

Is Senate Bill 415 Constitutional? A Critical Analysis of the Law & the Evidence

Paul Benjamin Linton, Esq.
Special Counsel, Texas Alliance for Life
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Executive Summary

This memorandum evaluates the constitutionality of S.B. 415, which, subject to very narrow exceptions, would prohibit the performance of dismemberment (D&E) abortions on live, unborn children, in light of the oral testimony and written submissions presented in support of the bill to the Senate Health & Human Services Committee on February 15, 2017.¹ This memorandum supplements, and is not intended to repeat, the analysis set forth in my memorandum of September 1, 2016, which concluded that legislation like S.B. 415 would not be upheld by any state or federal court because it would effectively prohibit the performance of the most commonly used second-trimester abortion procedure, dismemberment (D&E) abortions.

None of the medical or legal witnesses who testified in favor of S.B. 415 came to grips with the fundamental flaw in the legislation, specifically, that causing the death of the unborn child before performing a dismemberment abortion is simply not an option that may be used throughout the second trimester with equal safety to the health of the pregnant woman. A careful analysis of the fourteen studies cited by Dr. Donna Harrison (representing the American Association of Pro-Life Obstetricians and Gynecologists) in support of her written testimony (the list of the studies is attached to this memorandum) reveals that the techniques for causing the death of the unborn child before performing a second-trimester abortion are not routinely performed before the seventeenth week of gestation and never before the fifteenth week, by which time thousands of dismemberment abortions have been performed in Texas (the same studies were cited by Dr. Maureen Condic in her May 23, 2013, testimony in support of the District of Columbia “Pain-Capable Unborn Child Protection Act,” which addressed an entirely different issue). Moreover, these techniques are normally performed either in hospitals by specialists in maternal and fetal care, or by highly experienced practitioners in free-standing surgical centers. Most second-trimester abortions, however, are performed *outside* of hospitals by physicians who are neither specialists in maternal and fetal care, nor experienced in causing fetal death before performing a D&E. Furthermore, causing fetal death before beginning a dismemberment abortion may pose various risks to the pregnant woman. And, as this memorandum shows, alternative procedures are not practical alternatives to D&Es. In the absence of compelling evidence that there are safe and available alternatives to performing a dismemberment abortion upon live, unborn children, no court would uphold S.B. 415. Indeed, the experience in the four States where similar legislation has been challenged — Alabama, Kansas, Louisiana and Oklahoma — supports this conclusion because not one of those laws is currently in effect.

¹ The audio-video of the first session may be found at http://tlcsenate.granicus.com/MediaPlayer.php?view_id=42&clip_id=11709, and the audio-video of the second session may be found at http://tlcsenate.granicus.com/MediaPlayer.php?view_id=42&clip_id=11718.

Would a federal court find the bill constitutional?

As my memorandum of September 1, 2016, said, whether a ban on performing dismemberment abortions on live, unborn children is constitutional depends on whether there are safe, readily available alternatives to pregnant women seeking second-trimester abortions. The safety and availability of alternatives is critical because, as the bill's author, Senator Charles Perry acknowledged, dismemberment abortions account for 96% of all second-trimester abortions. Hearings, First Session, 1:00:15. The principal alternative suggested by Dr. Harrison is to cause the death of the unborn child before beginning a D&E, either by an injection of potassium chloride, digoxin or some other lethal agent, or by transecting the umbilical cord.² Although Dr. Harrison cited studies showing that *some* physicians, usually specialists in maternal and fetal care or very experienced practitioners, may use one or another of these techniques to cause fetal death in *some* situations before performing a dismemberment abortion, particularly late in the second trimester, she cited *no* studies demonstrating that it is possible for physicians who perform such abortions to cause fetal death throughout the second trimester with equal safety for the patient.

First, *none* of the cited studies addressed the safety of causing fetal death at the earlier stages of the second trimester when D&E (dismemberment) abortions are performed. As the chart accompanying this memorandum indicates, none of the studies included abortions performed before fifteen weeks, and only three included any abortions performed between fifteen and sixteen weeks. A recent study, not cited by Dr. Harrison, revealed that "the earliest gestation at which any provider reported routinely inducing fetal demise before D&E was 17 weeks," with most doing so "around 20 weeks." Denny, *et al.*, "Induction of fetal demise before pregnancy termination: practices of family planning providers," *Contraception* 92 (2015) 243 & Fig. 1. Yet, thousands of D&E abortions are performed in Texas before the seventeenth week.

Second, as the chart indicates, almost all of the cited studies were based on the experience of highly qualified physicians (frequently specialists in maternal and fetal care) who perform D&E abortions on a regular basis, often in a hospital, not on the experience of *all* physicians who perform D&E abortions. One of the studies cited by Dr. Harrison noted that causing fetal demise by an injection of a lethal agent (*e.g.*, digoxin, potassium chloride or other substance) "requires additional training and a high level of ultrasonography skills and equipment." Study No. 2 (Tocce, *et al.*). None of the studies she cited demonstrated that the average physician performing D&E (dismemberment) abortions has the required training and skill to cause fetal death by lethal injection. Yet another study cited stated that "feticide is a specialised procedure that should really be undertaken in tertiary fetal medicine units after comprehensive evaluation of the fetus and pregnancy." Study No. 4 (Pasquini, *et al.*). Yet, data from the Texas Department of State Health Services reveals that in 2014, only *eighteen* D&E procedures (out of almost *four thousand* D&Es) were performed in hospitals. See <http://www.dshs.texas.gov/chs/vstat/vs14/t38.aspx>. That represents less than one-half of one percent of all D&E (dismemberment) abortions.

² Premature induction of labor, which accounts for five percent of all second trimester abortions, is not a realistic option because inductions take more time than D&Es, are more expensive, cannot be performed at earlier stages of the second-trimester and are contraindicated for some patients. And D&C (dilation and curettage) is not a plausible option to replace D&Es because D&Cs can be performed only at the very earliest stage of the second-trimester.

Third, causing fetal death before beginning a dismemberment abortion is not without risks to the patient. One article cited by Dr. Harrison noted that the safety of using digoxin “has recently been evaluated by several investigators, yielding conflicting results.” Study No. 2 (Tocce, *et al.*). The article noted that “a retrospective cohort study utilizing historical controls showed that women who received digoxin were more likely to experience spontaneous abortion, infection and hospital admission than those who underwent D&E without feticidal injection.” *Id.* Another study cited by Dr. Harrison noted that vomiting was “significantly more frequent” among patients who had been given an injection of digoxin than those who had been given an injection of a placebo. Study No. 13 (Lohr). The clinical guidelines issued by the Society of Family Planning, not cited by Dr. Harrison, note that techniques for transecting the umbilical cord “are far more invasive and bear more risk than other methods of feticide before an abortion is performed” “Induction of fetal demise before abortion,” *Contraception* 81 (2010) 466.

What is the purpose of the legislation?

What is the purpose of S.B. 415? Surprisingly, the supporters of the legislation and its author did not appear to agree on the answer. John Seago, Legislative Director of Texas Right to Life, stated in his testimony that S.B. 415 “will stop [second-trimester] elective abortions” in Texas. Hearings, Second Session, 03:23. Emily Cook, General Counsel for Texas Right to Life, stated that S.B. 415 would advance a “unique legal precept, taking direct aim and a different approach to contesting *Roe v. Wade* and its progeny.” Hearings, Second Session, 1:06:56-1:07:03.

The author of S.B. 415, who understands that a ban on dismemberment abortions would not be found constitutional, took a more modest view. Throughout the discussion of his bill and in his exchanges with several witnesses who testified on the legislation, Senator Perry emphasized that S.B. 415 does *not* ban any method of abortion, including D&E abortions. Rather, it merely requires that the unborn baby is “killed” (Senator Perry’s word) before the procedure begins. That S.B. 415 would *not* prevent a single abortion or save a single life is apparent from his comments later in the afternoon session, “the outcome, unfortunately, and this is the saddest thing I’ll say today, is that still, [there is] an aborted baby, even under 415’s legislation, *so that didn’t change the outcome*” Hearings, Second Session, 32:00-32:14 (emphasis added).

If banning abortions and saving the lives of unborn children is not the purpose of S.B. 415, then what is its purpose? Senator Perry repeatedly stated that the legislation is intended to prevent “torturous and inhumane pain.” Hearings, Second Session, 21:37. But it is doubtful that S.B. 415, as drafted, would prevent the unborn child from experiencing pain.

First, nothing in S.B. 415 requires the unborn child to be anesthetized *before* it is killed by one of the techniques that are used to cause fetal death before beginning an abortion. Yet, as one of the studies cited by Dr. Harrison observed, “Injection of KCl [potassium chloride] is likely to be painful.” Study No. 7 (Senat, *et al.*). The study authors recommended that “fetal analgesia should precede KCl injection as a critical procedure” which “allows the fetus to die without pain when late [termination of pregnancy] is indicated.” To avoid “fetal pain and fetal awareness,” another study recommended more generally that “fetal analgesia should optimally precede feticide.” Study No. 6 (Senat, *et al.*). S.B. 415, however, does not require fetal analgesia.

Second, the techniques used to cause fetal demise do not always cause immediate death. One study cited by Dr. Harrison noted that fetal demise took between one and three hours following an intra-fetal injection of digoxin, and a minimum of four hours with an intra-amniotic injection. Study No. 3 (Nucatola, Roth & Gatter). Yet another study cited reported that “Most patients continue to have fetal cardiac activity at 4 h [hours] post-injection” of digoxin. Study No. 2 (Tocce, *et al.*). That same study, which recommended umbilical cord transection, acknowledged that fetal demise took up to eleven minutes after transection. *Id.* It must be emphasized that nothing in S.B. 415 requires that the unborn child be anesthetized while he or she is dying.

Third, with respect to the very few dismemberment abortions that could be performed on live, unborn children under the exceptions set forth in the bill, S.B. 415 does not require that the child be given an anesthetic or other drug to prevent it from experiencing excruciating pain. Why not?

Conclusion

Whether S.B. 415 could withstand a federal constitutional challenge depends on whether causing fetal death before beginning a dismemberment (D&E) abortion can be performed with equal safety for the pregnant woman. That is because no court will uphold a law that, in effect, bans D&E abortions, the most commonly performed second-trimester abortion procedure. As the foregoing analysis reveals, the studies cited by Dr. Harrison fail to establish that conclusion. While some very experienced physicians may routinely cause fetal death late in the second-trimester before performing a dismemberment (D&E) abortion, there is *no* evidence that causing fetal death earlier in the second-trimester is as safe for the patient as not causing fetal death, or is within the skill set of all physicians who perform D&Es. The Society of Family Planning has noted in its clinical guidelines that “Although numerous methods have been used over the years to achieve fetal demise, data remain scarce documenting the effect of these techniques upon the safety of the abortion itself.” “Induction of fetal demise before abortion,” *Contraception* 81(2010) 463. No court will uphold a ban on the performance of dismemberment abortions on live, unborn children in the absence of compelling evidence that causing the death of the child before beginning the procedure can be done with equal safety for the woman throughout the second trimester of pregnancy by any physician who performs D&E abortions.³ No such evidence was presented to the Committee, nor does such evidence exist in the literature. Accordingly, a court would find S.B. 415 to be unconstitutional.

³ The failure of either of the attorneys testifying in favor of S.B. 415 to mention, much less engage, the analysis set forth in Judge Thompson’s detailed critique of the safety and availability of these techniques, is remarkable. *See* Hearings, First Session, 1:11:00 to 1:19:30 (Mary Balch); Second Session, 1:05:00-1:07:04 (Emily Cook). *See* Opinion, *West Alabama Women’s Center v. Miller*, Civ. Action No. 2:15cv497-MHT (October 27, 2016). In support of her testimony, Ms. Cook introduced an *amicus curiae* brief filed by Professor Teresa Collett in the Kansas Supreme Court in defense of a bill similar to S.B. 415. Professor Collett’s brief (p. 11, n. 6) cited two studies showing that digoxin can be administered at or after eighteen weeks gestation. Those studies do not support the inference that digoxin may be safely administered at earlier stages of pregnancy, a time when thousands of dismemberment abortions are performed.