ProLife OB|GYNS
AAPLOG American Association of Pro-life Obstetricians & Gynecologists

AAPLOG POLICY STATEMENT

Dismemberment Abortion Bans

What are dismemberment abortions (i.e. Dilation and Evacuation, D&E)?

During the hearings regarding the Partial Birth Abortion Ban, abortionists testified about the distinction between D&E procedures and Partial Birth Abortion procedures. In the Majority opinion, the United States Supreme Court summarized abortionists' testimonies describing D&E:

> *"In the usual second-trimester procedure, 'dilation and evacuation' (D&E), the doctor dilates the cervix and then inserts surgical instruments into the uterus and maneuvers them to grab the fetus and pull it back through the cervix and vagina. The fetus is usually ripped apart as it is removed, and the doctor may take 10 to 15 passes to remove it in its entirety."*[1]

In the dissenting opinion, Justice Ginsburg recognized that the brutality inherent in performing D&E (which the court terms "non-intact D&E") on living fetuses was equal to the brutality of partial birth abortion (i.e. "intact D&E"):

> *"... the Court emphasizes that the Act does not proscribe the nonintact D&E procedure." See ante, at 34. But why not, one might ask. Nonintact D&E could equally be characterized as "brutal," ante, at 26, involving as it does "tear[ing] [a fetus] apart" and "ripp[ing] off" its limbs, ante, at 4, 6. "[T]he notion that either of these two equally gruesome procedures . . . is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one but not the other, is simply irrational." Stenberg, 530 U. S., at 946–947 (STEVENS, J., concurring).*

Dr. Anthony Levatino[2] briefly and accurately describes the D&E procedure in an illustrated video available at http://www.abortionprocedures.com/ .

What does a dismemberment abortion ban forbid?

Most dismemberment abortion bans forbid ripping apart a *living* fetus during a D&E procedure. Most bans also have an exception to the ban when a physician must perform a D&E on a living fetus in order to save the mother's life (e.g. severe chorioamnionitis or other situations which involve an immediate

The American Association of Pro-Life Obstetricians and Gynecologists is a medical professional organization of 3500 physician members and associates. AAPLOG exists to encourage and equip concerned medical practitioners to give evidence-based reasons for defending the lives of both our pregnant patient and her unborn child.

threat to the mother's life), or immediate threat of serious irreversible physical harm which will be alleviated by separating the mother and the fetus.

Why ban dismemberment abortions on living fetuses?

The structures which transmit painful stimuli from the skin to the brain are present very early in fetal life[3] and anesthesiologists for the last decade have used fetal anesthesia as standard of care for in utero fetal surgery, as evidenced by the review by Gupta[4] et al. in 2008:

> *Fetal stress*
>
> *There is considerable evidence that the fetus may experience pain. Not only is there a moral obligation to provide fetal anaesthesia and analgesia, but it has also been shown that pain and stress may affect fetal survival and neurodevelopment.[7][5] Factors suggesting that the fetus experiences pain include the following.*
>
> *i. Neural development. Peripheral nerve receptors develop between 7 and 20 weeks gestation, and afferent C fibres begin development at 8 weeks and are complete by 30 weeks gestation. Spinothalamic fibres (responsible for transmission of pain) develop between 16 and 20 weeks gestation, and thalamocortical fibres between 17 and 24 weeks gestation.*
>
> *ii. Behavioural responses. Movement of the fetus in response to external stimuli occurs as early as 8 weeks gestation, and there is reaction to sound from 20 weeks gestation. Response to painful stimuli occurs from 22 weeks gestation.*
>
> *iii. Fetal stress response. Fetal stress in response to painful stimuli is shown by increased cortisol and β-endorphin concentrations, and vigorous movements and breathing efforts.[7,9][6,7] There is no correlation between maternal and fetal norepinephrine levels, suggesting a lack of placental transfer of norepinephrine. This independent stress response in the fetus occurs from 18 weeks gestation.[10] There may be long-term implications of not providing adequate fetal analgesia such as hyperalgesia, and possibly increased morbidity and mortality.*

A 2012 review article[8] on fetal anesthesia concurs, and concludes with a call for adequate fetal pain relief:

> *Evidence is increasing that from the second trimester onwards, the fetus reacts to painful stimuli and that these painful interventions may cause long-term effects. It is therefore recommended to provide adequate pain relief during potentially painful procedures during in utero life.*

Fetuses who are victims of D&E abortions react to painful stimuli with the same physiological responses that any other human being would display: increase in heart rate, increase in stress hormones in the blood stream, and withdrawal from painful stimuli. As the science of in-utero fetal surgery has progressed, it has become clear that fetuses do better when given pain relief during the surgery.

It is also very clear that fetuses who are candidates for abortion by D&E (i.e. second and third trimester) display all the same physical reactions to pain that any other human being would display. A living fetus

References

[1] USSC Gonzales.
[2] Dr. Anthony Levatino is a board certified obstetrician and gynecologist in private practice, former abortion privider, and current member of the AAPLOG Board of Directors.
[3] https://judiciary.house.gov/_files/hearings/113th/05232013/Condic%2005232013.pdf
[4] Gupta R, Kilby M, Cooper G. Fetal surgery and anaesthetic implications Contin Educ Anaesth Crit Care Pain (2008) 8 (2): 71-75. available at https://academic.oup.com/bjaed/article/8/2/71/338464/Fetal-surgery-and-anaesthetic-implications
[5] Boris P, Cox PBW, Gogarten W, Strumper D, Marcus MAE. Fetal surgery, anaesthesiological considerations. Curr Opin Anaesthesiol 2004; 17: 235–40
[6] Ibid.
[7] Giannakoulopoulos X, Teixeira J, Fisk N. Human fetal and maternal noradrenaline responses to invasive procedures. Pediatr Res 1999; 45: 494–9.
[8] Van de Velde M, De Buck F. "Fetal and maternal analgesia/anesthesia for fetal procedures" Fetal Diagn Ther 2012;31:201–209.