SB 798 February 28, 2023
Declaration of Rights-Right to Reproductive Freedom
Finance Committee
Unfavorable

I'm Dr. Sandy Christiansen, a board-certified ob/gyn licensed in the state of Maryland. I am opposed to the passage of SB 798. I stand in solidarity with a majority (80%) of obstetricians who are not in favor of abortion on demand and who do not perform abortions. I represent Care Net, a non-profit organization that supports one of the largest networks of pregnancy centers in North America. With 1,200 affiliates and 30,000 volunteers, we provide immediate support to women and men considering abortion, to equip them for a life decision. Last year alone, our pregnancy centers provided clients with more than $62 million in free services.

Maryland doesn't need stronger abortion laws

With the Food and Drug Administration decision to permanently remove the in-person requirement from the mifepristone label, every woman in Maryland has ready access to abortion services via telemedicine. Maryland ranks third in the Nation for best reproductive rights and abortion access with an A- rating.

The fall of Roe has had zero impact on access to abortion in Maryland. In fact, we are now an "abortion destination" state.

The deregulation of abortion will harm women: FDA & REMS

The impetus for the passage of Roe v. Wade was to make abortion "safe, legal, and rare." It was supposed to end "coat hanger" abortions. The abortion industry's push to make abortion available everywhere has led to the removal of nearly all the safeguards surrounding the distribution of the abortion pill. Women are now faced with a "chemical coat hanger" abortion.

The FDA's Risk Evaluation & Mitigation Strategy (REMS) is reserved for drugs where the risks may outweigh the benefits if certain safety measures aren't followed to reduce the risk of complications. Out of the 19,000 current FDA approved drugs, only 62 have a REMS requirement and mifepristone is one of them.

The abortion pill, mifepristone, didn't have REMS at first, it took women dying before it was added. And now, the FDA is dismantling it. In the case of mifepristone, the FDA required the following for physicians who wished to dispense mifepristone:

1. Prescribers to be trained and certified by Danco Labs
2. Must follow FDA approved use guidelines: which originally included 3 visits, drugs directly handed to the patient
3. Patient must be counseled about the risks, must sign Agreement Form, and be given a copy

When mifepristone was first approved by the FDA, **three in-person visits were required:**

1. First visit:
    a. Confirm/diagnose an intrauterine pregnancy: this is a critical step. Without performing an ultrasound exam, there is no way to know for sure if:
        i. Is she even pregnant? Pregnancy tests can be wrong
        ii. Does she have a living pregnancy? If she's miscarrying, she doesn't need an abortion, nor does she need to live with the falsehood that she ended her baby's life.
        iii. Does she have an intrauterine pregnancy? If she has a pregnancy outside the uterus (termed "ectopic", usually in the Fallopian tube), she is at risk for life-threatening internal bleeding. Ectopic pregnancies are not ended by the abortion pill.
        iv. Is she expecting twins? The abortion pill regimen is for a single pregnancy. With multiple gestations, the risk of abortion failure is increased, as is the risk of hemorrhage.
    b. Abortion provider collects a health history, checks vital signs, screens for contraindications to the abortion pill regimen
    c. Abortion provider hands her the first drug, mifepristone, and observes her swallowing it.
        i. Mifepristone is a potent progesterone blocking drug. Progesterone is necessary for the embryo to remain attached to the uterus, receiving nutrients. Mifepristone causes breakdown of the embryo's attachment to the uterus, eventually resulting in the embryo's death.
2. Second visit: she returns two days later and is assessed for complications. Then, she is given the second drug, misoprostol, in the abortion pill regimen. This causes the uterus to contract, resulting in cramping and bleeding and expulsion of the embryo and pregnancy tissues.
3. Third visit: return two weeks from the first visit to make sure the procedure was complete and to check for complications.

As of December 2021, the FDA succumbed to pressure from abortion lobbyists and made the following changes to the mifepristone label:

- Eliminated the in-person requirement. This is a HUGE change. Not only did it pave the way for "telehealth" abortions, but it required the involvement of pharmacists and pharmacies to dispense the drug.
- There are **ZERO** required in-person visits!

How is less care better for women? It isn't. There are no shortcuts in the delivery of good medical care.

What's so bad about no in-person requirement to get the abortion pill?

Now, the woman seeking an abortion can schedule a telemedicine visit, which is either a video visit, a phone call, a text or via email. Think about it. No face to face interaction is required. When I went to medical school, the cornerstone of diagnosis was observation, followed by the medical interview. Next, the physical exam to add clues. A monitor screen is not a substitute for a direct examination where nuances may be observed such as pallor, weakness and hands-on evaluation of well-being may be properly assessed. But in many cases, there is not even a visual visit—just a phone call, or chat room online. If you had told me when I began my residency in Ob/Gyn that doctors would give people they've never met in person advice over the phone, much less prescribing and inducing abortion, it would have hands down been considered malpractice. Here's the reality: **it still is malpractice**. **The "self managed abortion" is the modern day chemical coat hanger abortion and it will be the women of Maryland (and those who cross state lines) who will suffer.**

How does the telemedicine abortion work?

1. Proof of positive pregnancy test not required. Over the counter pregnancy tests can be wrong. She may not even be pregnant, but will pay hundreds of dollars to be exposed to risky drugs and spend her life believing she aborted a living pregnancy. No in person visit means no easy opportunity to perform a physical exam—a pelvic exam which can provide an estimate of gestational age, no testing for STIs and if there are risk factors for ectopic pregnancy. These telemed clinics don't require proof of a positive PT!
2. Incorrect Dates: Gestational age based on LMP: When the abortion provider interviews the patient on the phone, they will determine her pregnancy dating based on her last menstrual period (LMP) which may be wrong, she may be further along. Ordering an ultrasound exam is optional and will cost the patient more. Abortion providers are going off-label and offering the Abortion Pill past 10 weeks LMP, women will be taking these abortive drugs further in pregnancy. There is a greater risk of complications due to incorrect dates: the risk of incomplete abortion, failed abortion , more surgeries and death increases with increasing gestational age.
3. Missed ectopic pregnancy: Further, if an ultrasound is not done, than there is no definitive assessment for ectopic pregnancy. Verbally screening for an ectopic pregnancy is inadequate…plus, patients may not reveal symptoms such as pain or bleeding for fear that they won't be given the pill. The abortion pill won't abort an ectopic pregnancy. A missed ectopic could be life-threatening if it burst and caused internal bleeding.
4. Missed twins or other unusual ultrasound finding: if the patient had a pelvic exam done and the uterus is larger than expected, any reputable obstetrician would perform an ultrasound to determine if the baby is further along or if the mother is carrying twins or a molar pregnancy. If she has undiagnosed twins or a molar pregnancy and takes abortive pills, she is more likely to suffer complications like severe hemorrhage, incomplete abortion and infection.
5. Missed nonviable pregnancy (miscarriage): Women will undergo abortions for nonviable pregnancies and spend the rest of their lives believing they had aborted their baby.

6. Increased risk of future pregnancy complications: without blood testing for the Rh factor, women face potential complications with future pregnancies.
7. No exam to verify completion of the procedure or assess for complications. The abortion kits contain a urine PT with instructions to test 4 weeks after taking mifepristone, That's a long time to wait to know if it's done.
8. Complications? She's essentially on her own—will likely be instructed to go to the ER. Abortion providers are telling women to lie to the ER doctors and not disclose they have taken the abortion pill. This is shocking to me that a "healthcare" person would care so little for the safety of their patient that they would not want the treating physician to have all the facts in order to take the best care possible of their patient.

In summary, if the woman has regular menses, knows her LMP and has never had an IUD or pelvic infection, she will be prescribed the abortive pills without a physical exam or ultrasound exam, assuming the risk of missed ectopic, nonviable pregnancy, and more.

I can't stress enough how the practice of medicine is being eroded to the detriment of the patient. Less care, worse care. Women receive substandard care in the name of unrestricted access to abortion.

Direct medical oversight is critical when going through a procedure that involves significant risks-hemorrhage, severe infection, and pain. Telemedicine has its application, but abortion should not be one of them.

Analysis of Adverse Event Reports for Mifepristone

Induced abortion is associated with very real risks. But, in the U.S. we have incomplete data on abortion complications. The CDC collects voluntary reports with no enforcement arm. A recent study analyzed the adverse event reports to the FDA about mifepristone abortions between 2000-2019. From data of previous studies of complications following mifepristone abortions, there should have been over 180,000 adverse event reports—there were only 3000. Clearly the FDA is only receiving the tip of the iceberg.

From the year that mifepristone was FDA approved in 2000, until 2016, the FDA collected all adverse event reports: blood transfusions, hospitalizations, surgeries for—incomplete or failed abortion, hemorrhage, ectopic pregnancy; infections, and death. In 2016 the FDA stopped collecting data on the morbidity associated with mifepristone, and only collects maternal mortality. Wow. If you had to take your teenage daughter to the ER because she was hemorrhaging from a mifepristone abortion, wouldn't you expect our government to be concerned about that? Abortion harms women, men, and families, and ends the life of an individual who does not have representation.

Medication abortion riskier than surgical abortion

In a population-based study in Finland from 2000-2006, 42,619 women at 63 days or less of gestation underwent medication or surgical abortions and were followed up for 42 days. 20% of women who underwent medication abortion suffered complications, while only 5.6% of women who underwent surgical abortion suffered complications (p value of < 0.001, unlikely to be attributable to chance and statistically significant). In the words of the authors: "The overall incidence of adverse events was fourfold higher in the medical compared with the surgical abortion cohort."[1]
Simply put, medication abortion is higher risk in every category:

- The risk of hemorrhage is 15.6% (1 in 6) in medication abortion and 2.1% (1 in 50) for surgical abortion.
- The risk of incomplete abortion is 6.7% (1 in 15) in medication abortion and 1.6% (1 in 60) for surgical abortion.
- The risk of emergency surgery is 5.9% (1 in 15) in medication abortion and 1.8% (1 in 60) for surgical abortion.

Putting these statistics in perspective 20% of women who undergo medication abortion have a serious adverse event, including hemorrhage (15%), incomplete abortion (tissue left inside, 7%), and need for repeat procedure (6%, overlaps with incomplete abortion for total 20%).
In the second trimester, after 13 weeks, the rate of surgical evacuation in one study was as high as 30.8%, meaning that one-third of women who underwent medication abortion required surgical completion.[9]

Induced abortion is not health "care"

If abortion is necessary for women's health and well-being, how have the nearly 63 million abortions performed since the passage of Roe v. Wade advanced and improved women's lives? The answer: they haven't. There is no proven health benefit to induced abortion. However there is a lot of data pointing to negative health outcomes.

Abortion is not healthcare, it is the taking of an innocent life in the name of privacy. It should not be a right codified into the constitution. Please don't let this be the legacy you leave your grandchildren.

Laws like this one tramples on the physician's right to practice medicine according to their conscience. It is a breach of a physician's oath to first do no harm and to do what is in her patient's best interest.

[1] Maarit Niinimaki, MD, Anneli Pouta, MD, PhD, Aini Bloigu, Mika Gissler, BSc, PhD, Elina Hemminki, MD, PhD, Satu Suhonen, MD, PhD, and Oskari Heikinheimo, MD, PhD, Immediate Complications After Medical Compared With Surgical Termination ofPregnancy. (Obstet Gynecol 2009;114:795-804).

Maryland taxpayers would choose reducing maternal mortality over unleashed access to abortion

The maternal mortality rate in the U.S. (in 2018- 17.4 for every 100,000) ranks the highest compared to nations such as the U.K. (6.5), Canada (8.6), Sweden (4.3), and France (8.7). The U.S. maternal mortality ratio is comparable with Romania, the Russian Federation and Tajikistan and worse than Iran's (16). The maternal mortality ratio in Maryland is 14. This is where the state of Maryland should be investing time, effort and taxpayer's money, not on advancing abortion.

MATERNAL MORTALITY & ABORTION STATS

What do we know about later term abortion risks?

Available data confirm that the further along in pregnancy a woman seeks an abortion, the greater the risk to her health and life.[2]

1. At or below 8 weeks gestation: the risk of death is 0.3 woman per 100,000 abortions
2. From 14-17 weeks gestation; the risk of death is 2.5 women per 100,000 births.
3. By 18 weeks gestation: the risk of dying is 6.7 women per 100,000 women.
4.

Gestational age is the strongest risk factor for abortion-related mortality. There are approximately 13,000 abortions annually in the U.S. past 21weeks gestation.[3]

Cause of death in second trimester abortion[4]:

- 38% hemorrhage
- 19% embolism
- 19% anesthesia
- 14% infection
- 11% other (includes cardiac and cerebrovascular)

A later term abortion is riskier than a first trimester abortion because:

• Baby larger: The cervix must be stretched open much wider because the baby is much larger. This increases the risk that the cervix will be torn and hemorrhage.
• Uterus soft and full of blood vessels: The uterus is large, soft and highly vascular, and is more at risk for being punctured by abortion instruments, which can cause massive hemorrhage-internally and externally.
•Lethal injections given to end the baby's life to prevent a live birth could get into the mother's bloodstream and cause complications.
• Damage to organs: A D&E abortion is a destructive procedure that involves grasping, tearing, and pulling fetal parts out through the opened cervix. Bony fragments can cut or tear maternal tissue causing damage and hemorrhage.

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[2] Zane S et al., Abortion-related mortality in the United States, 1998–2010, *Obstetrics & Gynecology*, 2015, 126(2):258–265, doi:10.1097/AOG.0000000000000945.

[3] https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

[4] Barlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. 2004;Obstet Gynecol 103:729-37.

• Retained tissue & Infection: abortion provider keeps track of fetal parts to avoid leaving parts behind that could cause infection.
•Need for Anesthesia: increasing degrees of sedation and general anesthesia further increase the risks inherent with later term abortions.

There are additional long term risks associated with surgical abortion that increase maternal morbidity and mortality beyond any risk associated with childbirth that are not included in available databases.

There is evidence in the literature that women who undergo later term abortions experience a statistically significant increase in symptoms consistent with PTSD, such as disturbing dreams, reliving the abortion, and trouble falling asleep[5].

In the National Abortion Federation approved textbook on induced abortion, "advanced stage of pregnancy" is listed as a "risk factor for negative emotional sequellae" following induced abortion[6].

Placenta previa[7],[8],[9],[10]: the risk of having a pregnancy complicated by placenta previa is higher in women who have had an induced abortion. Placenta previa occurs when the placenta covers or partially covers the cervix. This can result in unpredictable massive bleeding that threatens the life of baby and mother, especially during labor. In addition to the risk of bleeding, it is associated with the risk of preterm birth and death early in infancy
Preterm birth[11]: it is well established in the medical literature that induced abortion increases the risk of delivering prematurely with subsequent pregnancies.

Does removing later term abortion access increase maternal mortality?

A 2012 study[12] conducted in Chile compared maternal mortality rates during two different time periods in that nation's history: one when induced abortion was legal, and a second time frame when it was illegal.

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Behrman, R., Stith, B. (2006). Preterm birth: Causes, consequences, and prevention. Institute of Medicine of the National Academy of Sciences.
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The authors found that the maternal mortality rates went DOWN when abortion was made illegal. This data convincingly demonstrates that the 1989 law prohibiting abortion has not put women's lives at risk, effectively refuting the claims that abortion advocates routinely employ against most abortion restrictions.

Does induced abortion provide a health benefit?[13]

The majority of the published research to date has consistently shown that late-term abortion poses serious risks to women's mental and physical health very little to no evidence of established health benefits of the procedures.

Does induced abortion provide a health benefit in the context of adverse prenatal diagnosis?[14]

Based upon available research, the answer appears to be NO. A recent study looked at women who aborted and women who carried after learning their babies were diagnosed with severe abnormalities that would likely end in death before or soon after birth. The abortion group experienced more grief, depression, and emotional stress and had symptoms consistent with post-traumatic stress disorder (PTSD) for up to seven years after the abortion. In contrast, women who chose to carry also had symptoms of PTSD at the time of diagnosis, but their symptoms markedly decreased after the baby's birth. Further, these women deeply valued the time spent with their child both in utero and after the birth. They spoke of deriving meaning and positive insights and experienced personal growth as a result of allowing their babies to live as long as their natural lives allowed.

Is Induced Abortion Safer Than Childbirth?

The answer is no, but if you believe the findings in Grimes' 2012 article in Obstetrics & Gynecology, the answer would be a resounding yes! The authors found that childbirth was 14 times more likely to result in death than an induced abortion. A closer look at this study reveals a number of flaws which invalidate their conclusions.

The authors admit their conclusions are based on estimates and not actual data points: The total number of legal induced abortions was available or estimated from all reporting areas; however, not all of these areas collected information regarding some or all of the characteristics of women who obtained abortions.[15]

They excluded abortion-related deaths in later term abortions, and only looked at first trimester abortion related deaths. This misses at least 12% of the data.

They used data from the Centers for Disease Control (CDC) and Guttmacher to capture the number of deaths related to childbirth and induced abortion. The CDC admits that their system under-represents abortion morbidity and mortality because:

1. CDC collects data using two systems and only 54% of data shows up in both.
2. Voluntary abortion reporting: no federal law requires reporting and many states/counties within states don't report abortion-related deaths to the CDC. Only 26 states require providers to report.

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[14] http://www.wecareexperts.org/content/coleman-pk-coyle-c-t-rue-vm-2010-late-term-elective-abortion-and-susceptibility-posttraumati.

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3.CDC notes that 40% of deaths occur in the other non-live birth category. This over-inflates the maternal mortality.

In calculating the abortion related mortality ratio, authors used CDC numbers for the abortion deaths in the numerator and Guttmacher numbers for the total number of abortions in the denominator, (which the CDC states is usually 30% more than their totals), yielding a much lower ratio (0.6 abortion deaths per 100,000) than what is actual.

The systems that the U.S. currently uses to capture maternal and abortion related mortality are woefully inadequate and are riddled with flaws.

[AAPLOG] A pregnancy question was added to the United States standard death certificate in 2003 in order to improve the identification of maternal deaths. The individual states were initially inconsistent in implementing a pregnancy checkbox on death certificates, rendering data so useless that the United States (U.S.) did not published an official maternal mortality report between 2007 and 2016.1

[AAPLOG] Determining pregnancy-related deaths

The Centers for Disease Control and Prevention (CDC) relies heavily on death certificates to determine maternal deaths, but death certificates have been proven unreliable in accurately identifying all maternal deaths. Deaths due to live births are likely to be the most accurately recorded because most live births occur in a hospital setting or with the assistance of medical personnel. However, deaths from other pregnancy outcomes such as induced abortion are not accurately reported.35 Information about abortion is often not recorded on death certificates for women of reproductive age. Inconsistent implementation of a pregnancy checkbox on death certificates and search engine failures to provide ICD-10 obstetric-specific codes for abortion-related deaths thwart this documentation.36

[AAPLOG] Determining induced-abortion deaths

Published abortion mortality rates are inaccurate because the total number of legal abortions performed in the U.S. is not known.39 Estimated numbers of abortions are voluntarily reported to the CDC by state health departments. California, the state with the largest volume, does not report any data.40 The Guttmacher Institute also tracks these numbers, and it consistently reports higher numbers than the CDC. For example, the CDC reported 652,639 abortions in 2014 while the Guttmacher Institute reported 926,000.41,42 Twenty-seven states require abortion providers to report complications but there are no enforcement penalties for noncompliance. Only 12 states require coroners, emergency rooms and other health care providers to report abortion-related complications or deaths for investigation.43 If an abortion initiates a cascade of events resulting in death, only the closest antecedent events may be listed on the death certificate due to space limitations and provider time constraints. Since most abortion providers lack hospital-admitting privileges, other health care providers are required to provide hospital care. The physician certifying the death may be unaware of the abortion or mistakenly believe that a miscarriage led to the complications. Furthermore, ideological commitments may lead a certifier to omit this information.44,45 Due to the social stigma surrounding abortion, families of women dying from complications are unlikely to initiate malpractice lawsuits. Correlating public documentation of malpractice cases with autopsy reports, an investigative reporter was able to document 30 %

more abortion-related deaths nationwide than the CDC. The reported death rate from abortion represents only the tip of the iceberg, a problem much larger than it appears.

Death certificates list the complication as the cause of death (i.e. infection) and NOT the procedure (i.e. abortion). Further, it is estimated that 50% of cases of maternal death certificates do not report pregnancy status.[16] Bartlett in her 2004 paper writes: "On average, the Abortion Mortality Surveillance System reports more than twice as many deaths related to legal induced abortion than are reported on routine death-certificate data." A Finnish study of pregnancy associated deaths reported 73% of deaths missed by relying solely on the death certificates[17].

Suicide deaths are rarely linked back to the abortion in state reporting.

Most women (2/3's) never return to abortion clinics with complications-therefore not reported as abortion complications.[18] Abortion clinics don't provide emergency follow-up: women go to the hospital with their post abortion complications and frequently, these deaths are not linked to the abortion.

What is Needed to Get Quality Data for Accurate Maternal Mortality Numbers?

Clearly, death certificates, alone are not sufficient. Large, population-based record linkage studies containing complete reproductive history data in conjunction with data related to deaths, provide the best opportunity to bypass many of the limitations of the currently available maternal mortality data in most countries.

a. Data from these types of studies in the U.S. and abroad clearly show a statistically significant increased risk of death associated with induced abortion, as compared to carrying to term.
    i. Gissler, post-pregnancy death rates within one year were reported to be nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000)[19].
    ii. Gissler and colleagues again found that mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000)[20].

From this information, one can conclude that reliable record-linked data supports that abortion is riskier than childbirth.

It is clear that we do not have high quality statistics in the U.S. regarding pregnancy related deaths. Based upon what is available in the medical literature, it is clear that later term abortion is decidedly NOT safer than childbirth. Later term induced abortion (after 18 weeks gestation) is associated with 22 times increased risk of death when compared to an abortion performed at or below eight weeks from a woman's last menstrual period.[21]

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Key Definitions from MARYLAND MATERNAL MORTALITY REVIEW 2018 ANNUAL REPORT
http://healthymaryland.org/wp-content/uploads/2019/01/Health-General-Article-%C2%A713-1207-2018-Annual-Report-Maryland-Maternal-Mortality-Review.pdf

• A maternal death is defined by the World Health Organization's (WHO's) International Classification of Diseases Ninth and Tenth Revisions (ICD-9 and ICD-10) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes."

• The maternal mortality ratio or rate (MMR) is the number of maternal deaths per 100,000 live births in the same time period.

• A pregnancy-associated death is defined by the Centers for Disease Control and Prevention (CDC) as "the death of a woman while pregnant or within one year or 365 days of pregnancy conclusion, irrespective of the duration and site of the pregnancy, regardless of the cause of death."

• The pregnancy-associated mortality rate is the number of pregnancy-associated deaths per 100,000 live births in the same time period.

• A pregnancy-related death is defined by the CDC as "the death of a woman while pregnant or within one year of conclusion of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes."

• The pregnancy-related mortality rate is the number of pregnancy-related deaths per 100,000 live births in the same time period.

The three terms "maternal death," "pregnancy-associated death," and "pregnancy-related death," create a challenge when comparing data from different sources and reports for different jurisdictional entities.

The WHO monitors maternal deaths worldwide as a key indicator of population health, and of social and economic development. Maternal deaths are identified solely from information on the death certificate or similar registration of the occurrence and cause of death. Maternal deaths are limited in both the time period and causes considered. In more developed countries with improved medical care, many deaths related to pregnancy occur beyond 42 days after the end of pregnancy.

In 1986, the CDC and the American College of Obstetricians and Gynecologists (ACOG) collaborated to recommend the use of expanded definitions to more accurately identify deaths among women where pregnancy was a contributing factor. This collaboration led to the definitions for pregnancy-associated and pregnancy-related deaths. Enhanced surveillance

methods are necessary to determine pregnancy-associated and pregnancy-related deaths and will be discussed below.

The CDC uses a different measurement; it tracks pregnancy related deaths for up to one year after the end of the pregnancy. They collect data from states who voluntarily give it.

Finally, how comfortable will you be telling your grandchildren and great-grandchildren that you helped put Maryland on the map---for being one of the top per capita abortion producers in the Nation? Is that the legacy you want for your work and for the citizens of Maryland? I pray not.

I ask for an unfavorable report on SB 798

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