

THE ISSUE

The Wisconsin Section of the American Congress of Obstetricians and Gynecologists (ACOG) urges Wisconsin lawmakers to reject legislative proposals that are not based on sound science or that attempt to replace physicians' medical judgment with political ideology. Interference in how physicians should care for their patients poses a threat to women's health. Politicians are not medical experts. Many circumstances exist in which a woman may need to seek an abortion after 20 weeks, including saving her own life. Her decision should be based on individual circumstances and personal beliefs without interference from politicians.

In Wisconsin, the majority of pregnancy terminations after 20 weeks are performed for medical indications, including lethal fetal anomalies and serious medical conditions of the mother. By not allowing any exceptions, the proposed legislation forces a pregnant woman to carry her pregnancy to term when 1) there is no chance of meaningful neonatal survival, and 2) the woman herself is at risk of death.

Many obstetricians, neonatologists and pediatricians provide supportive and palliative care to neonates who cannot be saved at term and to babies born as a result of a medically indicated pregnancy termination prior to viability. We opposed mandates of life-sustaining care that is illogical and not desired by parents or their physicians.

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 Pain perception requires conscious recognition or awareness of a noxious stimulus. Neither withdrawal reflexes nor hormonal stress responses to invasive procedures prove the existence of fetal pain, because they can be elicited by nonpainful stimuli and occur without conscious cortical processing. Fetal awareness of noxious stimuli requires functional thalamocortical connections. Thalamocortical fibers begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks. The review concluded that fetal perception of pain is unlikely before the third trimester.

In 2010, The Royal College of Obstetricians and Gynecologists (RCOG) rigorously reviewed the scientific literature and "in reviewing the neuroanatomical and physiological evidence in the fetus, it was apparent that connections from the periphery to the cortex are not intact before 24 weeks of gestation and, as most neuroscientists believe that the cortex is necessary for

pain perception, it can be concluded that the fetus cannot experience pain in any sense prior to this gestation".

Supporters of fetal pain legislation only present studies that support the claim of fetal pain prior to the third trimester. When other studies are equally weighted, supporters' conclusion does not stand.

FETAL VIABILITY

Most obstetrician-gynecologists understand fetal viability as occurring near 24 weeks gestation utilizing LMP dating, with individual determinations varying on a case-by-case basis. Supporters of fetal pain present 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. Supporters may point to the survival of live-born infants in a 2015 *New England Journal of Medicine* study, but fail to mention that the vast majority of infants born prior to 24 weeks (LMP) died prior to or during birth. In this study, overall 95% of infants at 22 weeks died, 76% at 23 weeks, and 45% at 24 weeks.² Even among neonates that received

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 Rysavy M et al. Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants. *NEMJ* 2015; 372;19: 1801-1811

intensive medical care, survival at 22 weeks only reached 23 percent, and 91% of those had moderate to severe neurological impairment.³ Importantly, this study only looked at infants without fetal anomalies, which likely would have further lowered the survival rates.

Also not mentioned by supporters is the fact that survival alone is not the only endpoint for neonatologists. Intact survival is. In a June 2009 JAMA 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.⁴ 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%).” The incidence of disability remains high until 25 weeks (LMP).⁵ Babies delivered at these gestational ages often suffer hemorrhaging bowel, blindness, deafness, and stroke as a result of their premature delivery.

FETAL ANOMALIES

Numerous fetal anomalies are only detected after 20 weeks. Legislation that bans abortion after 20 weeks will force some women, because of time constraints, to consider termination of pregnancy before they have appropriate counseling on neonatal outcomes. Such action leads to the possibility that more women seek abortions under such legislation.

While chromosomal anomalies can generally be diagnosed by 20 weeks, some low-risk couples do not elect to have testing and instead learn that their fetus has a chromosomal anomaly during a fetal anatomy screen at 18-20 weeks. Moreover, many lethal or serious fetal problems that are not compatible with life

outside of the womb are caused by conditions that are structural (not chromosomal) and are not susceptible to testing by amniocentesis. Thus, these can only be diagnosed by detailed ultrasound examination.

Many tests cannot definitively diagnose grave conditions affecting a pregnancy prior to 20 weeks because the fetus is not sufficiently developed for those conditions to be detected. Even in cases where an ultrasound detects indications of a structural anomaly prior to 20 weeks, additional tests (such as amniocentesis or echocardiogram) are often necessary to confirm the diagnosis. Scheduling those additional tests and obtaining the results will take additional time, often up to two weeks. By the time a diagnosis is confirmed by a specialist capable of diagnosing these anomalies, the pregnancy has often progressed beyond 20 weeks. As a result, a woman whose fetus is critically impaired often will not learn that fact until well into the second trimester.

The medical difficulty—if not impossibility—of diagnosing many of these lethal structural defects before 20 weeks is heightened by the fact that additional tests and doctors' appointments are often needed to confirm the anomaly. Once the diagnosis is confirmed, additional time is often needed to make a well-informed and careful decision about whether to terminate the pregnancy. General obstetricians who suspect a problem based on an ultrasound at 18 to 20 weeks often refer their patient to a perinatologist for confirmatory study and then diagnosis. These confirmatory tests take additional time—sometimes several weeks—to schedule and obtain results, particularly for women who live in rural or underserved areas. The final diagnosis will thus regularly take place near or after 20 weeks. Please reference additional position paper on Fetal Anomalies.

ABOUT THE WISCONSIN SECTION, ACOG

The American Congress of Obstetricians and Gynecologists is the leading professional association of physicians specializing in women's health care. The Wisconsin Section represents over 600 obstetricians and gynecologists from throughout the state and works to protect and improve the health and welfare of all women in Wisconsin.

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³ *Ibid.*

⁴ EXPRESS group. One-year survival of extremely preterm infants after active perinatal care in Sweden. *JAMA* 2009; 301: 2225-2233.

⁵ MacDonald H & the Committee on Fetus and Newborn. Perinatal care at the threshold of viability. *Pediatrics* 2002; 110: 1024-1027.