Testimony in Support of HB 20-1098 – Prohibition on Abortion after 22 Weeks

Introduction

Late abortions (after 22 weeks gestational age) are extreme by any national and international comparison. Just seven of the 50 States in the US permit abortion after 25 weeks.[1] Most (38) prohibit abortion at 22 weeks or less. Internationally, only five of the 198 countries, independent states, and semi-autonomous regions with populations exceeding 1 million permit elective abortion after 20 weeks.[2] Three of the five nations that permit late abortion are notorious human rights abusers: China, North Korea, and Vietnam. Colorado should not aspire to join the ranks of the few states and countries that dehumanize the developing fetus and permit the killing of these most vulnerable human beings. Colorado should also not jeopardize the health of Colorado women by allowing the unregulated out-patient practice of late abortion which is known to pose serious risks to the health and life of the woman.[3]

Late abortion is predicated on the notion that a woman's right to bodily autonomy trumps the human fetus' right to life. Both prolife and prochoice advocates would agree that a woman's autonomy is an extremely important value; however, both sides differ on whether autonomy supersedes another human being's fundamental right to life. These competing rights are why proponents of access to late abortion go to extreme lengths to minimize the humanity of the fetus. They refer to "terminating the pregnancy" as if the termination could occur without killing a vital, developing human being. A recent series on abortion rights by the Editorial Board of *The New York Times* refers to the developing human merely as a "cluster of cells" as if her brain, heart, circulatory system, appendages, hands/feet and nervous system were immaterial.[4] Planned Parenthood of the Rocky Mountains characterizes the dismemberment of late second trimester fetus during a Dilation and Evacuation (D&E) abortion as removing "pregnancy tissue".[5] Orwellian language is utilized to refer to the crushed and dismembered human fetus as "products of conception" or simply "POC". Even the preferred term "fetus" is an attempt to dehumanize the developing human. OB-GYN physicians commonly refer to the "baby" during a woman's *wanted* pregnancy, but abortionists will rarely refer to the "fetus", much less use the term "baby", when counseling a woman on abortion.

There is little doubt that there is a bipartisan consensus that late abortions should be regulated. According to a 2018 Gallup poll, only 18% of Democrats, 13% of Independents, and 6% of Republicans believe that third trimester abortions should be legal.[6] The polling presumably reflects the public's widespread recognition that late abortion kills a human being not materially different than a newborn infant and that late abortion represents a substantial medical risk to the pregnant woman.

Is the 22 week fetus a human being?

Human embryology has long established the fact that human life begins at fertilization and that human development is a seamless process that continues for years after birth. It should not be surprising that 96% of 5577 biology scientists who were recently surveyed agreed that human life begins at

fertilization.[7-8] No matter how hard abortion rights activists try to obfuscate, human zygotes, embryos and fetuses are biological human beings.

A primordial heart develops in the human embryo by the third week (post fertilization) and begins to pump blood by the fourth week.[9] Rapid development of the brain occurs in the fifth week. By the eighth week, the embryo has distinctly human characteristics, developed the beginnings of all major organ systems, and demonstrates purposeful limb movements. During the 17th week, the mother can feel the fetal movements.

Fetal surgeries, in which the human fetus is operated on by specially trained fetal surgeons and anesthesiologists, have been pursued as early as the 19th- week gestation (post last menstrual period).[10-11] Human fetuses have been born in the 21st-week gestation with excellent neurodevelopmental outcomes.[12] Based on one national study performed on infants born at 22 weeks gestation between 2006 and 2011, 23% survived with active treatment.[13] However, more recent data from the University of Iowa encompassing outcomes between 2006 and 2015, suggest a much more robust 70% survival.[14] The majority had no or mild neurodevelopmental impairments.

While there is considerable debate concerning when the human fetus can experience pain, it is very likely that a 22-week-old human fetus can experience pain – likely, more intensely than an infant or adult.[15] The experience of pain in humans is characterized by two neurological functions: nociception which involves the transmission of painful stimuli to the central nervous system and perception which entails the organization, identification, and interpretation of the painful sensory information. Nociception occurs early in fetal life, but perception occurs later. In a systematic multidisciplinary review published in 2005, researchers (who opposed abortion restrictions) argued that the processing of painful stimuli can only occur once the brain cortex is fully functional – not before the third trimester.[16] However, the majority of contemporary fetal medicine specialists now consider the evidence that a 22-24 week fetus experiences pain compelling.[15,17-21] They cite the adequacy of nociceptive pathways, the presence of a working thalamus (which relays painful stimuli), the development of the subplate (which is an active, albeit transient, layer of the human brain cortex), documented periods of wakefulness/arousability, hormonal stress/pain responses, and fetal behavioral correlates of pain. This conclusion is reinforced by measurements of nociception-specific brain activity using near-infrared spectroscopy (NIRS), electroencephalography (EEG), and functional MRI.[22-24] More sophisticated 4D ultrasound technology has also enhanced our ability to use facial expression to assess fetal pain.[25-26] Because inhibitory descending pathways, which down-regulate pain perception, mature only after birth, the human fetus may be much more sensitive to pain than infants or adults.[17,19-20] Clinicians have long observed that preterm infants at the lowest limit of viability have "profound, acute adverse reactions" to major painful stimuli.[27] Physicians and nurses in neonatal intensive care units witness this every day and utilize multiple different pain assessment tools to help measure and mitigate the pain.[19]

Late second trimester and third trimester human fetuses display a number of other advanced cortical functions. The human fetus' sensorimotor behavior demonstrates the same characteristics later observed in the child's behavior.[28] They show curiosity or intrinsic motivation to explore their body and

environment, perform repetitive actions to elicit sensations, react to sensory inputs, display intentionality, and demonstrate goal directed movements. It has also long been recognized that the human fetus can respond to sound as early as 19 weeks.[29-30] The human fetus specifically responds to her/his mother's voice. At 25 weeks human fetuses have been observed to mimic their mother's resuscitation of a nursery rhyme by opening and closing their mouths.[31] Furthermore, a newborn human shows preference for her/his mother's voice and for musical pieces to which she/he were previously exposed, which confirms a capacity for a fetus to learn in utero. Studies have shown that prenatally acquired acoustical memory can persist at least 6 weeks after birth.[32]

Human fetuses in utero with gestational ages of 22 weeks or greater are biologically indistinguishable from infants born at 22 weeks – they are vital human beings. They have developed all the essential organ systems, they can perceive pain, they can demonstrate sophisticated behaviors, they can respond to and learn from familiar sounds, and they can undergo curative operative therapies as independent patients. The only difference is location. Location should not be the determinant of human value. A human's inalienable right to life, proclaimed in our Declaration of Independence, has not, and should not be, contingent on location.

Why do women choose late abortion, how common is the practice, and what are the alternatives?

There is very limited information available in the United States regarding who pursues very late abortions. Most studies suggest women have later abortions for similar reasons that they have early abortions with several caveats.[33-35] Age and educational level were not associated with abortions after 16 weeks but black women and women with higher incomes were more likely to have late abortions in one Guttmacher sponsored study.[33] Another study which was based on the baseline Turnaway data concluded that "reasons for seeking abortion are not different whether women sought abortion early or late in pregnancy."[34] They did not find a statistically significant difference between early and late second trimester abortions based on finances, parity, timing of pregnancy, degree of interference with future opportunities, emotional/mental preparedness, health related reasons, prospects for the baby, level of independence/maturity, influences from family/friends or the inability to contemplate adoption. A second study based on the Turnaway data suggested statistically significant differences in the age of the woman (younger patients, later abortions OR 2.7) and time that pregnancy was recognized (before 8 weeks, earlier abortions OR 0.1).[35] They also found that women who had late abortions faced more logistical delays (finding a provider, raising funds, and travel costs). Both Turnaway studies excluded abortions for fetal anomalies or life endangerment.

Many people are under the impression that most late abortions are necessitated by terrible fetal anomalies or life endangering conditions. Ron Fitzsimmons, the executive director of the National Coalition of Abortion providers, famously admitted that he lied to Congress and the public when he stated that late abortions are rare and performed primarily to save the lives of women and to prevent them the burden of bearing severely deformed babies.[92] He stated that late abortion is performed much more commonly than acknowledged and generally on healthy women bearing healthy fetuses. He feared the truth would hurt the cause of abortion rights. Other late abortionists have admitted that 80% of their practice is purely elective.[93] Hillary Clinton famously repeated the false spin that late

abortions "are because of medical necessity" during a debate with candidate Donald Trump. This assertion was widely debunked by fact checkers.[36] Diana Foster, Professor at the University of California San Francisco's Bixby Center for Global Reproductive Health stated that "there aren't good data on how often later abortions are for medical reasons". Her opinion, based on the limited research and discussions with fellow researchers in the field, was that abortion for fetal anomalies "make up a small minority of later abortions". There are other sources including investigations, blog posts, interviews and documentaries that suggest it is not hard to schedule a late abortion or uncommon to abort an entirely normal fetus after 24 weeks gestation.[37-41]

In Colorado, the Boulder Abortion Clinic advertises elective abortions, **(for any reason)** to **26** weeks and then to 36 weeks for "medically indicated terminations".[42] Few Colorado abortionists publicly admit performing late/third trimester abortions and Dr. Warren Hern from the Boulder Abortion Clinic is the exception. In a number of newspaper and magazine stories, the impression is given that he only performs late abortions for fatal fetal anomalies and life-endangering conditions of the mother.[43-44] However, anecdotal reports and a scientific publication suggests that the Boulder Abortion Clinic is willing to consider later abortions for normal human fetuses.[37,40,42,45] Dr. Hern has admitted that 70% of his abortion practice is for normal human fetuses.[45] In those 30% of abortions performed for fetal anomaly, he reports that Down Syndrome is his most common indication (24%). Potentially treatable structural anomalies are included in his series (such as spina bifida, aortic stenosis, abdominal wall abnormalities, urinary obstruction, extra digits, fused digits, deformed hands or feet, scoliosis, and cleft lip/palate).

There is no mandatory reporting for abortion numbers, indications or complications in the United States. Consequently, it is difficult to independently assess the practices of late term abortionists and the patients they serve. It is also uncommon for an independent expert to review late abortionists' practices. In a rare move that resulted in significant controversy/litigation, Kansas Attorney General Phil Kline had Dr. Paul McHugh, University Distinguished Service Professor of Psychiatry at Johns Hopkins School of Medicine, review redacted records of prominent third-trimester abortionist, George Tiller.[46] Dr. McHugh reported that he found instances where abortions were obtained for "trivial reasons" (like a desire to play sports) and for psychiatric reasons (such as adjustment disorder, anxiety, and depression) that could have been more appropriately remedied without resorting to late abortion. He indicated that from his review of the records "anybody could have gotten an (third trimester) abortion if they wanted one".

To obtain Colorado-specific abortion data is extremely difficult. The Colorado Department of Health (CDPHE) collects an (admittedly) incomplete survey of abortion providers (since it is not mandatory and there is no enforcement mechanism). In their 2018 Report of Induced Terminations of Pregnancy, 323 abortions were performed after 21 weeks gestation in Colorado (which represents 3.6% of the total abortions performed).[47] The Guttmacher Institute pegs the abortion rate in Colorado approximately 40% higher (based on 2017 data)[48] Assuming the CDPHE underestimation persists and is uniformly distributed amongst all gestational ages, this would translate into approximately 450 abortions after 21 weeks in the last reporting year.

How often is it medically necessary to abort a human fetus to preserve the life or health of the mother? Dr. Diane Foster from the University of California San Francisco states that the number is very hard to characterize.[36] Although there is almost no literature on the subject, one Maternal-Fetal Medicine expert concludes that this is an exceedingly rare event, perhaps encompassing as few as 4 extremely uncommon conditions: pulmonary hypertension (primary or Eisenmenger's syndrome), Marfan's syndrome with aortic root involvement, complicated coarctation of the aorta, and peripartum cardiomyopathy with residual dysfunction.[49] These would all likely be adjudicated long before 22 weeks gestation. Dr. Hern has said that he is unaware of a situation where abortion was necessary (as opposed to delivery) to save the life of a mother in the third trimester.[50] When a mother has a true medical emergency after 22 weeks gestation, abortion is never the safest approach. Emergent delivery of the baby via cesarean section is considered the medically appropriate option. To pursue a multi-day abortion procedure would be widely perceived to be medical malpractice.

There is no question that woman contemplating late abortion make heart-wrenching decisions. They often feel that abortion is their only choice because of lack of support from family/friends. They may be unaware of life-affirming alternatives. Women need to know that in Colorado there are many private and governmental organizations that can provide medical, financial, housing, educational, adoption, emotional and spiritual support to them and their families. They should also be made aware of the many compassionate services that Perinatal hospice offers as an alternative to late abortion for families facing a fetus with life-limiting genetic or congenital abnormalities.[51]

Some women may still feel the need to abort their fetus if they discover chromosomal or structural abnormalities. Prenatal screening tests can confirm fetal abnormalities by 18-20 weeks using currently recommended national screening guidelines – first trimester screen or quadruple marker screen, or integrated stepwise sequential/contingent screening, or cell free DNA screening, and mid-trimester ultrasound – followed by confirmatory invasive studies including chorionic villous sampling and amniocentesis.[52] These women who choose to abort these fetuses should not be impeded by a prohibition on abortion after 22 weeks gestation. Similarly, women who have fetuses conceived in rape and choose abortion need not be affected by late abortion restrictions.

Late abortions are performed for the same reasons that early abortions are performed. There may be more abortions for fetal anomalies late in pregnancy, but this is still likely a small proportion overall. Late abortions occur commonly in Colorado, but figures are inaccurate and lack some demographic and medical detail. Late abortions to preserve the life of the mother are a very rarely, if ever, indicated. Perinatal hospice offers a compassionate, life-affirming alternative to late abortion for families struggling with a fatal fetal diagnosis. Late abortion restrictions need not affect the choices for women with chromosomally or structurally abnormal fetuses and those suffering from rape.

How are late abortions performed and are they "humane"?

There are many different abortion techniques and remarkable procedure variability among physicians performing late second trimester and third trimester abortions. This reflects the lack of consensus in the abortion community.

Generally, beginning at 16 weeks gestation, Dilation and Evacuation (D&E) replaces sharp curettage and suction curettage as the surgical abortion procedure of choice.[53] During D&E, cervical dilation is achieved over one or more days by osmotic dilators (+/- adjuvant misoprostol) to facilitate the subsequent mechanical destruction and dismemberment of the fetus. Parts of the human fetus grasped/torn from her/his torso are then easily removed through the dilated cervix. A large-bore vacuum curette is used to remove the placenta and remaining tissue. Administration of a pre-procedure feticide such as intraamniotic/intrafetal digoxin, intracardiac potassium chloride or transection of the umbilical cord sometimes proceeds the D&E.

Dilation and Extraction (D&X) or Intact D&E is similar to the D&E procedure except that a suction cannula is utilized to evacuate the brain after delivery of the fetal human body/legs through the dilated cervix.[53] The ensuing collapse of the head facilitates its passage through the cervical canal. In the popular vernacular this procedure is sometimes referred to as "Partial-Birth Abortion". In order to comply with the Partial-Birth Abortion Ban Act of 2003, fetal demise must be ensured prior to the procedure. This is accomplished using a pre-procedure feticide or by transection of the umbilical cord.

During an Induction Abortion, labor is induced using mechanical means and/or by chemical means after several days of osmotic dilators.[53] The human fetus is usually delivered intact. To remain within the framework of the law, fetal demise is achieved prior to delivery using a feticide. This is the method used in third trimester abortions.

Abortion proponents make the claim that fetal death during abortion is more compassionate and painless than natural fetal/infant death in instances where the fetus has a terminal diagnosis. However, there are no published studies comparing the pain/suffering induced during abortion vs. natural fetal/infant death.

During D&E, only 30-50% of human fetuses are routinely killed prior to the dismemberment procedure in second trimester abortions.[54-55] It is hard to imagine that dismemberment would be less painful than natural death in conjunction with advanced perinatal hospice/palliative care services.

Even for those human fetuses who are killed before they are dismembered or delivered in second and third trimester abortions, there may be substantial suffering. A recent post-mortem MRI study of fetuses who have been administered a feticide indicate secondary pneumothorax – collapsed lung (23%), hemothorax – hemorrhage in lung (42%), pneumopericardium – air around the heart (31%), and hemopericardium – hemorrhage around the heart (35%).[56] These fetuses also had higher intraabdominal injuries. This suggests that just the process of injecting the feticide may inflict substantial pain. Furthermore, a highly concentrated potassium infusion can cause intense intravascular burning in normal patients.[57] Even though an intracardiac infusion of potassium can kill a fetus within 2

minutes, It's impossible to ascertain whether the human fetus experiences intense pain prior to its demise.[58] Intraamniotic or intra-fetal digoxin is the more commonly used poison to achieve fetal demise.[59] A digoxin overdose in older humans causes intense nausea, vomiting, abdominal pain, visual disturbances and delirium.[60-62] Digoxin kills by causing severe bradycardia (slow heart rate) culminating in asystole (heart stopping), but it does not kill quickly. It can take up to 4 hours for intra-fetal and up to 24 hours for intraamniotic digoxin to achieve asystole.[63-64] Women are routinely told to anticipate "kicks" for hours after the feticide is administered.[65] The visual, gastrointestinal, neurological and cardiac manifestations of digoxin toxicity could arguably represent fetal human cruelty. Indeed, if this same methodology was utilized in a death penalty case, it would be considered "cruel and unusual punishment".

In more candid moments, even abortion advocates sometimes characterize late abortion procedures on human fetuses as "morally abhorrent".[66] It is a form of intimate human violence which is unparalleled in medicine. The only reason that it persists is that the violence is hidden within the confines of the uterus. When the mother (and the broader public) are shielded from the reality of the carnage that is being inflicted on the human fetus, it is easier to rationalize its utility. Since there are no studies on the pain associated with late fetal abortion, to regard this as a painless, humane procedure is either wishful thinking or horribly misguided.

What is the risk to the woman undergoing a late abortion?

Late abortion is associated with significant morbidity and mortality. The precise magnitude of the risk associated with abortion can't be reliably gleaned from the CDC or state databases because reporting abortion numbers and related complications is not consistently state mandated and never federally mandated. Furthermore, abortion procedures in the US are not linked to other sources of health data such as birth or death certificates making meaningful estimates of mortality rates nearly impossible. Since the system is voluntary and physicians are reluctant to disclose serious complications (including death), underreporting is also a major problem.[67] There have been multiple instances documented where abortion related morbidity and mortality were not captured by the official state/federal databases. Since Colorado does not have require any oversight of abortion clinics (other than low-bar licensing requirements for their nursing/physician employees), there is substantial risk that maiming and death of affected women may go unreported. The Gosnell grand jury report in Pennsylvania should serve as a sober reminder that assuming major injuries and deaths from abortion are reported to and acted upon by civil authorities or medical boards is extremely naïve.[68]

Even using the admittedly inadequate medical claims/surveillance data, late abortion poses a substantial risk compared to early abortion in both relative and absolute terms. Using California Medicaid billing data, Emergency Department visits and complications were 2.5 times more likely following a second trimester abortion compared to a first trimester abortion.[69] Data from the national Abortion Surveillance System indicate that while the overall risk of death from abortion was 0.7/100000 induced abortions, the risk of death increased exponentially (by 38%) for each additional week of gestation.[70] CDC researchers found that gestational age was the strongest predictor of abortion-related-mortality.[3] In absolute terms, the risk goes from 0.1 deaths/100000 for surgical abortions < 9 weeks to 8.9

deaths/100000 at > 20 weeks.[71] To put this in perspective, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) compiled a 5 1/2 year database of over 1 million out-patient surgeries performed in ambulatory surgery centers.[72] The death rate was 2/100000 for patients that were, on average, significantly older than patients undergoing late abortion. This is only 22% of the mortality rate seen in late abortion. The Canadian counterpart, the Canadian Association for Accreditation of Ambulatory Surgical Centers (CAAASF), conducted a survey that pointed to a death rate of approximately 1/100000 which represents only 11% of the risk of late abortion.[73] The risk must be viewed in the context of strict oversight of ambulatory surgical centers in Colorado and the absence of oversight or regulations pertaining to abortion facilities in Colorado.[74] Media Trackers reported that "while standard healthcare and out-patient surgical clinics in the state fall under the authority of the Health Facilities division of the Colorado Department of Health and Environment for regular licensing and regulation, Planned Parenthood (and other abortion providers) are not held to the same standard". Not only does late abortion represent a significant mortality risk to women but the lack of health/safety oversight potentially compounds that risk.

Mortality studies that are based on countries with linked birth, pregnancy, abortion and death registries give an even more stark view of the risk from abortion. In Denmark, the 180-day mortality associated with late abortion (>12 weeks) was 55/100000.[75] This is far worse than US surveillance data would suggest and places it in a league with neurosurgery (lumbar discectomy 60/100000), and abdominal surgery (laparoscopic appendectomy, inguinal herniorrhaphy 20/100000, laparoscopic cholecystectomy 200/100000).[76-79] While this study is not adjusted for socioeconomic factors, marital status or psychological history, they suggest that mortality risk for women undergoing late abortion might be substantially underestimated in the US.

Some have tried to claim that a legal induced abortion is much safer than childbirth.[80] However, others have pointed out that these studies are inherently biased and plagued with differences in ascertainment of deaths, duration of susceptibility to mortality, lack of accounting for gestational age and inappropriate comparators.[67] The relative risk of pregnancy associated death between delivery and abortion may be better assessed by looking at countries with linked birth/medical/death databases. A systematic review and meta-analysis suggested that based on 11 studies from three such countries, termination of pregnancy is a marker for reduced life expectancy.[81] They found that within a year of their pregnancy outcomes, women experiencing pregnancy loss (from either abortion or natural loss) were twice as likely to die compared to women giving birth. In Denmark this adverse mortality rate persisted for 10 years.[75] While there could be confounding variables complicating this analysis, the notion that abortion leads to better health outcomes is unlikely (and certainly speculative without more rigorous research).

The morbidity associated with abortion also increases with gestational age. A large retrospective study from the University of California San Francisco suggested that the complication rate for second trimester abortions was 9.8% (including cervical laceration, hemorrhage, uterine atony, anesthesia complications, uterine perforation, disseminated intravascular coagulation, and retained products of conception). Major life-threatening complications (complications requiring hospitalization, transfusion, or further surgical intervention) occurred in 1.7% of patients.[82] Any of these complications increased with each

additional week of gestation beyond 20 weeks. Unfortunately, there are no published studies specifically addressing the likely extremely high morbidity/mortality associated with third trimester abortions.

Long-Term health effects of abortion are controversial.[3] Retrospective studies suggested a correlation of abortion with breast cancer. Better, case control studies suggested no correlation. There appears to be an association of abortion with postpartum hemorrhage in later pregnancies, but the mechanism is undefined. Late abortions may result in an increased risk for premature birth in subsequent pregnancies (aOR= 1.13, 99% CI 0.91-1.4). This trend becomes statistically significant for women who have had multiple abortions. Researchers have found a dose-response relationship between the number of prior abortions and the risk for extreme premature birth. Since black women have, on average, more late abortions and more multiple abortions, one might speculate that the scourge of increased infant mortality (tied largely to premature birth and low birth weight infants) in the black community could be partially caused by abortion.

The adverse effects of abortion on mental health is particularly controversial. Recent reviews cited by abortion proponents rely heavily on the methodologically flawed Turnaway study to conclude that abortion is not associated with new mental health disorders.[3] Better studies from Denmark utilizing national health registries suggest that abortion is a powerful marker for, rather than a cause of, affective disorders and suicide attempts.[83-84] Other recent studies from America, China, and Korea suggest adverse mental health outcomes related to abortion.[85-88] A balanced synthesis of the literature suggests several consensus opinions regarding the nexus between abortion and mental health: "1) abortion is consistently associated with elevated rates of mental illness compared to women without a history of abortion, 2) the abortion experience directly contributes to mental health problems for at least some women, 3) there are risk factors, such as pre-existing mental illness, that identify women at greatest risk of mental health problems after an abortion."[89] The risk of affective disorder and suicide ideation may be even more pronounced after the abortion of a wanted pregnancy – such as for fetal anomaly or maternal indications.[90] Adverse mental health associations or effects may be tied with increased mortality in women having induced abortion.[75, 81, 91]

Conclusions:

Late abortion is extreme by any measure and should be prohibited. Passing HB 20-1098 is not only medically/morally correct, it is consistent with the views of a majority of Coloradans. Very few countries in the world permit abortion after 20 weeks. Most Americans, regardless of their political affiliation, feel that abortion should be illegal in the third trimester. A 22-week fetus is biologically indistinguishable from a baby born at 22 weeks. There is scientific evidence that a 22-week human fetus demonstrates all the fundamental characteristics of more developed humans, including the ability to perceive pain and perform sophisticated behaviors. The reasons women choose late abortion are similar to the reasons that women choose early abortion. Most late abortions are performed on normal human fetuses. For those tragic situations where a human fetus has a life-limiting prognosis because of a genetic or congenital fetal abnormality, perinatal hospice offers a compassionate, life-affirming alternative to late abortion. Late abortions are violent procedures that commonly involve the crushing and

dismemberment of the human fetus. Late abortions pose a substantial morbidity and mortality risk to the pregnant woman, which is further exacerbated by the lack of regulatory oversight. Long term sequelae of abortion include the risk for future premature birth and adverse future pregnancy outcomes. There may be an increased risk of early mortality in women who have abortion compared to women who deliver babies. This may be related to antecedent poor mental health in women who choose abortion and possibly adverse long-term mental health outcomes from abortion.

Please vote yes on HB 20-1098

Thomas J. Perille MD FACP FHM **Revised February 2020**
Democrats for Life of Colorado

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