



**Written Testimony of Emily Hoegler, J.D.
Policy Counsel, Americans United for Life
In Support of H.B. 49
Submitted to the House Health Committee
March 19, 2026**

Dear Chair Bagnall, Vice-Chair Cullison, and Members of the Committee,

My name is Emily Hoegler, and I serve as Policy 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 Policy 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. 49. This bill establishes protections for preborn children after a detectable heartbeat and ensures physicians provide women with the information necessary to make an informed decision. It is my expert opinion that H.B. 49 is constitutional under Maryland’s Constitution because protecting maternal health and preborn life and ensuring informed consent are compelling state interests and H.B. 49’s provisions further these compelling interests through the least restrictive means. Accordingly, I urge this Committee to pass H.B. 49 to 1) safeguards informed consent, empowering women with authentic choice, and 2) protects pregnant women from abortion violence.

I. Maryland’s Constitutional Right to Abortion Recognizes the State May Regulate Abortion if the Law Passes Strict Scrutiny.

Maryland’s Constitution creates a right to terminate a human being in the womb. The amendment provides:

That every person, as a central component of an individual’s rights to liberty and equality, has the fundamental right to reproductive freedom, including but

¹ *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, <https://aul.org/law-and-policy/> (last visited Feb. 24, 2025).

² *State Spotlight*, AMS. UNITED FOR LIFE, <https://aul.org/law-and-policy/state-legislation-tracker/> (last visited Feb. 24, 2025).

not limited to the ability to make and effectuate decisions to prevent, continue, or end one's own pregnancy. The State may not, directly or indirectly, deny, burden, or abridge the right unless justified by a compelling State interest achieved by the least restrictive means.³

Accordingly, the Maryland Constitution now protects a right “to make and effectuate decisions to . . . end one's own pregnancy.”

Although the Maryland Constitution confers a right to abortion, this right is not absolute. The Maryland Constitution permits laws regulating abortion if those laws, first, are “justified by a compelling State interest,” and, second, have a compelling State interest that is “achieved by the least restrictive means.” This is commonly known as the strict scrutiny test. H.B. 49 passes strict scrutiny because its provisions further the State's compelling interest in protecting a woman's right to be fully informed to enable her to consent to or decline an abortion, and the provisions do so through the least restrictive means.

II. H.B. 49's Provisions Requiring Informed Consent to Abortion Accomplish a Compelling State Interest.

Informed consent is a foundational principle of modern medicine.⁴ Upholding a woman's right to be fully informed to enable her to consent to or decline an abortion is a widely accepted and evidence-based standard of care. Aware of the gravity of this decision, 30 states currently protect a woman's right to be fully informed to enable her to consent to or decline an abortion.⁵ Additionally, informed consent is not unique to abortion; healthcare providers must receive a patient's informed consent before they perform *any* medical intervention.⁶

In 1992, the U.S. Supreme Court recognized that “the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus.”⁷ There, the Court upheld a state's 24-hour abortion informed consent law, which required “a woman seeking an abortion give her informed consent prior to the abortion procedure, and specific[d] that she be provided with certain information at least 24 hours before the abortion is performed.”⁸ In doing so, the Court determined that “the giving of truthful, nonmisleading information about the nature of the abortion procedure, the attendant health risks and those of childbirth, and the probable gestational age of the fetus” as well as “requiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy

³ MD. CONST., DECL. OF RTS. art. 48.

⁴ Christine S. Cocanour, *Informed Consent—It's More Than a Signature on a Piece of Paper*, 214 AM. J. SURGERY 993, 993 (2017).

⁵ The states are Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin.

⁶ *Id.*

⁷ Cocanour, *supra* note 4, at 846.

⁸ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).

to full term is a reasonable measure to ensure an informed choice,” was not a substantial obstacle and did not impose an undue burden on abortion rights, even if it “might cause the woman to choose childbirth over abortion.”⁹

H.B. 49’s provisions requiring informed consent uphold the right of a woman to be fully informed to enable her to consent to or decline an abortion. These provisions further the compelling state interest because they promote informed consent and protect against coercion.

a. Ensuring informed consent to abortion is a compelling state interest because it is a widely accepted and evidence-based standard of care.

Ensuring informed consent to abortion is a compelling state interest because it is a widely accepted and evidence-based standard of care. The state has a compelling interest in protecting informed consent because a woman cannot agree to medical treatment unless she is “competent, adequately informed and not coerced” in giving informed consent.¹⁰ This assistance includes information regarding medical assistance benefits for prenatal care, childbirth, and neonatal care, and the father’s liability for child support. This is important and material information that lets a woman know she is not alone in her decision. She has financial and social support, which provides her with real options of giving birth and raising her child or placing her child for adoption to a loving family.

H.B. 49 acknowledges that the decision to abort one’s unborn child is a life-altering decision. It gives woman access to the facts—including the nature of the procedure, medical risks, alternatives, and availability of resources—and the space to make her decision.¹¹ Accordingly, H.B. 49 establishes standard informed consent requirements to protect a woman’s right to be fully informed to enable her to consent to or decline an abortion.

b. Ensuring informed consent to abortion is compelling state interest because it protects against coerced and involuntary abortion.

Women considering abortion often face unique informed consent challenges, necessitating a robust informed consent framework that ensures access to all relevant information. Coerced abortion, the correlation between coerced abortion and intimate partner violence, and the dangers of chemical abortion make abortion informed consent counseling difficult. A woman who is fully informed can mitigate these challenges and make informed decisions about her health care. H.B. 49 empowers women with authentic choice when considering their pregnancy options.

⁹ *Id.* at 882-83.

¹⁰ Cocanour, *supra* note 4, at 993.

¹¹ See, e.g., Owen A. Anderson & I. Mike J. Wearne, *Informed Consent for Elective Surgery—What Is Best Practice?*, 100 J. ROYAL SOC’Y MED. 97, 97 (2007) (“Sufficient information to make a decision should also include an explanation of (1) the risks and benefits involved; (2) any alternative treatments; and (3) the risks and benefits of doing nothing.”).

H.B. 49’s informed consent provisions include screening for coerced or involuntary abortions, which empower women by protecting them against abortion coercion. These safeguards against abortion coercion are critical in Maryland because many women are pressured or coerced into having abortions. In a 2017 study about women’s abortion experiences, 73.8% of women said that they “disagreed that their decision to abort was entirely free from even subtle pressure from others to abort.”¹² Additionally, in a 2023 national study published in *Cureus* medical journal, researchers found that over 60% of women who had abortions reported experiencing high levels of pressure to abort from one or more sources.¹³

Women may be coerced into having an abortion due to intimate partner violence (“IPV”) or reproductive control from an intimate partner, family member, employer, or sex-trafficker.¹⁴ There are “[h]igh rates of physical, sexual, and emotional IPV . . . among women seeking a[n] abortion.”¹⁵ In fact, the prevalence of IPV for women seeking an abortion is nearly *three times greater than a woman continuing a pregnancy*.¹⁶ IPV victims who do obtain

¹²Priscilla K. Coleman et al., *Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experience*, 22 J. AM. PHYSICIANS & SURGEONS 113, 113-15 (2017) (finding that, of a given group of women who received abortions, 58% reported having their abortions just to make others happy; 28% reported that they thought they would lose their partner unless they received an abortion; 74% reported experiencing at least some pressure to abort; and 68% reported that the decision to get an abortion was one of the hardest decisions of their lives); see also Moria Gaul, *Protecting Women from Coerced Abortions: The Important Role of Pregnancy Help Centers*, CHARLOTTE LOZIER INST., Mar. 2022, at 2, https://lozierinstitute.org/wp-content/uploads/2022/03/On-Point-78_Protecting-Women-from-Coerced-Abortion_2022.pdf (finding that “[o]ne provider of post-abortive counseling reported . . . that, in any given year, 75-85% of women who received post-abortive counseling reported that ‘they felt they were misled by the abortion clinics and that their decisions were uninformed and, in many ways, coerced.’”).

¹³ David C. Readon & Tessa Longbons, *Effects of Pressure to Abort on Women’s Emotional Responses and Mental Health*, 15 CUREUS 1 (2023).

¹⁴ See Sam Rowlands & Susan Walker, *Reproductive Control by Others: Means, Perpetrators and Effects*, 45 BMJ SEXUAL & REPROD. HEALTH 65 (2019) (stating that individuals who assert reproductive control over pregnant women include intimate partners, family members, and sex traffickers); see, e.g., *Testimony Directory*, SILENT NO MORE AWARENESS, <http://www.silentnomoreawareness.org/testimonies/> (last visited Dec. 1, 2025) (testimonies from women who were coerced into having an abortion and the devastating effects it had on them); Adrienne P. Samuels, *Police Say Maine Couple Kidnapped Daughter, Intent on Forcing Abortion*, BOSTON.COM (Sept. 18, 2006), http://archive.boston.com/news/local/articles/2006/09/18/police_say_maine_couple_kidnapped_daughter_intent_on_forcing_abortion/; Welch Suggs, *Former Coach at Berkeley is Accused of Pressuring Assistant to Have an Abortion*, CHRONICLE HIGHER EDUC. (Sept. 17, 2002), <https://www.chronicle.com/article/coach-is-accused-of-urging-assistant-to-have-an-abortion/>; Jessica Hopp et al., *Mystics Coach was Cited in Pregnancy Suit*, WASH. POST (September 16, 2002), <https://www.washingtonpost.com/archive/politics/2002/09/16/mystics-coach-was-cited-in-pregnancy-suit/75f3fd03-184c-4292-9264-3ba074460c4c/>; Damon Sims, *Cleveland Man Accused of beating 16-year-old Pregnant Daughter*, CLEVELAND.COM: COVERING NORTHEAST OHIO (July 8, 2008), http://blog.cleveland.com/metro/2008/07/cleveland_man_accused_of_beat.html; *Girl, 16, Forced to Drink Turpentine to Induce Abortion*, N.Y. SUN (Sept. 27, 2006), <https://www.nysun.com/article/national-girl-16-forced-to-drink-turpentine-to-induce>; *Forced Abortion in America*, THE ELLIOT INST., 3 (Oct. 2007), <http://www.theunchoice.com/pdf/FactSheets/ForcedAbortions.pdf>.

¹⁵ Megan Hall et al., *Associations Between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, 11 PLOS MED. 1, 15 (Jan. 2014).

¹⁶ COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, *Reproductive and Sexual Coercion*, Comm. Op. No. 554, at 2 (reaffirmed 2022) (internal citation omitted).

abortions also have “significant association” with “psychosocial problems including depression, suicidal ideation, stress, and disturbing thoughts.”¹⁷

Additionally, victims of sex trafficking are among the number of women who experience abortion coercion. A 2014 study on the health consequences for sex trafficking victims found that 66 sex-trafficking victims had a total of 114 abortions, “[w]ithout accounting for possible underreporting.”¹⁸ “The [sex-trafficking] survivors in this study [] reported that they often did not freely choose the abortions they had while being trafficked.”¹⁹ A majority of the 66 sex-trafficking victims “indicated that one or more of their abortions was at least partly forced upon them.”²⁰

In addition to coercion, economic constraints and lack of support often make women feel they have no real choice but abortion. Most women who seek abortions do so because they are not financially able to raise a child.²¹ Some women also report that they were forced to undergo an abortion by a parent, would have been kicked out of the home, or did not have sufficient support to raise a child.²² “A majority of women who had abortions [60%] reported they would have carried to term if they had received more support from others and/or had more financial security.”

The high rates of coerced and unwanted abortions are especially disturbing due to the negative mental health ramifications suffered by women who feel they are forced to receive abortions they did not want. Nearly half of women who receive abortions experience persistent post-abortion distress disorder for decades following their abortion.²³ Women who experienced pressure to abort (61% in this study)²⁴ experienced significantly more negative emotions; greater disruptions to their daily lives, work, and relationships; more frequent posttraumatic stress symptoms, grief, and sadness about the abortion; more conflict about the abortion; and an overall decline in mental health that they attributed to the abortion.²⁵ Specifically, this study found that

[w]omen frequently choose abortion due to perceived pressures from other people, financial concerns, or other circumstantial pressures. These pressures, individually and/or together, are strongly associated with more negative emotions about their abortion; more disruptions of their daily life, work, or relationships; more frequent dreams, flashbacks, or intrusive thoughts about their abortions; more frequent feelings of loss, grief, or sadness about their

¹⁷ Hall, *supra* note 15, at 15.

¹⁸ Laura J. Lederer & Christopher A. Wetzel, *The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities*, 23 ANNALS HEALTH L. 61, 73 (2014).

¹⁹ *Id.*

²⁰ *Id.*

²¹ Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPS. SEXUAL & REPROD. HEALTH 110, 117–18 (2005).

²² See FREDERICA MATHEWES-GREEN, REAL CHOICES (1997).

²³ Donald Paul Sullins, *Persistent Emotional Distress after Abortion in the United States*, 10 INT. J. WOMEN'S HEALTH CARE 1, 7 (2025).

²⁴ Readon & Longbons, *supra* note 13, at 8.

²⁵ *Id.* at 3.

abortions; more moral and maternal conflict over their abortion decisions; a perceived decline in their overall mental health that they attribute to their abortions; and a higher degree of desire or need for help to cope with negative feelings about their abortions.²⁶

Similarly, another study found that women who aborted wanted pregnancies experienced a 43% higher risk of mental health issues compared to those who aborted unwanted pregnancies.²⁷ This includes an increased risk of both depression and suicidality.²⁸ The study noted, “[c]ompared to corresponding births, abortions of wanted pregnancies are associated with a greater risk of negative psychological [e]ffect, particularly depression and suicide ideation . . . than are abortions of unwanted pregnancies.”²⁹

In sum, H.B. 49’s informed consent provisions would provide women with a necessary safeguard against the dangers of coerced and involuntary abortion. At least 21 states currently have some form of coercive abuse prevention law to protect women considering abortion.³⁰ By enacting H.B. 49, Maryland will be joining numerous states that have recognized the need to provide women and adolescents with safeguards from being coerced to have an abortion against their will by partners, family members, employers, or sex traffickers.

III. H.B. 49’s Provisions Requiring Informed Consent Use the Least Restrictive Means to Accomplish a Compelling State Interest.

As discussed above, H.B. 49’s provisions requiring informed consent further the compelling state interest of protecting women’s informed consent. These provisions are also narrowly tailored to apply only to physicians performing elective, non-emergency abortions. Accordingly, this Committee should support H.B. 49

a. H.B.’s provisions governing the medical standard of care are narrowly tailored to apply only to physicians performing elective, non-emergency abortions.

H.B. 49 directly enforces a woman’s right to receive a certain medical standard of care from her provider at least 24 hours before an abortion. It is narrowly tailored because the bill applies only to the physician performing or assisting the abortion, providing a woman with a cause of action when someone performs an abortion on her without meeting the medical standard of care, such as the informed consent or physician-only requirements. In this regard, the bill is narrowly tailored to empower the woman to enforce her right to receive a medical standard of care. It is important to note that this bill empowers the

²⁶ *Id.* at 9.

²⁷ Donald Paul Sullins, *Affective and Substance Abuse Disorders Following Abortion by Pregnancy Intention in the United States: A Longitudinal Cohort Study*, 55 *MEDICINA* 741, 754–68 (2019).

²⁸ *Id.*

²⁹ *Id.*

³⁰ Alabama, Arizona, Arkansas, Georgia, Idaho, Indiana, Louisiana, Maine, Michigan, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, and Wisconsin.

woman—and not the state—to enforce her own right to care without needing a state actor to vindicate her rights for her.

H.B. 49 also balances situations in which a medical emergency interferes with a woman’s right to be fully informed. For example, the bill does not contain the same robust informed consent requirements for medical emergencies that prevent compliance with the informed consent requirements. Accordingly, H.B. 49 narrowly tailors its requirements to protect a woman’s right to be informed while accounting for medical emergencies.

b. The reflection period provision protects informed consent through the least restrictive means.

Under H.B. 49, the pregnant woman has a right to receive all relevant information at least 24 hours before an abortion. The 24-hour reflection period—like the reflection periods ranging from 18-to-72-hours in 24 other states³¹—helps ensure a woman has the time she needs to take all the given information into account without the pressure of making an immediate decision. This is important, as the “medical, emotional, and psychological consequences of an abortion are serious and can be lasting.”³² However, H.B. 49 accomplishes this through the least restrictive means to the woman considering abortion by considering the potential burden upon a woman if she needs to travel. The reflection period is reduced to 2 hours “[i]f the woman resides at least 100 miles from the facility in which the abortion will be performed.”³³

Before the Supreme Court overruled *Roe v. Wade*,³⁴ it notably upheld a 24-hour reflection period under the purported federal constitutional right to abortion.³⁵ In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court determined a 24-hour reflection period was not an “undue burden” and “[t]he idea that important decisions will be more informed and deliberate if they follow some period of reflection” was not “unreasonable.”³⁶

Even beyond the abortion context, many States have established reflection periods that implicate other fundamental rights concerning the family and parenting, such as reflection periods for marriage, adoption, or divorce.³⁷ Thus, the 24-hour reflection period

³¹ The following 23 states have 24–72-hour reflection periods: Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Iowa, Kentucky, Louisiana, Mississippi, Montana, Nebraska, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin. Additionally, Indiana contains an 18-hour reflection period.

³² *H.L. v. Matheson*, 450 U.S. 398, 411 (1981), *overruled on other grounds by Dobbs*, 597 U.S.

³³ *Id.*

³⁴ *Roe v. Wade*, 410 U.S. 113 (1973), *overruled by Dobbs*, 142 S. Ct. 2228.

³⁵ 505 U.S. at 887.

³⁶ *Id.* at 885.

³⁷ *See, e.g., Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State*, 975 N.W.2d 710, 719 (Iowa 2022) (“In any event, Iowa law has waiting periods for other important decisions that implicate fundamental rights, including marriage, adoption, and divorce.” (citations omitted)).

gives a woman the ability to safeguard, clarify, and protect her right to be fully informed in the least restrictive way possible.³⁸

In sum, the reflection period provision serves the compelling State interest of empowering a woman to give informed consent, and the bill does this through the least restrictive means to the woman considering abortion.

c. The sonogram provisions protect informed consent through the least restrictive means.

The sonogram requirement promotes the State’s compelling interest in safeguarding a woman’s informed consent through the least restrictive means. H.B. 49 foremost sets a standard of care for the medical provider. The medical professional must perform an ultrasound and allow the pregnant woman the opportunity to view the sonogram and hear the preborn child’s heartbeat.

Ultrasound provisions both promote the woman’s physical and psychological health and are critical to informed consent counseling.³⁹ The ultrasound provisions serve an essential and irreplaceable medical purpose because it is the only method of diagnosing ectopic pregnancies, which if left undiagnosed can result in infertility or even fatal blood loss for the mother.⁴⁰

An ultrasound enables the healthcare provider to more accurately date the gestational age of a child. Accurate dating of pregnancy protects the woman’s physical health and ensures the abortion provider offers appropriate pregnancy options. For example, the U.S. Food and Drug Administration has only approved chemical abortion drugs up to ten weeks gestation.⁴¹ Likewise, abortion providers offer different surgical options based upon the gestational age of the unborn child.⁴² “[W]omen who do not receive an ultrasound prior to abortion are suboptimally dated, which diminishes the accuracy of providers’ counseling about procedure risks.”⁴³ This is especially concerning because “[t]he frequency of complications increases with gestational age due to the greater degree of anatomic and physiologic changes later in pregnancy.”⁴⁴

³⁸ Similarly, before the Supreme Court overruled *Roe v. Wade*, it notably upheld a 24-hour reflection period under the purported federal constitutional right to abortion. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court determined a 24-hour reflection period was not an “undue burden” and “[t]he idea that important decisions will be more informed and deliberate if they follow some period of reflection” was not “unreasonable.” 505 U.S. 833, 885 (1992).

³⁹ See *Dobbs*, 142 S. Ct. at 2284 (discussing the State’s “legitimate interests includ[ing] . . . the protection of maternal health and safety . . . [and] the preservation of the integrity of the medical profession”).

⁴⁰ See, e.g., *Ectopic Pregnancy*, MAYO CLINIC (Mar. 12, 2022), <https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/symptoms-causes/syc-20372088>.

⁴¹ *Mifeprex Prescribing Information*, U.S. FOOD & DRUG ADMIN. (Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s025Lbl.pdf.

⁴² RSCH. COMM., AM. ASS’N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, *Concluding Pregnancy Ethically*, Prac. Guideline No. 10, at 8 (2022).

⁴³ *Id.* at 9.

⁴⁴ *Id.* at 12.

Allowing a woman the opportunity to view her ultrasound and hear the fetal heartbeat helps ensure an informed choice. At least sixteen states recognize this value and require medical professionals to perform ultrasounds as part of informed consent counseling for abortion.⁴⁵ The ultrasound imaging gives the mother the option of seeing her unborn child as he or she really is—by seeing his or her form and face on a screen and by hearing his or her heartbeat. Medical evidence indicates that a woman feels bonded to her unborn child after seeing him or her on the ultrasound screen.⁴⁶ Once that bond is established, researchers argue, a woman no longer feels ambivalent toward her pregnancy and in fact begins to feel invested in her unborn child.⁴⁷ And thus, by giving every woman the choice to view her child’s ultrasound image, the State also furthers its interest in protecting life, as some women may ultimately decide to carry their child to term. In fact, a 2015 study found that 78% of women who see an ultrasound image of their infant in utero choose life for their baby.⁴⁸

In sum, ultrasonography is critical to providing complete informed consent counseling about pregnancy options. H.B. 49 furthers this compelling interest in safeguarding informed consent through the least restrictive means to a woman’s right to continue or end her pregnancy. The bill sets a standard of care for abortion providers, while empowering women with accurate informed consent counseling and the option of viewing the ultrasound image.

IV. H.B. 49’s Provisions Prohibiting Abortion After a Detectible Heartbeat Accomplish a Compelling State Interest.

The U.S. Supreme Court recognized that “the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus.”⁴⁹ H.B. 49 accomplishes both interests.

a. H.B. 49 Protects Women Against the Negative Mental Health Impacts of Abortion.

H.B. 49’s heartbeat provision furthers the compelling state interest of protecting maternal health and wellness by protecting women from the mental health effects of abortion. Abortion has a negative impact on women’s and girls’ mental health. Scholarship shows that “both sides agree that (a) abortion is consistently associated with elevated rates

⁴⁵ The states are Alabama, Arizona, Arkansas, Florida, Indiana, Iowa, Kansas (temporarily enjoined), Kentucky, Louisiana, Mississippi, North Carolina, Ohio (temporarily enjoined), Oklahoma, Tennessee, Texas, and Wisconsin.

⁴⁶ See John C. Fletcher & Mark I. Evans, *Maternal Bonding in Early Fetal Ultrasound Examinations*, 308 NEW ENG. J. MED. 392 (1983).

⁴⁷ *Id.*

⁴⁸ Thomas A. Glessner, *National Survey of Pro-life Pregnancy Centers Shows Major Influence of Ultrasound on a Mother’s Choice for Life*, STANDARD NEWSWIRE (Mar. 4, 2015), <http://standardnewswire.com/news/23610063.html> (surveying 75,318 ultrasounds performed for pregnant patients identified as either abortion-minded or abortion-vulnerable and finding 58,634 chose to allow their children to live, or about 78%).

⁴⁹ *Cocanour, supra* note 4, at 846; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).

of mental illness compared to women without a history of abortion; [and] (b) the abortion experience directly contributes to mental health problems for at least some women.”⁵⁰

Research has found that “women who ha[ve] undergone an abortion experienced an 81% increased risk of mental health problems,” and “the strongest effects were observed when women who had had an abortion were compared with women who had carried to term and when the outcomes measured related to substance use and suicidal behaviour.”⁵¹ Other research has found that “[w]omen whose first pregnancy ends in induced abortion are significantly more likely than women whose first pregnancy ends in a live birth to experience mental health problems throughout their reproductive years.”⁵² Additionally, women who receive abortion are more likely to commit suicide counterpart women who carried a pregnancy to term and gave birth, and that giving birth made women even less likely to commit suicide than the general population.⁵³ Abortion is also associated with an increased

⁵⁰ David C. Reardon, *The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations, and Research Opportunities*, 6 SAGE OPEN MED. 1, 1 (Oct. 2018).

⁵¹ Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009*, 199 BRITISH J. PSYCHIATRY 180, 183 (2011); see also Jesse R. Cogle et al., *Depression Associated with Abortion and Childbirth: A Long-Term Analysis of The NLSY Cohort*, 9 SIGNATURE 164 (2003) (“[W]omen whose first pregnancies ended in abortion were 65% more likely to score in the ‘high-risk’ range for clinical depression than women whose first pregnancies resulted in a birth.”); Kathryn R. Grauerholz et al. *Uncovering Prolonged Grief Reactions Subsequent to a Reproductive Loss: Implications for the Primary Care Provider*, 12 FRONTIERS IN PSYCH. 1, 2 (2021) (“Several recent international studies have demonstrated that repetitive early pregnancy loss, including both miscarriage and induced abortions, is associated with increased levels of distress, depression, anxiety, and reduced quality of life scores in social and mental health categories.”); see, e.g., Louis Jacob et al., *Association Between Induced Abortion, Spontaneous Abortion, and Infertility Respectively and the Risk of Psychiatric Disorders in 57,770 Women Followed in Gynecological Practices in Germany*, 251 J. AFFECTIVE DISORDERS 107, 111 (2019) (finding “[a] positive relationship between induced abortion . . . and psychiatric disorders”); see also James Studnicki et al., *A Cohort Study of Mental Health Services Utilization Following a First Pregnancy Abortion or Birth*, 15 Int’l J. Women’s Health 955, 959 (2023); Nathalie Auger et al., *Induced Abortion and Implications for Long-Term Mental Health: A Cohort Study of 1.2 Million Pregnancies*, 187 J. PSYCHIATRIC RSCH. 304 (2025) (“Rates of mental health-related hospitalization were higher following induced abortions than other pregnancies . . . [a]bortion was associated with hospitalization for psychiatric disorders . . . substance use disorders . . . , and suicide attempts . . . compared with other pregnancies. The associations were greater for patients who had preexisting mental illness or were aged less than 25 years at the time of the abortion. Abortion was strongly associated with mental health hospitalization within five years but risks waned over time.”).

⁵² James Studnicki et al., *A Cohort Study of Mental Health Services Utilization Following a First Pregnancy Abortion or Birth*, 2023 INT’L J. WOMEN’S HEALTH 955, 959 (2023); see also Zoe Bradshaw & Pauline Slade, *The Effects of Induced Abortion on Emotional Experiences and Relationships: A Critical Review of the Literature*, 23 CLINICAL PSYCH. REV. 929, 948 (2003) (finding that one-third of women who obtain abortions experience serious mental health issues afterward).

⁵³ Mika Gissler et al., *Suicides after Pregnancy in Finland 1987-1994: Register Linkage Study*, 313 BMJ 1431, 1433–34 (1996); see also Grauerholz, *supra* note 51, at 2 (finding an increased correlation with substance abuse and suicidal ideation for women who had an elective abortion).

risk of experiencing PTSD.⁵⁴ Further, research associating abortion with positive mental health outcomes have been found unreliable upon further review.⁵⁵

Research on the mental health outcomes for adolescent girls who have abortions remains less extensive than for adults, yet existing data points to distinct challenges. Compared to their peers who carry a pregnancy to term, some studies indicate that adolescents who undergo an abortion are more likely to seek psychological counseling and report issues such as sleep disturbances and increased marijuana use.⁵⁶

Given the negative impact of abortion on women and girls' mental well-being, H.B. 49 serves as a critical safeguard for women's mental health. By enacting H.B. 49, Maryland would protect women from the mental health risks of abortion—including increased vulnerabilities to depression, substance use, and trauma.

b. H.B. 49 Protects Women Against the Negative Physical Health Impacts of Abortion.

i. Carrying a child to term is safer for women's long-term health than abortion.

Abortion proponents argue that abortion is a safer alternative to carrying a child to term. But there is no evidence that carrying a child to term is more dangerous to women than receiving an abortion.⁵⁷ For example, researchers “[a]nalyz[ing] all cases of maternal death between 1970-[19]79 at [a] National Maternity Hospital” found that “therapeutic abortion would *not have saved a single life*.”⁵⁸

⁵⁴ Maureen Curley & Celeste Johnston, *The Characteristics and Severity of Psychological Distress after Abortion among University Students*, 40 J. BEHAV. & HEALTH SER. & RSCH. 279, 290–92 (2013); Lydia Hamana et al., *Previous Experience of Spontaneous Abortion or Elective Abortion and Risk for Post Traumatic Stress and Depression during Subsequent Pregnancy*, 27 DEPRESSION & ANXIETY 699, 705–06 (2010); Arnold P. van et al., *Prevalence and Prediction of Re-Experiencing and Avoidance after Elective Surgical Abortion: A Prospective Study*, 15 CLINICAL PSYCH. & PSYCHOTHERAPY 378, 381–84 (2008); Vincent M. Rue et al., *Induced Abortion and Traumatic Stress: A Preliminary Comparison of American and Russian Women*, 10 MED. SCI. MONITOR SR5, SR15 (2004).

⁵⁵ For a comprehensive review of the errors and issues with the Turnaway Study, see David C. Reardon, *The Embrace of the Proabortion Turnaway Study*, 85 LINACRE Q. 204 (2018); Priscilla K. Coleman, *The Turnaway Study: A Case of Self-Correction in Science Upended by Political Motivation and Unvetted Findings*, 13 FRONT PSYCH. 905221 (2022).

⁵⁶ Priscilla K Coleman, *Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences*, 35 J. YOUTH & ADOLESCENCE 903 (2006); see also Donald Paul Sullins, *Abortion, Substance Abuse and Mental Health in Early Adulthood: Thirteen-Year Longitudinal Evidence from the United States*, 4 SAGE OPEN MED. 1 (2016) (finding similar negative mental health effects of abortion on adults and minors).

⁵⁷ *Why We Need Accurate Data on Abortions*, ELLIOT INST. <https://www.afterabortion.org/why-we-need-accurate-data-on-abortions/> (last visited January 26, 2026).

⁵⁸ John Murphy & Kieran O’Driscoll, *Therapeutic Abortion: The Medical Argument*. 74 IRISH MED. J. 304, 306 (1982) (emphasis added).

Existing evidence suggests that carrying a child to term is *safer* for a women’s long-term health than abortion.⁵⁹ Specifically, research has found that abortion *increases* a woman’s chance of premature death.⁶⁰ Other research found that women are nearly *four times* more likely to die after abortion than after carrying a child to term.⁶¹ Another study found that, compared to women who gave birth, women who had abortions had a significantly higher risk of death from all causes for at least eight years after their pregnancies.⁶² The death rate is higher for women receiving abortions than for delivering a child for several reasons. “Compared with women who delivered, those who aborted had a significantly higher age-adjusted risk of death from all causes[], from suicide[], and from accidents[], as well as a higher relative risk of death from natural causes[], including the acquired immunodeficiency syndrome (AIDS)[], circulatory diseases[], and cerebrovascular disease.”⁶³

Because carrying a pregnancy to term presents significantly fewer long-term health risks and a lower overall mortality rate for women than undergoing an abortion, H.B. 49 protects women’s health by restricting harmful abortions after a fetal heartbeat is detected.

ii. Late-term abortions are especially dangerous to women’s health.

H.B. 49 protects women from later-term abortions (after approximately six weeks), which are especially dangerous to women’s health. Gestational age is the strongest risk factor for abortion-related mortality, and the incidence of major complications is significantly higher after 20 weeks’ gestation.⁶⁴ After 8 weeks’ gestation, the relative risk of mortality increases exponentially by 38 percent for each additional week of pregnancy.⁶⁵ For example, the mortality from an abortion performed at 21 weeks or more is 77 times higher than the mortality from an abortion at 8 weeks or less based on data from the CDC between 1988-1997.⁶⁶

⁵⁹ David C. Reardon & John M. Thorp, *Pregnancy Associated Death in Record Linkage Studies Relative to Delivery, Termination of Pregnancy, and Natural Losses: A Systematic Review with a Narrative Synthesis and Meta-Analysis*, 5 SAGE OPEN MED. 1, 14 (2017).

⁶⁰ *Id.* at 5 (finding that women who received abortions were at a greater risk of premature death than women who gave birth).

⁶¹ Mika Gissler et. al., *Pregnancy Associated Deaths in Finland 1987–1994 – Definition Problems and Benefits of Record Linkage*, 76 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 651, 653 (1997).

⁶² David C. Reardon et. al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95 S. MED. J. 834, 841 (2002).

⁶³ *Id.* at 834; see also David C. Reardon & Priscilla K. Coleman, *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980–2004*, 18 MED. SCI. MONITO: INT’L MED. J. EXPERIMENTAL & CLINICAL RSCH. 71, 75 (2012) (finding significantly higher maternal death rates following abortion compared to delivery).

⁶⁴ Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004).

⁶⁵ *Id.*; 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).

⁶⁶ Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729 (2004).

Further, researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the “inherently greater technical complexity of later abortions.”⁶⁷ This is because later-term abortions need to dilate the cervix to a greater degree, and the increased blood flow predisposes women to hemorrhage, and the myometrium relaxes and is more subject to perforation. Some immediate complications from abortion include blood clots, hemorrhage, incomplete abortions, infection, and injury to the cervix and other organs.⁶⁸ Immediate complications affect approximately 10% of women undergoing abortion, and approximately one-fifth of these complications are life-threatening.⁶⁹ Given the increased physiological complexity and the exponential rise in mortality risk as pregnancy advances, late-term abortions present severe, and often unavoidable, threats to a woman’s long-term physical and mental well-being and policies like H.B. 49 protect women from these threats by restricting abortion after approximately six weeks.

iii. Abortion increases the risk of complications in subsequent pregnancies.

Additionally, abortion negatively effects subsequent pregnancies. This is particularly notable because, one year after an abortion, nearly twenty-three percent of women conceive at least once and two years after an abortion, nearly thirty-eight percent of women conceive at least once.⁷⁰ Therefore, physical health issues with subsequent pregnancies will likely be imminently experienced by many women who obtain an abortion.

A woman is at an increased risk of an ectopic pregnancy in a subsequent pregnancy after at least one induced (elective) abortion.⁷¹ Secondary infertility “is a common occurrence” after certain abortion procedures.⁷² Consequently, women who receive abortions to delay child-rearing may struggle to subsequently conceive. “Induced abortion by vacuum aspiration is associated with an increased risk of first-trimester miscarriage in the subsequent pregnancy.”⁷³ Abortion also increases the risk of Cesarean deliveries and retained placenta in subsequent pregnancies.⁷⁴

⁶⁷ Bartlett, *supra* note 66, at 735.

⁶⁸ See *How Safe Is an In-Clinic Abortion?*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion> (last visited Jan. 4, 2023).

⁶⁹ REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 48 (2005).

⁷⁰ David C. Reardon & Christopher Craver, *Intervals and Outcomes of First and Second Pregnancies in Low-Income Women: A Record-Linkage Longitudinal Prospective Cohort Study*, 27 MED. SCI MONITOR: INT’L MEDICAL J. EXPERIMENTAL & CLINICAL RSCH. 1, 6 (2021).

⁷¹ F. Parazzini et al., *Induced Abortions and Risk of Ectopic Pregnancy*, 10 HUM. REPROD. 1841, 1844 (1995); Catherine Tharaux-Deneux et al., *Risk of Ectopic Pregnancy and Previous Induced Abortion*, 88 AM. J. PUB. HEALTH 401, 405 (1998).

⁷² Arjola Agolli et al., *Secondary Infertility due to Fetal Bone Retention: A Systematic Literature Review*, 22 SULTAN QABOOS UNIV. MED. J. 448, 453 (2022).

⁷³ Yuelian Sun et al., *Induced Abortion and Risk of Subsequent Miscarriage*, 32 INT’L J. EPIDEMIOLOGY 449, 453 (2003).

⁷⁴ Lisa Rapaport, *Miscarriage, Abortion May Pose Similar Risks for Next Pregnancy*, REUTERS (July 22, 2015 12:36 PM), <https://www.reuters.com/article/idUSKCN0PW1XH/>.

Abortion is also associated with a myriad of subsequent placental abnormalities that can negatively affect subsequent pregnancies. For example, “pregnant women with a history of abortion were more likely to have a premature delivery[], gestational diabetes mellitus[], placenta abnormality[], placenta previa[], placenta accreta[], and placenta adhesion[] than those who obtained singleton pregnancies without a history of abortion.”⁷⁵ Additionally, pregnant women with a history of abortion have an increased risk of placenta accreta spectrum (PAS) in subsequent pregnancies.⁷⁶ PAS is an incorrect attachment of the placenta to the uterine wall.⁷⁷ Specifically, studies have found that the “risk of placenta previa increased with the number of sharp curettage [as opposed to vacuum aspiration] abortions.”⁷⁸

Abortion also increases the risk of hemorrhage (excessive bleeding) during subsequent pregnancies. One study found that abortion increased the risk of antepartum hemorrhage (bleeding during the first twenty-four weeks of pregnancy) in subsequent pregnancies.⁷⁹ Additionally, women who had previously had medication abortions were significantly more likely to experience postpartum hemorrhaging during vaginal delivery compared with women who had never had an abortion.⁸⁰

Abortion increases the risk of subsequent preterm birth. “The higher the number of abortions, the greater the risk of subsequent preterm birth”⁸¹ Numerous studies have found an increased risk of very preterm (less than twenty-eight weeks' gestation) births after at least one abortion.⁸² Some studies have found “a dose-response relationship between the number of prior abortions before a first birth and an increased risk of *very* preterm birth . . . after two abortions [] and after three or more abortions [] compared with first births among women with no abortion history.”⁸³ In other words, receiving one or more abortions predictably caused preterm delivery in subsequent pregnancies.

The evidence suggests that abortion entails extensive and long-term consequences for a woman's reproductive health, ranging from immediate physical complications to

⁷⁵ Hanxiang Sun et al., *Impact of Spontaneous Abortion History and Induced Abortion History on Perinatal Outcomes of Singleton Pregnancies*, 23 BMC PUB. HEALTH 2360, 2360 (2023).

⁷⁶ Rui Li et al., *Associations of Characteristics of Previous Induced Abortion with Different Grades of Current Placenta Accreta Spectrum Disorders*, 36 J. OF MATERNAL-FETAL & NEONATAL MED. 1, 5 (2023).

⁷⁷ *Id.*

⁷⁸ L.G. Johnson et al., *The Relationship of Placenta Previa and History of Induced Abortion*, 81 INT'L J. GYNECOLOGY & OBSTETRICS 191, 191 (2003).

⁷⁹ Andrea Woolner et al., *Risk of Spontaneous Preterm Birth Elevated After First Cesarean Delivery at Full Dilatation: A Retrospective Cohort Study of Over 30,000 Women*, 230 AM. J. OBSTETRICS & GYNECOLOGY 358, 358 (2024).

⁸⁰ *Id.*

⁸¹ Jing-Yun Yu et al., *History of Induced Abortion and the Risk of Preterm Birth: A Retrospective Cohort Study*, 36 J. MATERNAL-FETAL & NEONATAL MED. 1, 1 (2023); *see also* Hanes M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-Analyses.*, 54 J. REPROD. MED. 95, 107 (2009).

⁸² S.K. Gissler et al., *Risks of Adverse Perinatal Outcomes After Repeat Terminations of Pregnancy by Their Methods: A Nationwide Register-Based Cohort Study in Finland 1996–2013*, 31 PAEDIATRIC & PERINATAL EPIDEMIOLOGY 485, 492 (2017).

⁸³ R. Klemetti et al., *Birth Outcomes After Induced Abortion: A Nationwide Register-Based Study of First Births in Finland*, 27 HUM. REPROD. 3315, 3320 (2012).

significant risks that can jeopardize her future fertility and the safety of subsequent pregnancies. Given that many women conceive shortly after an abortion, these cumulative risks present a substantial concern for long-term maternal and neonatal well-being. Therefore, policies like H.B. 49 support women by restricting harmful abortions.

V. H.B. 49’s Provisions Prohibiting Abortion After a Detectible Heartbeat Using the Least Restrictive Means to Accomplish a Compelling State Interest

H.B. 49 is narrowly tailored to achieve the state’s compelling interest in protecting women’s health because it addresses specific, documented risks—both mental and physical—that increase as a pregnancy progresses, using a threshold that provides women notice while preventing the most significant harms.

a. The heartbeat provision addresses mental health risks through early intervention.

Because the state’s interest includes protecting women from the elevated rates of mental illness, substance abuse, and suicidal behavior associated with abortion, H.B. 49 is the least restrictive means of intervention. By establishing the detection of a heartbeat as the limit, the state prevents the specific psychological trauma associated with terminating a more developed pregnancy, which carries a higher emotional and cognitive weight for many women. This bright-line rule is less restrictive than a total ban, as it allows for a window of time for decision-making while effectively shielding the majority of women from the severe mental health declines linked to later-stage procedures.

b. The heartbeat provision mitigates physical risks that scale with gestational age.

H.B. 49 acts as the least restrictive means to advance compelling state interests in maternal health by restricting abortion at a six-week gestation point, which directly addresses the exponential increase in mortality and complication risks associated with later-term procedures. A less restrictive limit—such as a 15-week or 20-week ban—would fail to achieve the state’s interest because it would leave women exposed to the 38% weekly increase in mortality risk that begins after 8 weeks. By tethering the restriction to the detection of a heartbeat (approximately six weeks), the state intervenes at the final point of relative safety before the technical complexity and risks of hemorrhage, organ damage, and secondary infertility rise to life-threatening levels.

c. The heartbeat provision preserves emergency exceptions.

H.B. 49 advances the state’s interest in protecting maternal health by the least restrictive means because it includes essential exceptions for the life and physical health of the mother. It creates a tailored regulatory framework that prohibits elective procedures known to cause long-term harm while maintaining a safety valve for medical emergencies. This ensures the law is not a blunt instrument, but a precise tool focused on preventing the documented negative health outcomes of elective abortions.

VI. Conclusion

H.B. 49 directly advances Maryland’s compelling interest in safeguarding maternal health. Women have the right to know what is being done to their bodies, those of their preborn children, and the risks and possible side effects the procedure entails. H.B. 49’s requirements are critical to protecting women’s agency and decision making when considering abortion. Further, H.B. 49’s heartbeat provisions address the documented risks of psychological trauma and long-term physical complications—including increased mortality rates—that are statistically associated with the procedure. Ultimately, H.B. 49 serves as a comprehensive health measure that prioritizes the long-term wellness of women and protects the most vulnerable lives within the state. I urge you to pass H.B. 49.

Respectfully submitted,



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