to our society. We must ask ourselves, is this justice?

64. 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".

65. 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".

66. Black women therefore have higher rates of abortion, higher rates of abortion-related mortality, and higher rates of maternal mortality compared with white women. While these mortality statistics are highly aggregated, it is difficult or impossible to reconcile them with the assertion that higher rates of abortion in African American women are, or can be, associated with lower rates of maternal mortality. 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 total number of abortions in African American women was 292,675.

This is true even though African Americans (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.

We must ask ourselves: is there any benefit to African American women, and indeed African Americans as a people group, to this immense loss of life?

It has been asserted that women, especially black women, benefit from abortion because it reduces poverty increases women's economic prospects. There is no conclusive evidence that abortion reduces poverty. As the abortion rate has fallen, and there are fewer and fewer abortions in white women, the poverty gap between unmarried women with children and unmarried women without children has reversed for white women. As the percentage of abortions performed in black women has increased, the poverty gap between black women with children and black women without children has persisted and even widened. This is exactly opposite what we have been told to expect: that is, more abortions

mean women, especially unmarried women, would do better financially. Relative to their peers, that is not what the data show.

In reviewing the data on associations between abortion and women's economic advancement, the conclusions advanced by those who claim a positive association are more accurately inferences – inferences that at best unintentionally neglect seemingly far more, and more powerful, causal factors for any supposed economic benefit of abortion.

The link between child sex trafficking and abortion

92. 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/.

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

94. 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 appearred 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.

95. 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 clinics may be enabling childhood sex traffickers.

96. 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.

The heart of a mother

98. We hear the heart of a mother in the poignant story of AK at https://wng.org/articles/false-positives-1632365820. AK, a young woman who posted this past February on Shout Your Abortion, had written “about her chemical abortion in the United Kingdom. She described how she was a 17-year-old college student struggling to work with morning sickness and not getting any support from the father, so she decided to abort. ‘It’s been a week since I said my last goodbye to you,’ she wrote. ‘I remember sitting on the toilet, I saw you. That’s when I felt guilt. … Words can’t explain how I feel. I want you back. You’re my baby. … Mummy loves you. Sleep tight. I’m sorry.”

It is this devastating loss that pro-life clinicians, scientists, lawyers and advocates seek to end. Thank you.