Written Testimony of Catie Kelley, J.D.
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In Support of Legislative Document 682 (SP 297)
Submitted to the Joint Committee on Judiciary
March 28, 2025

Dear Chair Carney, Chair Kuhn, Ranking Minority Member Poirier, and Members of the Committee:

My name is Catie Kelley, and I serve as Policy Counsel at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization that specializes in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states. Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

Thank you for the opportunity to testify in support of Legislative Document 682 ("S.P. 297" or "bill"), a bill that:

(1) improves the state's current reporting on abortion data by reinstating reporting requirements on the patient's age, race, marital status, and education level, as well as any other information prescribed by the National Association for Public Health Statistics and Informational Systems;

(2) requires that post-viability abortions of preborn children are medically necessary to preserve the life or health of the mother;

(3) sets out requirements for post-viability abortions in the case of a diagnosable fatal fetal anomalies;

(4) sets out penalties for any abortions performed by an individual who is not properly licensed under Maine law; and

[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Mar. 28, 2025).
[2] *State Spotlight*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Mar. 28, 2025).

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(5) sets out penalties for abortions performed post-viability that are not medically necessary to save the life or health of the mother.[3]

S.P. 297 is a constitutionally valid exercise of the State's right to ensure access to accurate, reliable data and statistics on abortion procedures, as well as the State's right to promote women's health and safety and protect preborn children by requiring that abortions after viability are well regulated, medically necessary interventions, performed only by licensed individuals.

Abortion reporting is vital to preventing maternal morbidity and mortality resulting from abortion, improving women's healthcare by strengthening safeguards around abortion, and ensuring not only doctors, but their patients, are fully informed when treating women and their preborn children. Carefully regulating post-viability medically necessary interventions to save the life and health of the mother is critical, as elective late-term abortions are extremely dangerous to women and end the lives of preborn children who are hypersensitive to pain. S.P. 297 promotes women's health and safety by applying common sense requirements to a procedure intended to terminate a human life—elective abortion.

I. Abortion Reporting Promotes Women's Health and Safety

Reporting on medical procedures, medications, and associated results, side-effects, risks, and outcomes, including the demographic data of the persons involved, is a scientific and evidentiary norm which ultimately promotes the health and safety of the public.[4] This is true even more so when the "procedure" involves the intentional termination of a human life.

The medical community has instituted the collection, analysis, and dissemination of information related to abortion procedures, abortion morbidity, and abortion mortality as an established branch of epidemiological surveillance.[5] This is because abortion reporting is necessary for medical and public health professionals to evaluate and determine the risks of different forms of abortion to women and the impact on their preborn children.

[3] S.P. 297, 132nd Maine Legislature, First Reg. Sess. (Feb. 2025). The scope of this testimony is limited to the reporting requirements and the amendment of post-viability abortions requiring "medical" necessity "to preserve the life or health of the mother," but Americans United for Life supports the current medical standard of care for providing perinatal palliative care/perinatal hospice as described by the American Association of Pro-Life Obstetricians and Gynecologists to effectively care for women and their preborn children when the preborn child is diagnosed with a "life-limiting condition." *See* RSCH. COMM., AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Concluding Pregnancy Ethically*, Prac. Guideline No. 10 (Aug. 2022); *see also* RSCH. COMM., AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Perinatal Palliative Care and Perinatal Hospice*, Prac. Guideline No. 1 (Nov. 2014, updated 2017, 2021).

[4] Jack C. Smith & Willard Cates, Jr., *The Public Health Need for Abortion Statistics*, 93 PUB. HEALTH REP. 194, 194–97 (1978). *See also* Keith Maule, *Record Keeping: Is It Really that Important?*, J. AM. CHIROPRACTIC ASS'N 20–22 (2000). (highlighting that even the chiropractic industry acknowledges the importance and need for reporting and record keeping).

[5] *See id.*

The objective purpose of abortion reporting is the prevention of maternal morbidity and mortality associated with induced abortion.[6] The founder of the CDC abortion reporting system, Jack Smith, presented on the public health need for complete, accurate abortion reporting. He stated, "public health is very much part of the abortion issues. Moral and constitutional questions related to abortion may be argued philosophically; however, health questions related to abortion should be answered by sound epidemiologic reasoning based on adequate abortion statistics."[7]

It is critical that reliable, authoritative, accurate abortion data and statistics be available to women, the medical community, and the general public in order to address the known risks of elective abortion, especially how the risks impact different demographic groups. This can be accomplished in part through the passage of S.P. 297.

For example, the medical risks associated with abortion are different depending on the age of the woman seeking an abortion. As compared to adult women, adolescents are more likely to have high risk pregnancies. "Adolescence is a critical period marking phenomenal changes including rapid physical, psychosocial, sexual and cognitive maturation, and nutrient needs of adolescents are higher than at any other stage in the lifecycle."[8]

During pregnancy, "adolescent girls are a particularly vulnerable group since the demands of regular growth and development are augmented by the heightened nutritional requirements of supporting a fetus."[9] Because of this, they have a "biological predisposition for high-risk pregnancies."[10]

Likewise, the impact of abortion on women and preborn children of different races and ethnicities is important to effectively evaluate and address socio-economic and health disparities. According to the CDC's most recent abortion surveillance data, "[b]lack women had the highest abortion rate," while "[w]hite women had the lowest abortion rate."[11] And when Maine reported abortion data relating to race and ethnicity in 2022, 8.3% of abortions were performed on Black women.[12]

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[6] *See id.* at 194.
[7] *See id.*
[8] Nadia Akseer et al., *Characteristics and Birth Outcomes of Pregnant Adolescents Compared to Older Women: An Analysis of Individual Level Data from 140,000 Mothers from 20 RCTs*, 45 eClinicalMed 1, 3 (Feb. 26, 2022).
[9] *Id.*
[10] *Id.* at 12.
[11] Stephanie Ramer, et. al., *Abortion Surveillance – United States (2022)*, 73(7) Centers for Disease Control 1-28 (Nov. 28, 2024).
[12] *See id.* at *Table 6. Number and percentage of reported abortions, by known race and ethnicity and reporting area of occurrence – selected reporting areas, United States (2022).*

This is troubling, given that Black women comprise approximately 2% of Maine's population[13], and given the abortion industry's history of targeting Black families for abortion. Even Planned Parenthood admits that its founder's racism and motivation has harmed Black families: "[t]he difficult truth is that Margaret Sanger's racist alliances and belief in eugenics have caused irreparable damage to the health and lives of Black people…"[14]

Even though Planned Parenthood claims to denounce its founder's racist ideology and eugenics work, the abortion industry still disproportionately ends the lives of more Black preborn children than any other race.[15] Across 32 states reporting on race relating to abortion, the overall abortion rate for Black women was 24.4%, as opposed to 5.7% for White women, 9.4% for women reporting themselves as Alaskan Native, Native American, Asian, Pacific Islander, other races, or multiple races, and 11.6% for Hispanic women.[16]

Because of these concerns, reporting on the age and race of women seeking abortion, along with other demographic information, is vital for Maine's policymakers and public to adequately address the unique risks and challenges that different groups of women face when considering elective abortion.

II. The Only Lawful Post-Viability Abortions in Maine Should be Medically Necessary Interventions that Prioritize Preserving Both the Life of the Mother and the Life of the Preborn Child When Possible

Maine's current law on post-viability abortions provides, "[a]fter viability, an abortion may be performed only when it is necessary in the professional judgment of a physician … us[ing] the applicable standard of care in making a professional judgment."[17]

S.P. 297, however, would amend Maine's law to:

> After viability, an abortion may be performed only when it is medically necessary to preserve the life or health of the mother or, in the professional judgment of a physician licensed pursuant to Title 32, chapter 36 or 48, the fetus is diagnosed with a lethal fetal anomaly. The physician shall apply the applicable standard of care in making a professional judgment under this subsection. For purposes of this subsection, "lethal fetal anomaly" means a fetal condition diagnosed before birth that, if the

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[13] *See QuickFacts Maine*, United States Census Bureau https://www.census.gov/quickfacts/fact/table/ME/HCN010222 (last visited Mar. 28, 2025).

[14] *See Planned Parenthood's Reckoning with Margaret Sanger*, Planned Parenthood of the Pacific Southwest (April 23, 2021), https://www.plannedparenthood.org/planned-parenthood-pacific-southwest/blog/planned-parenthoods-reckoning-with-margaret-sanger (last visited Mar. 28, 2025).

[15] *See supra* notes 11 and 12.

[16] *See supra* note 12.

[17] *See* 22 M.R.S.A. § 1598(1-B).

pregnancy results in a live birth, will, with reasonable certainty, result in the death of the child not more than 3 months after birth.[18]

Right now, a woman in Maine could obtain a post-viability abortion if a physician determines that it is "necessary," without evaluating whether the post-viability abortion is "medically" necessary or necessary "to preserve the life or health of the mother."[19] There is effectively no oversight or accountability for a physician to justify why an abortion on a preborn child who could survive outside the womb is lawful.

S.P. 297 would further promote women's health and safety, as well as provide additional protections for preborn children who could survive outside the womb, by requiring that any post-viable abortion is performed only when "medically necessary to preserve the life or health of the mother" or where "the fetus is diagnosed with a lethal fetal anomaly."[20]

This is a step in the right direction for protecting women and preborn children in Maine, as elective late-term abortions are dangerous to women and end the lives of preborn children who are hyperresponsive to pain.

A. Elective Late-Term Abortions Are Dangerous to Women

As noted above, *elective abortion is not healthcare. It is the intentional destruction of innocent preborn human life.* As the Supreme Court acknowledges in *Dobbs*, states have a legitimate interest in preserving prenatal life, mitigating fetal pain, and protecting maternal health.[21] According to the American Association of Pro-life Obstetricians and Gynecologists ("AAPLOG"), "elective abortion is defined as those drugs or procedures used with the primary intent to end the life of the human being in the womb."[22]

Nor are elective abortions medically required, as AAPLOG explains: "[e]lective' . . . refers to inductions done in the absence of some condition of the mother or the fetus which requires separation of the two in order to protect the life of one or the other (or both)."[23] Indeed, "there is no medical indication for elective induced abortion, since it cures no medical disease."[24] Thus, Maine can regulate abortion in furtherance of these important interests.

Moreover, elective late-term abortions are extremely dangerous to women's health and safety Maine's current law on post-viability abortions is insufficient to protect women and preborn children, as it does not require these abortions to be *medically* necessary and imposes no penalties on individuals who perform abortions and are not

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[18] *See* S.P. 297 Sec. 3; *see also supra*, note 3, scope of this testimony.
[19] *See id.*
[20] *See id.*
[21] *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2284 (2022).
[22] *AAPLOG Statement: Clarification of Abortion Restrictions*, AM. ASS'N PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS (July 14, 2022), https://aaplog.org/aaplog-statement-clarification-of-abortion-restrictions/.
[23] *See* AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *supra note* 3, at 5.
[24] PRO. ETHICS COMM., AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Hippocratic Objection to Killing Human Beings in Medical Practice*, Comm. Op. No. 1, at 8 (May 8, 2017).

licensed nor on individuals who perform post-viability abortions that are not medically necessary.

Despite the common narrative that late-term abortions are only performed in rare circumstances for medically necessary reasons, "most abortions are done for social reasons."[25] One study on abortion notes,

> [t]he Guttmacher Institute has provided a number of reports over 2 decades which have identified the reasons why women choose abortion, and they have consistently reported that childbearing would interfere with their education, work, and ability to care for existing dependents; would be a financial burden; and would disrupt partner relationships.[26]

Thus, the overwhelming majority of abortions occur for elective reasons of the mother, not because of either the baby's or the mother's medical condition.[27]

The Guttmacher Institute further estimates that abortionists perform around 10,000 abortions at 21 weeks' gestation or later *each year*.[28] However, the number of late term abortions is likely significantly higher given that states voluntarily report abortion data and abortion destination states, such as California and Maryland refuse to provide any abortion data to the Centers for Disease Control and Prevention.[29]

i. <u>The Risk of Mortality to the Mother from Late-Term Abortion is Significant</u>

Gestational age is the strongest risk factor for abortion-related mortality to women, and the incidence of major complications is significantly higher after 15 weeks' gestation.[30] Compared to an abortion at 8 weeks' gestation, the relative risk of mortality to the woman increases exponentially by an additional 38 percent each week of

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[25] AM. ASSOC. OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, STATE RESTRICTIONS ON ABORTION: EVIDENCE-BASED GUIDANCE FOR POLICYMAKERS, Comm. Op. 10, at 10 (updated Sept. 2022).

[26] James Studnicki, *Late-Term Abortion and Medical Necessity: A Failure of Science*, HEALTH SERVS. RSCH. & MANAGERIAL EPIDEMIOLOGY, Apr. 9, 2019, at 1, 1.

[27] *See, e.g.*, *The Assault on Reproductive Rights in a Post-Dobbs America: Hearing before the S. Comm. on the Jud.,* 118th Cong. 15 (2023) (written testimony of Monique Chireau Wubbenhorst, MD, MPH) (stating that "95 percent of abortions are for elective or unspecified reasons.").

[28] Guttmacher Institute, *Induced Abortion in the United States*, GUTTMACHER (2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[29] *See Questions and Answers on Late-Term Abortion*, CHARLOTTE LOZIER INST. (May 16, 2022), https://lozierinstitute.org/questions-and-answers-on-late-term-abortion/.

[30] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004); Janet P. Pregler & Alan H. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002). *See also* Slava V. Gauferg, *Abortion Complications*, https://emedicine.medscape.com/article/795001-overview (updated Jun. 24, 2016) (last visited Jan. 5, 2020) (Several large-scale studies have revealed that abortions after the first trimester pose more serious risks to women's physical health than first trimester abortions).

gestation.[31] Indeed, the risk of death to the woman related to gestational age of her preborn child is as follows:

- At 8 weeks' gestation, one death per one million abortions;
- At 16 to 20 weeks' gestation, one death per every 29,000 abortions; and
- At 21 week' gestation or more, one death per every 11,000 abortions.[32]

In other words, a woman seeking an abortion at 20 weeks' gestation is *35 times more likely to die* from abortion than she was in the first trimester. And at 21 weeks' gestation or more, she is *91 times more likely to die* from abortion than she was in the first trimester. Other documented immediate complications from abortion include:

- blood clots,
- hemorrhaging,
- incomplete abortions (part of the preborn child is not removed),
- infection, and
- injury to the cervix and other organs.[33]

Immediate complications affect approximately 10% of women undergoing abortion, and approximately one in five of these complications are life-threatening to the woman.[34]

ii. Abortion Subjects Women to Psychological Harm

Numerous studies demonstrate the psychological trauma women experience from abortion. "[P]regnancy loss (natural or induced) is associated with an increased risk of mental health problems."[35] "Research on mental health subsequent to early pregnancy loss as a result of elective induced abortions has historically been polarized, but recent research indicates an increased correlation to the genesis or exacerbation of substance abuse and affective disorders including suicidal ideation."[36]

Scholarship shows "that the emotional reaction or grief experience related to miscarriage and abortion can be prolonged, afflict mental health, and/or impact intimate or parental relationships."[37] In fact, a recent 2023 study found that American "women whose first pregnancy ends in induced abortion are significantly more likely than women whose first pregnancy ends in a live birth to experience mental health problems

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[31] *Id.* at 731; PRO. ETHICS COMM. OF AM. ASSOC. OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Induced Abortion & the Increased Risk of Maternal Mortality*, Comm. Op. 6 (Aug. 13, 2019).
[32] Barlett, *supra* note 30.
[33] *See id.*
[34] REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 48 (2005).
[35] David C. Reardon & Christopher Craver, *Effects of Pregnancy Loss on Subsequent Postpartum Mental Health: A Prospective Longitudinal Cohort Study*, 18 INT'L J. ENV'T RSCH. & PUB. HEALTH 1, 1 (2021).
[36] Kathryn R. Grauerholz et al., *Uncovering Prolonged Grief Reactions Subsequent to a Reproductive Loss: Implications for the Primary Care Provider*, 12 FRONTIERS IN PSYCH. 1, 2 (2021).
[37] *Id.*

throughout their reproductive years."[38] Similarly, "[s]everal recent international studies have demonstrated that repetitive early pregnancy loss, including both miscarriage and induced abortions, is associated with increased levels of distress, depression, anxiety, and reduced quality of life scores in social and mental health categories."[39]

B. Elective Late-Term Abortion Harms Preborn Children Who Are Hyperresponsive to Pain

In addition to harming women's physical and mental health, abortion also subjects preborn children to fetal pain. There is ample research on fetal pain in the 50 years after *Roe*. In 2019, scientists found evidence of fetal pain as early as 12 weeks' gestation.[40] "Pain receptors [] begin forming at seven weeks' gestational age, with the nerves linking pain receptors to the pain-sensing part of the brain, the thalamus, forming at 12 weeks."[41] By twelve weeks' gestation almost every organ and tissue has formed in a preborn baby[42] and the baby has arms, legs, fingers, toes, a face, and eyelids.[43] The preborn baby is also beginning to form unique fingerprints,[44] is able to suck his or her thumb,[45] and has a fully developed heart.[46]

A 2010 study found that "the earlier infants are delivered, the stronger their response to pain"[47] because the "neural mechanisms that inhibit pain sensations do not begin to develop until 34–36 weeks[] and are not complete until a significant time after birth."[48] As a result, preborn children display a "hyperresponsiveness" to pain.[49]

[38] James Studnicki et al., *A Cohort Study of Mental Health Services Utilization Following a First Pregnancy Abortion or Birth*, 15 INT'L J. WOMEN'S HEALTH 955, 959 (2023).
[39] Grauerholz, *supra* note 25; *see, e.g.*, Louis Jacob et al., *Association Between Induced Abortion, Spontaneous Abortion, and Infertility Respectively and the Risk of Psychiatric Disorders in 57,770 Women Followed in Gynecological Practices in Germany*, 251 J. AFFECTIVE DISORDERS 107, 111 (2019) (finding "[a] positive relationship between induced abortion . . . and psychiatric disorders").
[40] Stuart W.G. Derbyshire & John C. Bockmann, *Reconsidering Fetal Pain,* 46 J. MED. ETHICS 3 (2020)
[41] *12 Facts at 12 Weeks*, CHARLOTTE LOZIER INST. (Apr. 25, 2023), https://lozierinstitute.org/12-facts-at-12-weeks/.
[42] Thomas Sadler, MEDICAL EMBRYOLOGY 14th ed. (2019).
[43] *Carnegie Stage 23 Introduction*, VIRTUAL HUM. EMBRYO: DIGITALLY REPRODUCED EMBRYONIC MORPHOLOGY, https://www.ehd.org/virtual-human-embryo/intro.php?stage=23 (last visited Apr. 25, 2024).
[44] J. W. Babler, *Embryologic Development of Epidermal Ridges and Their Configurations*, 27 BIRTH DEFECTS ORIGINAL ARTICLE SERIES 95, 95-112 (1991).
[45] *See* Peter Hepper et al., *Prenatal Thumb Sucking Is Related to Postnatal Handedness*, 43 NEUROPSYCHOLOGIA 313 (JAN. 2005).
[46] *See* M. A. Hill, *Cardiovascular System Development*, EMBRYOLOGY (Apr. 26, 2024), https://embryology.med.unsw.edu.au/embryology/index.php/Cardiovascular_System_Development.
[47] Lina K. Badr et al., *Determinants of Premature Infant Pain Responses to Heel Sticks*, 36 PEDIATRIC NURSING 129 (2010).
[48] *Fact Sheet: Science of Fetal Pain*, CHARLOTTE LOZIER INST. (Sept. 2022), https://lozierinstitute.org/fact-sheetscience-of-fetal-pain/#_ednref14.
[49] Christine Greco & Soorena Khojasteh, *Pediatric, Infant, and Fetal Pain*, CASE STUDIES PAIN MGMT. 379 (2014).

According to one group of fetal surgery experts, "[t]he administration of anesthesia directly to the fetus is critical in open fetal surgery procedures."[50]

Given the medical advancements in fetal medicine and the evidence of fetal pain early in a pregnancy, it is well within the state's legitimate interests to enact laws that preserve prenatal life as well as minimize fetal pain as much as possible.[51]

Conclusion

S.P. 297 will promote women's health and safety by equipping Maine's policy makers and the public to mitigate and prepare for health risks associated with abortion, as abortion impacts different demographic groups in different ways. And S.P. 297 acknowledges the well-documented risks to women's health and safety caused by late-term abortions by more requiring post-viability abortions to be medically necessary to save the life and health of the mother. For these reasons, I urge the committee to support S.P. 297.

Respectfully Submitted,

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[50] Maria J. Mayorga-Buiza et al., *Management of Fetal Pain During Invasive Fetal Procedures. Lessons Learned from a Sentinel Event*, 31 EUROPEAN J. ANAESTHESIOLOGY 188 (2014).
[51] *See Dobbs*, 142 S. Ct. at 2284.