ACOG

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

June 18, 2012

ACOG STATEMENT ON HR 3803

The American Congress of Obstetricians and Gynecologists (ACOG) opposes HR 3803, the District of Columbia Pain-Capable Unborn Child Protection Act, and other legislative proposals that are not based on sound science or that attempt to prescribe how physicians should care for their patients. ACOG hopes our comments below will be helpful to the Committee in clarifying several inaccuracies in the bill's language and in testimony submitted in support of it. As the Nation's leading authority in women's health, our role is to ensure that policy proposals accurately reflect the best available medical knowledge.

Gestational Age

The bill's and supporters' language regarding post-fertilization age is vague and inaccurate. Obstetrician-gynecologists use last menstrual period (LMP) to date pregnancies. Post-fertilization dating is not an accurate substitute and should not be referenced in legislation.

Fetal Pain

The medical profession produced a rigorous scientific review of the available evidence on fetal pain in *Journal of the American Medical Association (JAMA)* in 2005[1]. The review concluded that fetal perception of pain is unlikely before the third trimester. No new studies since the publication of the *JAMA* paper have changed this dominant view of the medical profession. Supporters of HR 3803 only present studies which support the claim of fetal pain prior to the third trimester. When weighed together with other available information, including the *JAMA* study, the supporters' conclusion does not stand.

Fetal Viability

Most obstetrician-gynecologists understand fetal viability as occurring near 24 weeks gestation utilizing LMP dating. Submitted testimony by supporters of HR 3803 presents misleading evidence about fetal viability, especially in using post-fertilization age, instead of LMP dating, falsely implying high survival rates among neonates that are overwhelmingly pre-viable. While quoting survival of live-born infants in a June 2009 *JAMA* study, the testifier does not mention that the vast majority of infants born prior to 24 completed weeks (LMP) died prior to or during birth. In this study, 93% of infants at 22 weeks died, 66% at 23 weeks, and 40% at 24 weeks[2]. 91% of those that lived were admitted to the NICU.

Also not mentioned by the testifier is the fact that survival alone is not the only endpoint for neonatologists. Intact survival is. In this same study, 98% of infants born at 22 weeks (LMP) and 91% born at 23 weeks (LMP) had at least one major medical problem, such as hemorrhaging brain or bowel[2]. The American Academy of Pediatrics Committee on Fetus and Newborn states that "the incidence of moderate or severe neurodevelopmental disability in surviving children assessed at the age of 18 to 30 months is high (approximately 30 to 50%)[3]" and remains at that high level until 25 weeks (LMP). Babies delivered at these gestational ages often suffer hemorrhaging bowel, blindness, deafness, and stroke, as a result of their premature delivery.

Depression

Testimony submitted in support of HR 3803 asserts that women suffer from depression after abortion. A thorough review by the American Psychological Association in 2008 necessitates a more careful understanding of this issue:

> "[a]mong adult women who have an unplanned pregnancy, the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver

that pregnancy. The evidence regarding the relative mental health risks associated with multiple abortions is more equivocal. Positive associations observed between multiple abortions and poorer mental health may be linked to co-occurring risks that predispose a woman to both multiple unwanted pregnancies and mental health problems. The few published studies that examined women's responses following an induced abortion due to fetal abnormality suggest that terminating a wanted pregnancy late in pregnancy due to fetal abnormality appears to be associated with negative psychological reactions equivalent to those experienced by women who miscarry a wanted pregnancy or who experience a stillbirth or death of a newborn, but less than those who deliver a child with life-threatening abnormalities."

ACOG opposes HR 3803 and strongly urges the Committee and the US Congress to closely examine and follow scientific facts and medical evidence in its consideration of this and other health care legislation. We stand ready to provide you with factual information on medical issues that come before the Committee, and hope you'll contact Nevena Minor, ACOG Director of Federal Affairs at nminor@acog.org, at any time.

References:

1. Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal pain: A systematic multidisciplinary review of the evidence. *JAMA* 2005; 294: 947-954.
2. EXPRESS group. One-year survival of extremely preterm infants after active perinatal care in Sweden. *JAMA* 2009; 301: 2225-2233.
3. MacDonald H & the Committee on Fetus and Newborn. Perinatal care at the threshold of viability. *Pediatrics* 2002; 110: 1024−1027.
4. APA Task Force on Mental Health and Abortion. (2008). *Report of the APA Task Force on Mental Health and Abortion.* Washington, D.C.: Author.
5. Dietz PM, Williams SB, Callaghan WM, Bachman DJ, Whitlock EP, Hornbrook MC. Clinically identified maternal depression before, during, and after pregnancies ending in live births. *Am J Psychiatry* 2007; 164: 1515–20.