Written Testimony of Katie Glenn, Esq.
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On Massachusetts H. 3320 and S. 1209
Submitted to the Joint Committee on the Judiciary
June 17th, 2019

Dear Senator Eldridge, Representative Cronin, and Members of the Committee:

My name is Katie Glenn and I work as Government Affairs Counsel with Americans United for Life (AUL), the oldest and most active pro-life non-profit advocacy organization. Established in 1971, AUL has dedicated nearly 50 years to advocating for comprehensive legal protections for human life from conception to natural death. Thank you for the opportunity to provide legal testimony on H. 3320 and S. 1209, referred to collectively as "the Act," which would enshrine expansive pro-abortion measures in Massachusetts law. I have thoroughly reviewed both H. 3320 and S. 1209, and it is my legal opinion that they have severe consequences for the health of women and the unborn. The Act expands abortion allowances beyond *Roe v. Wade* and its progeny, rejects the state's legitimate interest in protecting life, and prohibits commonsense protections for women's health from being enacted in the future.

The Act effectively expands abortion up until birth.

The Act would result in the expansion of abortion beyond what was permissible in *Roe* to any time it is "necessary to protect the patient's life or physical or mental health."[1] The Act considers "health" to include all factors, including "physical, emotional, psychological, familial, and the person's age" for the purposes of post-viability abortions.[2] By intentionally creating a broad definition of "health," the Act allows for abortion up to the moment of delivery of the child which effectively creates abortion on demand at any point in the pregnancy.

The Act dehumanizes the unborn.

Current Massachusetts law defines "pregnancy" as the condition of a mother carrying an unborn child.[3] The Act would strip from the law the plain language in favor of the sanitized

[1] H. 3320 § 1, 191 Gen. Court, Reg. Sess. (Mass. 2019), S. 1209 § 1, 191 Gen. Court, Reg. Sess. (Mass. 2019).
[2] *Id.*
[3] Mass. Gen. Laws ch. 112 § 12K (Defining the unborn child in similarly human terms as the individual human life in existence and developing from implantation of the embryo in the uterus until birth).

Newspeak "presence of an implanted human embryo or fetus within a person's uterus."[4] Pregnant mother. Unborn child. It is not complicated. Eliminating the term "unborn child" entirely serves only the purpose of obfuscating what abortion is, and who is harmed. Lest one be left wondering, the Act repeals any requirement by physicians to resuscitate or otherwise preserve the life of a child who survives a late-term abortion.[5] Current law requires the presence of life-supporting equipment in the (hospital) room where any late-term abortion occurs. The Act removes this basic safeguard, leaving physicians unclear of their responsibilities to the mother or child.

Removing the hospital requirement is dangerous because late-term abortions carry high risks.

The Act would no longer require that abortions after 24 weeks gestation be performed in a hospital. The requirement was enacted into law precisely because these procedures are higher risk and can threaten the life of the mother. Women will face life-threatening and potentially life-ending complications as the result of this change.

It is undisputed that abortion carries a higher medical risk when performed later in pregnancy. Gestational age is the strongest risk factor for abortion-related mortality, and the incidence of major complications is significantly higher after 20 weeks' gestation.[6] For example, compared to an abortion at 8 weeks' gestation, the relative risk of mortality increases exponentially (by 38 percent for each additional week) at higher gestations.[7] Specifically, the risk of death at 8 weeks is reported to be one death per one million abortions; at 16 to 20 weeks, that risk rises to 1 per every 29,000 abortions; and at 21 weeks or more, the risk of death is 1 per every 11,000 abortions.[8] In other words, a woman seeking an abortion at 20 weeks is 35 times more likely to die from abortion than she was in the first trimester. And at 21 weeks or more, she is 91 times more likely to die from abortion than she was in the first trimester.

Researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."[9] This is because in later-term abortions, the cervix needs to be dilated to a greater degree, the increased blood flow predisposes to hemorrhage, and the myometrium is relaxed and more subject to

[4] H. 3320 § 1, 191 Gen. Court, Reg. Sess. (Mass. 2019), S. 1209 § 1, 191 Gen. Court, Reg. Sess. (Mass. 2019).
[5] Mass. Gen. Laws ch. 112 § 12P. ("If an abortion is performed pursuant to section twelve M, the physician performing the abortion shall take all reasonable steps, both during and subsequent to the abortion, in keeping with good medical practice, consistent with the procedure being used, to preserve the life and health of the aborted child. Such steps shall include the presence of life-supporting equipment, as defined by the department of public health, in the room where the abortion is to be performed").
[6] L.A. Bartlett et al., *Risk Factors for Legal Induced Abortion—Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004); J.P. Pregler & A.H. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002).
[7] Bartlett, *supra* note 6.
[8] *Id.*
[9] *Id.* at 735.

perforation. Even Planned Parenthood, the largest abortion provider in the United States, agrees that abortion becomes riskier later in pregnancy. On its national website, Planned Parenthood states: "The chances of problems gets higher the later you get the abortion, and if you have sedation or general anesthesia . . . ," which would be necessary for an abortion at or after 20 weeks of gestation.[10]

Massachusetts legislators took seriously these health risks when they initially passed the law requiring that abortions take place in a "hospital duly authorized to provide facilities for general surgery (post-13 weeks) or obstetrical services (post-24 weeks)."[11] Shifting these high-risk abortions to clinics that do not have the appropriate facilities to provide emergency medical care needlessly risks the safety of both mother and child.

The Act removes commonplace restrictions and impedes necessary regulatory oversight.

The Act removes the Commonwealth's commonsense safeguards, preventing regulation critical to keeping women safe. Some changes include watering down informed consent laws, eliminating parental consent requirements for minors seeking an abortion, and preventing future protections for the health of the mother and child, including protections against coerced abortion, sex-selective abortion, and abortion based on genetic anomalies such as Down syndrome. These changes are unnecessary and harmful.

First, the Act strikes all specifics, leaving a shell of "informed consent" remaining. It ends the 24-hour reflection period between signing the informed consent document and undergoing the abortion procedure. It no longer requires that the mother be given critical information about her unborn child or her own medical needs.[12] Coupling informed consent, which under current law includes recognition of possible health complications and of the availability of alternatives to abortion, with a 24-hour reflection period so the woman has time to process what she has learned and make a meaningful decision makes common sense. Without this law, there is no way to ensure that women receive and understand all the information given to them. It is no different from the conversations physicians have with patients for any number of simple procedures, and there is no benefit to removing this protection from Massachusetts law.

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[10] *See* Planned Parenthood, *How Safe Is An In-Clinic Abortion?*, https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion (last visited June 14, 2019).

[11] Mass. Gen. Laws ch. 112 § 12Q.

[12] *Id*. § 12S. (Removing the existing law that says, "This form shall be written in a manner designed to permit a person unfamiliar with medical terminology to understand its purpose and content, and shall include the following information: a description of the stage of development of the unborn child; the type of procedure which the physician intends to use to perform the abortion; and the possible complications associated with the use of the procedure and with the performance of the abortion itself; the availability of alternatives to abortion; and a statement that, under the law of the commonwealth, a person's refusal to undergo an abortion does not constitute grounds for the denial of public assistance").

Second, it repeals Massachusetts' parental consent law. The medical, emotional, and psychological consequences of abortion are often serious and can be lasting, particularly when the patient is immature. Parental consent is critical, given that parents usually possess information essential to a physician's exercise of his or her best medical judgment concerning the minor. And parents who are aware that their daughter has had an abortion may better ensure she receives the best post-abortion medical attention.

Further, minors who obtain abortions without parental notice or involvement are at the risk of being coerced due to an abusive situation. News stories frequently reveal yet another teen who has tragically been sexually abused by a person in authority: a coach, a teacher, or another authority figure. And teens are routinely taken to abortion clinics without the consent or even the knowledge of their parents. Minors are at risk of continuing, untreated trauma in the absence of parental consent laws. Current Massachusetts law provides multiple avenues for consent, including judicial bypass. There is no reason to repeal it and doing so will only harm young girls.

In *Roe v. Wade*, the Supreme Court explained that "a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life."[13] Most recently in *Whole Woman's Health v. Hellerstedt*, the Court reiterated that the "State has a legitimate interest in seeing to it that abortion, like any medical procedure, is performed under circumstances that insure maximum safety for the patient."[14] As a reflection of a state's legitimate interest in protecting life, a state may pass common-sense health and safety abortion regulations, including provisions to ensure the informed consent and health of a woman who chooses to have an abortion.[15] In blatant disregard of the State's prerogative, the Act not only circumscribes Massachusetts' ability to act upon its legitimate state interest in protecting life and ensuring the mother's health, but also rejects that Massachusetts has any affirmative interest in the life of the unborn altogether.

After stripping many robust protections from existing state law, the Act then prohibits regulations of abortion providers that could be considered a restriction on an individual from having an abortion. The Act thereby engenders a regulatory regime that is akin to the one in Pennsylvania that allowed the infamous abortion provider, Kermit Gosnell, to operate his "House of Horrors" for many years. Gosnell, who was ultimately convicted of involuntary manslaughter, was able to provide unsafe, unsanitary, and deadly abortions for many years because, according to

[13] 410 U.S. 113, 154 (1973).
[14] 790 F.3d 563, 567 (2016) (quoting *Roe*, 410 U.S. at 150).
[15] *See, e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) ("[R]equiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden").

the Grand Jury report, the Pennsylvania Department of Health thought it could not inspect or regulate abortion clinics because that would interfere with access to abortion.[16] By lowering professional accountability, abortion providers in Massachusetts will be free to operate without regulation and oversight, to the detriment of women and young girls.[17] If Massachusetts passes the Act, it will turn a blind eye to unsafe abortion practices by abdicating its proper duty to protect women.

In conclusion, passing the Act into Massachusetts law would create the conditions for Gosnell-like clinics that endanger women seeking abortions. Removing the highest risk abortions from hospitals while simultaneously limiting the ability of state regulators to oversee clinics is a recipe for disaster. This does not improve "women's health." It is dangerous and wrong.

I urge this Committee to further Massachusetts' important state interests in preserving human life and protecting women's health and reject H. 3320 and S. 1209.

Sincerely,

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[16] *See, e.g.*, Conor Friedersdorf, *Why Dr. Kermit Gosnell's Trial Should Be a Front-Page Story*, ATLANTIC (Apr. 12, 2013), https://www.theatlantic.com/national/archive/2013/04/why-dr-kermit-gosnells-trial-should-be-a-front-page-story/274944/ (discussing the case of Kermit Gosnell).

[17] *See, e.g.*, AMS. UNITED FOR LIFE, UNSAFE (2d ed. 2018) (report documenting unsafe practices of abortion providers and harm to women's health and safety).