Written Testimony of Steven H. Aden, J.D.
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In support of H.B. 373
Submitted to the House Health and Government Operations Committee
February 27, 2025

Dear Chair Pena-Melnyk, Vice Chair Cullison, and Members of the Committee:

My name is Steven H. Aden, and I serve as Chief Legal Officer and General Counsel at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization that specializes in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states. Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law. As General Counsel, I specialize in constitutional law and abortion jurisprudence, including informed consent laws that empower women with authentic choice.

Thank you for the opportunity to testify in support of H.B. 373, a bill requiring reporting on abortion data without disclosing personally identifiable health information. H.B. 373 is a constitutional, valid exercise of the State's right to ensure that accurate, reliable data and statistics on abortion procedures are available to women, the medical community, and the general public. H.B. 373 will accomplish this by requiring the Maryland Department of Health to report to the Centers for Disease Control and Prevention (CDC) "any data regarding abortion requested by the [CDC]" unless reporting such data "would be in violation of federal or state law."[3]

Abortion reporting is vital to preventing maternal morbidity and mortality resulting from abortion, improving women's healthcare by strengthening safeguards around abortion, and ensuring not only doctors, but their patients, are fully informed when treating women and their preborn children. H.B. 373 promotes women's health and safety by applying common sense reporting requirements to a procedure intent to terminate a human life—abortion.

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 25, 2025).

[2] *State Spotlight*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 25, 2025).

[3] H.B. 373, Gen. Assemb., Reg. Sess. (Maryland 2025).

I. Abortion Reporting Promotes Women's Health and Safety

Reporting on medical procedures, medications, and associated results, side-effects, risks, and outcomes is a scientific and evidentiary norm which ultimately promotes the health and safety of the public.[4] This is true even more so when the "procedure" involves the intentional termination of a human life.

The medical community has instituted the collection, analysis, and dissemination of information related to abortion procedures, abortion morbidity, and abortion mortality as an established branch of epidemiological surveillance.[5] This is because abortion reporting is necessary for medical and public health professionals to evaluate and determine the risks of different forms of abortion to women and the impact on their preborn children.

The objective purpose of abortion reporting is the prevention of maternal morbidity and mortality associated with induced abortion.[6] The founder of the CDC abortion reporting system, Jack Smith, presented on the public health need for complete, accurate abortion reporting. He stated, "public health is very much part of the abortion issues. Moral and constitutional questions related to abortion may be argued philosophically; however, health questions related to abortion should be answered by sound epidemiologic reasoning based on adequate abortion statistics."[7]

It is critical that reliable, authoritative, accurate abortion data and statistics be available to women, the medical community, and the general public in order to address the known risks of elective abortion. This can be accomplished in part through the passage of H.B. 373.

a. Reporting Gestational Age and Abortion Complications Directly Impacts Women's Health and Safety

Gestational age is the strongest risk factor for abortion-related mortality to women, and the incidence of major complications is significantly higher after 15 weeks' gestation.[8] Compared to an abortion at 8 weeks' gestation, the relative risk of mortality to the woman increases exponentially by an additional 38 percent each week of

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[4] Jack C. Smith & Willard Cates, Jr., *The Public Health Need for Abortion Statistics*, 93 PUB. HEALTH REP. 194, 194–97 (1978). *See also* Keith Maule, *Record Keeping: Is It Really that Important?*, J. AM. CHIROPRACTIC ASS'N 20–22 (2000). (highlighting that even the chiropractic industry acknowledges the importance and need for reporting and record keeping).

[5] Smith & Cates, *supra* note 7.

[6] *See id.* at 194.

[7] Smith & Cates, *supra* note 4.

[8] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004); Janet P. Pregler & Alan H. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002). *See also* Slava V. Gauferg, *Abortion Complications*, https://emedicine.medscape.com/article/795001-overview (updated Jun. 24, 2016) (last visited Jan. 5, 2020) (Several large-scale studies have revealed that abortions after the first trimester pose more serious risks to women's physical health than first trimester abortions).

gestation.[9] Indeed, the risk of death to the woman related to gestational age of her preborn child is as follows:

- At 8 weeks' gestation, one death per one million abortions;
- At 16 to 20 weeks' gestation, one death per every 29,000 abortions; and
- At 21 week' gestation or more, one death per every 11,000 abortions.[10]

In other words, a woman seeking an abortion at 20 weeks' gestation is *35 times more likely to die* from abortion than she was in the first trimester. And at 21 weeks' gestation or more, she is *91 times more likely to die* from abortion than she was in the first trimester. Other documented immediate complications from abortion include:

- blood clots,
- hemorrhaging,
- incomplete abortions (part of the preborn child is not removed),
- infection, and
- injury to the cervix and other organs.[11]

Immediate complications affect approximately 10% of women undergoing abortion, and approximately one in five of these complications are life-threatening to the woman.[12]

By requiring the Maryland Department of Health to submit any requested abortion data to the CDC, including data on the gestational age of aborted preborn children, as well as data on any complications women suffered as a result of the abortion, H.B. 373 will enable policymakers, public health officials, and medical professionals in Maryland to be better equipped to directly address and mitigate the well-documented risks to women associated with abortions later in pregnancy.

b. Reporting the Method of Abortion and Prescriptions Directly Impact Women's Health and Safety

There are significant differences in the risks and protocols depending on what method and medications the abortionist uses. Reporting each also promotes women's health and safety.

Medical evidence demonstrates that chemical abortions (abortions using mifepristone) pose more significant risks to women than surgical abortions. Importantly, peer-reviewed studies show that the overall incidence of immediate adverse events is *four times higher* for chemical abortions than for surgical abortions.[13]

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[9] *Id.* at 731; PRO. ETHICS COMM. OF AM. ASSOC. OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Induced Abortion & the Increased Risk of Maternal Mortality*, Comm. Op. 6 (Aug. 13, 2019).
[10] Barlett, *supra* note 9.
[11] *See id.*
[12] REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 48 (2005).
[13] M. Niinimaki et al., *Immediate Complications after Medical compared with Surgical Termination of Pregnancy*, Obstet. Gynecol. 114:795 (Oct. 2009).

Hemorrhaging and retaining the preborn child (incomplete abortions) are more common after chemical abortions. A 2009 study found the incidence of hemorrhage is 15.6 percent following chemical abortions, compared to 5.6 percent for surgical abortions.[14] It also found 6.7 percent of chemical abortions result in incomplete abortions, as compared to 1.6 percent of surgical abortions.[15] Further, 5.9 percent of women required surgery after failed chemical abortions.[16]

An earlier 1999 study found that chemical abortions failed in 18.3 percent of patients and that surgical abortion failed in only 4.7 percent of patients.[17] It also found that patients who undergo chemical abortions also report significantly longer bleeding and higher levels of pain, nausea, vomiting, and diarrhea than women who undergo surgical abortions.[18] And the CDC has found the risk of death to women from C. sordelli (bacterial infection) in a chemical abortion is *ten times* higher than the death rate to women due to all possible risks following a surgical abortion at a comparable gestational age.[19]

Moreover, the American College of Obstetricians and Gynecologists ("ACOG") admits that chemical abortions fail more often than surgical abortions.[20] ACOG takes special note that chemical abortions require multiple visits to a healthcare provider, while surgical abortions usually require only one visit,[21] and that chemical abortions can take days or weeks to complete, while surgical abortions take shorter, more predictable periods of time.[22] Finally, chemical abortions require patient participation throughout a multistep process, while surgical abortions require patient participation in a single-step process.

And reporting "prescriptions" used to induce abortions matter to women's health and safety, too. Mifeprex, or mifepristone, is the only FDA-approved prescription (which itself is highly questionable),[23] in a regimen with the prescription medication misoprostol, to terminate a pregnancy through 70 days gestation (70 days or less since the first day of a woman's last menstrual period).

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[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] J.T. Jenson et al., *Outcomes of Suction Curettage and Mifepristone Abortion in the United States: A Prospective Comparison Study*, Contraception 59:153-59 (1999).
[18] *Id.*
[19] M. Fisher et al., *Fatal Toxic Shock Syndrome Associated with Clostridium sordelli after Medical Abortion*, N.E. J.M. 353:2352-60 (2005).
[20] ACOG, *ACOG Practice Bulletin 67 Medical Management of Abortion*, at Table 2. *See also* J.T. Jenson et al., *supra*.
[21] *Id.*
[22] *Id.*
[23] *See* Br. of Amicus Curiae Americans United for Life in Support of Respondents, *FDA v. Alliance for Hippocratic Medicine*, 144 S. Ct. 1540 (2024) (Nos. 23-235, 23-236), https://www.supremecourt.gov/DocketPDF/23/23-235/301848/20240229121051265_23-235%20Amicus%20Brief%20of%20Americans%20United%20for%20Life.pdf.

Importantly, the manufacturer of Mifeprex admits that ***"[n]early all of the women who receive Mifeprex [RU-486] and misoprostol will report adverse reactions, and many can be expected to report more than one such reaction."***[24] These adverse reactions include, but are not limited to:

- abdominal pain,
- cramping,
- vomiting,
- headache,
- fatigue,
- uterine hemorrhage,
- viral infections, and
- pelvic inflammatory disease.[25]

Since 2016, the FDA has only required adverse events reporting for deaths resulting from chemical abortion drugs; reporting is otherwise voluntary. As one study concludes, "FAERS [the FDA Adverse Event Reporting System] is inadequate to evaluate the safety of mifepristone" due to reporting discrepancies, and the fact that the FDA no longer mandates reporting of non-lethal adverse events.[26]

Even so, the FDA has received FAERS Mifeprex reports through June 30, 2022, documenting 36 deaths, 4,252 adverse events, 1,056 hospitalizations (excluding deaths), 606 blood loss incidents requiring transfusions, 422 infections, and 79 severe infections.[27]

Because there are significant differences in the risks to women's health depending on the method of abortion and the prescriptions used to induce abortion, reporting this data to the CDC if requested will enable policymakers, public health officials, and medical professionals to be better prepared to address these risks to women's health. It's simple: if the risk factors to women (gestational age, complications, method of abortion, and prescriptions used) are known, then the public will be better prepared to mitigate those risks.

II. Abortion is a Significant Public Health Matter with Documented Risks to the Mother's Life and Health

The need for a mandatory abortion reporting law in Maryland is evident, as Maryland is one of only four states that does not provide abortion data to the CDC ("Maryland does not require reporting, or record information, on induced

[24] *See* Mifeprex FPL, *supra* (emphasis added).
[25] *Id.* at 12 (Table 3).
[26] Christina A. Circucci et al., *Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained Through the Freedom of Information Act*, Health Servs. Rsch. & Managerial Epidemiology, Dec. 21, 2021, at 1, 4.
[27] *Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2024*, U.S. Food & Drug Admin. 1, 1–2 (December 31, 2024), https://www.fda.gov/media/185245/download?attachment.

terminations").[28] In fact, "[t]he Centers for Disease Control's 2006 abortion surveillance report was the last to include Maryland data."[29]

Although some may argue that requiring reporting of abortion data targets abortionists and is an obstacle to women, this is not the case. Rather, H.B. 373 treats abortion as it is—a public health matter that has significant, documented health and mortality risks to women, and that ultimately ends the life of a preborn child.

To illustrate, Maryland requires its Department of Health to report data on a wide variety of public health matters that also have significant, documented health and mortality risks. Indeed, Maryland's Department of Health and Human Services is required by current law to report extensive data on over 70 other different diseases that impact public health, ranging from viral hepatitis to HIV to influenza-related pediatric deaths to Lyme disease.[30]

Each of these reporting requirements are used to promote public health, safety, and inform policymakers and the public of important data that will ultimately help improve responses and risk management for public health matters that have their own documented health and mortality risks.

As the CDC explains, "[o]ngoing surveillance of legal induced abortion is important … [as] routine abortion surveillance can be used to assess changes in clinical practice patterns over time … and determine rates for various outcomes of public health importance."[31] H.B. 373 recognizes that reporting data on abortion to the CDC is necessary to effectively regulate and respond to a public health matter that has significant health risks to the mother and results in the death of a preborn child.

Conclusion

H.B. 373 will promote women's health and safety by equipping Maryland policy makers and the public to mitigate and prepare for health risks associated with abortion. Because abortion is a public health matter with serious risks to women and their preborn children, I urge the committee to support H.B. 373.

Respectfully Submitted,

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[28] *See* Charlotte Lozier Institute, *Abortion Reporting: Maryland*, (last updated: Feb. 9, 2023), https://lozierinstitute.org/abortion-reporting-new-hampshire/.
[29] *See id.*
[30] *See id.*
[31] Katherine Kortsmit, et al., *Abortion Surveillance – United States 2020*, 71 CENTERS FOR DISEASE CONTROL (10); 1-27 (Nov. 25, 2022).