HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1429 Dismemberment Abortion
SPONSOR(S): Grall and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1890

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	9 Y, 6 N	McElroy	McElroy
2) Judiciary Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Dilation and evacuation (D&E) abortions commonly involve the dismemberment of the fetus as part of the evacuation procedure. This dismemberment is performed on a living fetus unless the abortion provider has induced fetal demise prior to initiating the evacuation procedure. HB 1429 prohibits a physician from knowingly performing a dismemberment abortion. The bill defines a dismemberment abortion as:

> An abortion in which a person, with the purpose of causing the death of an fetus, dismembers the living fetus and extracts the fetus one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or a similar instrument that, through the convergence of two rigid levers, slices, crushes, or grasps, or performs any combination of those actions on, a piece of the fetus' body to cut or rip the piece from the body.

The bill provides an exception to this prohibition under certain circumstances if a dismemberment abortion is necessary to save the life of a mother and no other medical procedure would suffice for that purpose.

Any person who knowingly performs or actively participates in a dismemberment abortion commits a third degree felony. The bill exempts a woman upon whom a dismemberment abortion has been performed from prosecution for a conspiracy to violate this provision.

The bill does not prohibit an abortion that exclusively uses suction to dismember the body of a fetus by sucking pieces of the fetus into a collection container. The bill also does not prohibit a D&E in which fetal demise is accomplished prior to the dismemberment of the fetus.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Federal Case Law on Abortion

Right to Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*[1], was decided by the U.S. Supreme Court. Using strict scrutiny, the Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right must be justified by a compelling state interest and must be narrowly drawn.[2] In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.[3]

The Viability Standard

In *Roe v. Wade*, the U.S. Supreme Court established a rigid trimester framework dictating when, if ever, states can regulate abortion.[4] The Court held that states could not regulate abortions during the first trimester of pregnancy.[5] With respect to the second trimester, the Court held that states could only enact regulations aimed at protecting the mother's health, not the fetus's life. Therefore, no ban on abortions is permitted during the second trimester. The state's interest in the life of the fetus becomes sufficiently compelling only at the beginning of the third trimester, allowing it to prohibit abortions. Even then, the Court requires states to permit an abortion in circumstances necessary to preserve the health or life of the mother.[6]

The current viability standard is set forth in *Planned Parenthood v. Casey*.[7] Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than the third trimester, the U.S. Supreme Court rejected the trimester framework and, instead, limited the states' ability to regulate abortion pre-viability. Thus, while upholding the underlying holding in *Roe*, which authorizes states to "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother[,]"[8] the Court determined that the line for this authority should be drawn at "viability," because "there may be some medical developments that affect the precise point of viability . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[9] Furthermore, the Court recognized that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[10]

---

[1] *Roe v. Wade*, 410 U.S. 113 (1973).
[2] *Id.*
[3] *Casey*, 505 U.S. 833 (1992).
[4] *Roe*, 410 U.S. 113 (1973).
[5] *Id.* at 163-64.
[6] *Id.* at 164-165.
[7] *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).
[8] *See Roe*, 410 U.S. at 164-65.
[9] *See Casey*, 505 U.S. at 870.
[10] *Id.*

Undue Burden

In *Planned Parenthood v. Casey*, the U.S. Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman's right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.[11] State regulation imposes an "undue burden" on a woman's decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.[12] However, not every law, which makes the right to an abortion more difficult to exercise, is an infringement of that right.[13]

The Medical Emergency Exception

In *Doe v. Bolton*, the U.S. Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability), except when determined to be necessary based upon a physician's "best clinical judgment," was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.[14] In its reasoning, the Court agreed with the district court decision that the exception was not unconstitutionally vague, by recognizing that:

> [T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.[15]

This broad interpretation of what constitutes a medical emergency was later tested in *Casey*[16], albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered "immediate."[17] The exception in question provided that a medical emergency is:

> [T]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[18]

In evaluating the more objective standard under which a physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten the life and health of a woman and imposed no undue burden on the woman's right to have an abortion.[19]

---

[11] *Id.* at 878. See also *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292 (U.S. 2016)
[12] *Id.* at 877. See also *Whole Woman's Health v. Hellerstedt,* 136 S.Ct. 2292 (U.S. 2016)
[13] *Id.* at 873.
[14] *Doe*, 410 U.S. at 179 (1973). Other exceptions, such as in cases of rape and when, "[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect." *Id.* at 183. *See also, U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971) (determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).
[15] *Doe*, 410 U.S. at 192.
[16] *Casey*, 505. U.S. 833 (1992).
[17] *Id.* at 880.
[18] *Id.* at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)).
[19] *Id.* at 880.

Partial Birth Ban

In 2003, Congress passed the Partial-Birth Abortion Ban Act (Act). The Act prohibits partial-birth abortions which it defines as an abortion in which the person performing the abortion:[20]

a. Deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
b. Performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.[21]

This prohibition applies to both pre-viability and post-viability abortions.[22]

The congressional purpose for the Act, besides maternal health, was to promote respect for human life and preserve the integrity of the medical profession. Congress expressed the prohibition was necessary to preserve the respect for the dignity of human life stating:[23]

> "Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life."

Congress also expressed the prohibition was necessary to maintain the integrity of the medical profession stating:[24]

> "Partial-birth abortion ... confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life."

In *Gonzales v. Carhart*, the U.S. Supreme Court was asked to determine, among other things, whether the Act created an undue burden on a woman's right to an abortion.[25] The plaintiffs argued that the Act created an undue burden because it banned second trimester abortions by prohibiting the most common second trimester method, dilation and evacuation.[26] The Court rejected this argument holding that the Act only prohibited an intended "intact" dilation and evacuation procedure on a living fetus.[27] It did not prohibit an "intact" dilation and evacuation that occurred either unintentionally or after fetal demise.[28] Additionally, it did not prohibit the standard dilation and evacuation procedure which entails dismemberment of the fetus.[29] The Court also held that the Act furthered legitimate congressional purposes of protecting the

[20] 18 U.S. Code § 1531.
[21] The physician accomplishes fetal demise by piercing the fetal skull with scissors or crushing it with forceps. *Gonzales v. Carhart*, 127 S.Ct. 1610 (U.S. 2007).
[22] *Gonzales v. Carhart*, 127 S.Ct. 1610 (U.S. 2007).
[23] PL 108–105, November 5, 2003, 117 Stat 1201 notes to 18 U.S. Code § 1531.
[24] *Id*.
[25] Supra note 22. Plaintiffs' alleged that the Act was unconstitutional on its face and did not pursue a constitutional challenged based upon its actual impact on women or physicians.
[26] Supra note 22 at 1627.
[27] Supra note 22 at 1632.
[28] Supra note 22 at 1627.
[29] Supra note 22 at 1632.

integrity and ethics of the medical profession.[30] Thus, the Court found the Act did not create an undue burden on a woman's right to an abortion and was therefore constitutional.

Florida Law on Abortion

Right to Abortion

Florida affords greater privacy rights to its citizens than those provided under the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the Supreme Court has long held that the state constitutions may provide even greater protections.[31] In 1980, Florida amended its Constitution to include Article I, s. 23 which creates an express right to privacy:

> Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law. [32]

This amendment is an independent, freestanding constitutional provision which declares the fundamental right to privacy and provides greater privacy rights then those implied by the federal Constitution.[33]

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[34] In *In re T.W.,* the Florida Supreme Court ruled that:

> [P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests . . . Under our Florida Constitution, the state's interest becomes compelling upon viability . . . Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical measures. [35]

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.[36]

Abortion Regulation

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[37] An abortion must be performed by a

[30] *Supra note 22* at 1626.
[31] *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989); citing *Pruneyard Shopping Center v. Robins*, 447 U.S. 74, 81, (U.S. 1980) ("Our reasoning ... does not ex proprio vigore limit the authority of the State to exercise its police power or its sovereign right to adopt in its own Constitution individual liberties more expansive than those conferred by the Federal Constitution."); *see also Cooper v. California*, 87 S.Ct. 788 (U.S. 1967).
[32] *Id.*
[33] *Id.* at 1191-92.
[34] *Id.* at 1192.
[35] *Id.* at 1193-94.
[36] *Id.* at 1194.
[37] Section 390.011(1), F.S.

physician[38] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[39]

The Agency for Health Care Administration (AHCA) licenses and regulates abortion clinics in the state, pursuant to ch. 390, F.S., and part II of ch. 408, F.S.[40] DOH and AHCA have authority to take licensure action against practitioners and clinics, respectively, which violate licensure statutes or rules.[41] Additionally, abortion providers are subject to criminal penalties for violation of certain statutes and rules.

Florida law prohibits abortions after viability, as well as during the third trimester, unless a medical exception exists. Section 390.01112(1), F.S., prohibits an abortion from being performed if a physician determines that, in reasonable medical judgment, the fetus has achieved viability. Viability is defined as the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures.[42] Section 390.0111, F.S., prohibits an abortion from being performed during the third trimester.[43] Exceptions to both of these prohibitions exist if:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.[44]

A physician must obtain informed and voluntary consent for an abortion from a woman before an abortion is performed, unless an emergency exists. Consent is considered voluntary and informed if the physician who is to perform the procedure, or the referring physician, orally and in person, informs the woman of the nature and risks of undergoing or not undergoing the proposed procedure and the probable gestational age of the fetus at the time the termination of pregnancy is to be performed.[45] The probable gestational age must be verified by an ultrasound.[46] The woman must be offered the opportunity to view the images and hear an explanation of them.[47] If the woman refuses this right, she must acknowledge the refusal in writing.[48] The woman must acknowledge, in writing and prior to the abortion, that she has been provided with all information consistent with these requirements.[49]

Florida law prohibits a physician from knowingly performing a partial-birth abortion.[50] However, there is an exception to this prohibition if the procedure is necessary to save the life of the mother and no other procedure would suffice.[51]

---

[38] Section 390.0111(2), F.S.
[39] Section 390.011(8), F.S.
[40] Section 408.802(3) provides for the applicability of the Health Care Licensing Procedures Act to abortion clinics.
[41] Section 390.018, F.S.
[42] Section 390.011(12), F.S.
[43] Section 390.011(11), F.S., defines the third trimester to mean the weeks of pregnancy after the 24th week of pregnancy.
[44] Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.
[45] Section 390.0111(3)(a), F.S. This requirement applies except in the case of a medical emergency.
[46] Section 390.0111(3)(a)1.b.II, F.S.
[47] Section 390.0111(3)(a)1.b.III, F.S.
[48] Section 390.0111(3)(a)(3), F.S.
[49] *Id.*
[50] Section 390.0111(5)(a), F.S.
[51] *Id.*

Any person who violates these abortion regulations commits a second degree felony.[52] Additionally, any health care practitioner who fails to comply with such laws is subject to disciplinary action under the applicable practice act and under s. 456.072, F.S.[53]

Florida Abortion Statistics

In 2016, there were 225,018 live births in the state of Florida.[54]

For the same year, AHCA reported that there were 69,770 abortion procedures performed in the state.[55] Of those performed:

- 64,342 (slightly more than 92%) were performed in the first trimester (12 weeks and under);
- 5,192 (slightly more than 7%) were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over). [56]

The majority of the procedures (64,578) were listed as "elective".[57] The remainder of the abortions were performed due to:

- Emotional or psychological health of the mother (77);
- Physical health of the mother that was not life endangering (74);
- Life endangering physical condition (17);
- Rape (295);
- Serious fetal genetic defect, deformity, or abnormality (494); and
- Social or economic reasons (4,471). [58]

Second Trimester Abortion Procedures

The majority of abortions are performed during the first trimester. Nationally, in 2014,[59] 652,639 abortions were reported to the Center for Disease Control and Prevention.[60] Only 9.5% were performed during the second trimester with 7.2% performed between 14-20 weeks gestation and 1.3% after 21 weeks gestation.[61] In 2016, approximately 7.4% of the 69,770 abortions performed in Florida occurred during the second trimester.[62]

---

[52] Section 390.0111(10)(a), F.S.
[53] Section 390.0111(13), F.S. The Department of Health and its professional boards regulate health care practitioners under ch. 456, F.S., and various individual practice acts. The range of disciplinary actions taken by a board includes citations, suspensions, reprimands, probations, and revocations.
[54] Ten-Year Live Birth Chart, Florida Department of Health, Bureau of Vital Statistics, available at http://www.flhealthcharts.com/charts/DataViewer/BirthViewer/TenYrsRpt.aspx?q=yNeb4i2no42x4Dcd1WE%2fkn56IIkXT75npe3ytPSLMHO6oavuZ454%2fKiGggs7ymAs (last visited January 22, 2018).
[55] Section 390.0112(1), F.S., requires the director of any medical facility in which any pregnancy is terminated to submit a monthly report to AHCA that contains the number of procedures performed, the reason for same, the period of gestation at the time such procedures were performed, and the number of infants born alive during or immediately after an attempted abortion.
[56] Reported Induced Terminations of Pregnancy (ITOP) by Reason, By Weeks of Gestation for Calendar Year 2016, AHCA, available at http://ahca.myflorida.com/MCHQ/Central_Services/Training_Support/docs/ReasonGestationYTD_2016.pdf (last visited on January 22, 2018).
[57] *Id.*
[58] *Id.*
[59] This is the most recent report for national abortion statistics.
[60] *Abortion Surveillance - United States, 2014*, Surveillance Summaries, Centers for Disease Control and Prevention, November 24, 2017 / 66(24);1–48, available at https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm?s_cid=ss6624a1_w (last visited on January 22, 2018).
[61] *Id.*
[62] Reported Induced Terminations of Pregnancy (ITOP) by Reason, By Weeks of Gestation for Calendar Year 2016, AHCA, available at http://ahca.myflorida.com/MCHQ/Central_Services/Training_Support/docs/ReasonGestationYTD_2016.pdf (last visited on January 22, 2018).

The 4 types of abortion procedures performed during the second trimester consist of dilation and evacuation, labor induction[63], hysterotomy[64] and hysterectomy[65]. Labor induction abortions represent approximately 2% of second trimester abortions.[66] Hysterotomy and hysterectomy abortions are generally only used in emergency situations[67] and combined represent less than 1% of all second trimester abortions.[68]

Dilation and Evacuation

The most common second trimester abortion procedure is an outpatient surgical procedure known as dilation and evacuation (D&E).[69] The process begins with the verification of the gestational age of the fetus through ultrasound. The next step is dilation of the cervix which is accomplished through insertion of osmotic dilators[70] into the woman's cervix.[71] Osmotic dilators expand when exposed to fluid and continue to expand and dilate the cervix until they are removed or reach their maximum size. The length of time the osmotic dilators remain in the cervix varies by patient and can be as little as a few hours or as long as 48 hours. Physicians may also utilize drugs, such as misoprostol, in conjunction with the osmotic dilators to accelerate the dilation of the cervix.[72]

The surgical component of the D&E begins once the cervix has been sufficiently dilated. The physician starts by inserting grasping forceps through the cervix and into the uterus, usually with ultrasound guidance.[73] The physician grips the fetus with the forceps and pulls until a portion of the fetus tears free and can be removed through the cervix.[74] This dismemberment process is repeated until the entire fetal body has been removed.[75] The remainder of fetal tissue and placenta are then suctioned or scraped out of the uterus.[76] The physician then examines the fetal remains to ensure the entire fetal body has been removed.[77] This procedure is generally completed in approximately 30 minutes.[78]

---

[63] Labor induction abortion is the expulsion of a second or third trimester fetus from the uterus without instrumentation. Fetal demise is generally accomplished prior to labor induction through the injection of a pharmacological agent such as digoxin or potassium chloride. Medication used for inducing labor include, among others, misoprostol, mifepristone, gemeprost, ethacridine lactate and high-dose oxytocin. *Clinical Guidelines: Labor Induction Abortion in the Second Trimester*, Society of Family Planning, Contraception 84 (2011) 4–18, available at http://www.contraceptionjournal.org/article/S0010-7824(11)00057-6/fulltext#s0065 (last viewed January 22, 2018).

[64] A hysterotomy abortion is accomplished through a physician making an incision in the woman's abdomen, similar to a cesarean section, and removing the fetus from the uterine cavity. *Gonzales v. Carhart*, 127 S.Ct. 1610, 1623 (U.S. 2007).

[65] A hysterectomy is the surgical removal of the uterus. *Hysterectomy, Frequently Asked Questions*, The American College of Obstetricians and Gynecologists, available at https://www.acog.org/Patients/FAQs/Hysterectomy#what (last viewed January 22, 2018).

[66] *Clinical Guidelines: Labor Induction Abortion in the Second Trimester*, Society of Family Planning, L. Borgatta and N.Kapp, Contraception 84 (2011) 4–18, available at http://www.contraceptionjournal.org/article/S0010-7824(11)00057-6/fulltext#s0065 (last viewed January 22, 2018).

[67] Supra note 22 at 1621.

[68] Supra note 60.

[69] Dilation and evacuation procedures are used for 96% of abortions performed during the second trimester. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care, National Abortion Federation, M. Paul, E. Lichtenberg, D. Grimes, P. Stubblefield and M. Creinin, 2009.

[70] Common osmotic dilators include laminaria (Japanese seaweed), lamicel (dry polyvinyl alcohol sponges impregnated with magnesium sulfate) and dilapan devices (synthetic, hydroscopic polyacrylonitrile rod-shaped dilators). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care, National Abortion Federation, M. Paul, E. Lichtenberg, D. Grimes, P. Stubblefield and M. Creinin, 2009.

[71] Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care, National Abortion Federation, M. Paul, E. Lichtenberg, D. Grimes, P. Stubblefield and M. Creinin, 2009.

[72] *Id.*

[73] Supra note 22.

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] *Id.*

[78] Dilation and Evacuation (D&E), Michigan Department of Health and Human Services, available at http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4909_6437_19077-46298--,00.html (last viewed on January 22, 2018).

Fetal Demise Prior to Abortion

When a D&E is performed, fetal demise is caused by exsanguination or other bodily reactions to the evacuation of the woman's uterus. However, there are methods of causing fetal demise prior to the evacuation. The three most common procedures to accomplish fetal demise are intra-fetal or intra-amniotic injection of digoxin, intra-cardiac or intra-umbilical injection of potassium chloride and transection of the umbilical cord.[79] The goal of each of these procedures is to terminate fetal cardiac activity.

Digoxin

Digoxin is the most common pharmacological agent used to accomplish fetal demise amongst abortion providers who induce fetal demise prior to abortion.[80] Abortion providers administer the digoxin through either a transvaginal or transabdominal injection into the amniotic sac or fetal body.[81] Digoxin decreases the conduction of electrical impulses in the atrioventricular node ultimately resulting in fetal cardiac arrest.[82] The rate of fetal demise varies from a few minutes for an intra-cardiac injection[83] to over 24 hours for an intra-amniotic injection.[84] The abortion provider confirms the fetal demise through ultrasound, generally a day or two after the injection, and performs the abortion. The most common side effects are vomiting, pain from the injection and labor and delivery of the fetus prior to the scheduled abortion.[85]

Potassium Chloride

Potassium chloride is commonly used to accomplish fetal demise for multifetal pregnancy reduction or termination of an abnormal fetus.[86] A physician administers potassium chloride through a transabdominal injection into the fetal heart or umbilical cord.[87] Potassium chloride disrupts the balance of intra- and extracellular potassium ions causing the heart rate to slow until cardiac arrests occurs, generally within minutes of the injection.[88]

This procedure requires a highly skilled physician due to the technically challenging nature of the injection.[89] Errors in conducting the injection caused serious adverse outcomes in two cases. There was one case of maternal cardiac arrest after the unintentional injection of potassium chloride into the woman's bloodstream.[90] There was also one case of sepsis after an umbilical cord injection.[91] Neither case resulted in maternal fatality.[92]

---

[79] *Induction of Fetal Demise Before Abortion*, Society of Family Planning, J. Diedrich and E. Drey, Contraception 81 (2010) 462-473, available at https://www.societyfp.org/_documents/resources/InductionofFetalDemise.pdf (last viewed January 22, 2018).
[80] *Id.*
[81] *Feasibility, Effectiveness and Safety of Transvaginal Digoxin Administration Prior to Dilation and Evacuation*, A. Sridhar, C. Kim, E. Forbes and A. Chen, Contraception, Vol. 90, Issue 3, September 2014, available at http://www.contraceptionjournal.org/article/S0010-7824(14)00371-0/pdf (last viewed January 22, 2018). This is commonly performed with ultrasound guidance, although an amniotic injection can be performed either without this guidance.
[82] Supra note 71.
[83] *Id.*
[84] Supra note 79. The skill level required to perform this procedure also varies with intra-amniotic injections requiring the least skill and intra-cardiac injections requiring the most.
[85] Supra note 79.
[86] Supra note 71.
[87] Supra note 79.
[88] *Id.*
[89] Supra note 71.
[90] *Potassium Chloride-Induced Fetal Demise: A Retrospective Cohort Study of Efficacy and Safety*, A. Sfakianaki, K. Davis, J. Copel, N. Stanwood and H. Lipkind, Ultrasound Med. 2014 Feb;33(2):337-41, available at http://onlinelibrary.wiley.com/doi/10.7863/ultra.33.2.337/full (last viewed January 22, 2018).
[91] *Id.*
[92] *Maternal Cardiac Arrest Associated with Attempted Fetal Injection of Potassium Chloride,* International Journal of Obstetric Anesthesia, A. Sfakianaki, K.Davis, J. Copel, N. Stanwood and H. Lipkind, 2004;Vol. 13; Issue 4; 287-290, available at http://www.obstetanesthesia.com/article/S0959-289X(04)00073-1/fulltext (last viewed on January 22, 2018)(Prompt institution of

Transection of Umbilical Cord

Transection of the umbilical cord is the least common method for inducing fetal demise prior to an abortion. The procedure consists of an abortion provider dilating the woman's cervix and then transecting the umbilical cord.[93] Fetal cardiac activity ceases shortly thereafter.

Use of Pre- D&E Fetal Demise Techniques

There is limited comparative research on the medical benefit of inducing fetal demise prior to performing abortion procedures as compared to only performing the abortion procedure. The results of the available research conflict and are primarily based upon retrospective case studies rather than randomized controlled tests.[94] Currently, practice guidelines do not recommend against fetal demise prior to abortion but instead note the lack of supporting evidence and need for additional research.[95] Thus, medical professionals induce fetal demise prior to abortion in circumstances they deem appropriate.

Fetal demise is induced prior to a second trimester abortion for a variety of reasons. Physicians may prefer fetal demise for medical reasons such as reducing the time of the abortion procedure or reducing the number of fetuses in a multiple gestation pregnancy.[96] Physicians may also prefer inducing fetal demise to ensure compliance with the federal Partial-Birth Abortion Ban Act of 2003 and any related state laws.[97] Additionally, patients may prefer fetal demise prior to abortion.[98]

Dismemberment Abortion Ban

D&Es commonly involve the dismemberment of the fetus as part of the evacuation procedure. This dismemberment is performed on a living fetus unless the abortion provider has induced fetal demise prior to initiating the evacuation procedure. Eight states[99] have enacted laws prohibiting physicians from performing a dismemberment abortion on a living fetus. Dismemberment abortions are generally defined as:

> An abortion in which a person, with the purpose of causing the death of an unborn child, dismembers the unborn child and extracts the unborn child one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or a similar instrument that, through the convergence of two rigid levers, slices, crushes, or grasps, or performs any combination of those actions on, a piece of the unborn child's body to cut or rip the piece from the body.

An abortion that exclusively uses suction to dismember the body of a fetus by sucking pieces of the fetus into a collection container is not considered a dismemberment abortion. Further, the prohibition does not extend to an abortion in which fetal demise has been induced prior to dismemberment.

---

maternal cardiac life-support protocols resulted in successful maternal resuscitation); *Sepsis due to Clostridium perfringens after Pregnancy Termination with Feticide by Cordocentesis: A Case Report*, S.V. Li Kim Mui, M.C. Boulanger, L Maisonneuve, L. Choudat and P. de Bievre, Fetal Diagn. Ther. 2002;17:124–126, available at https://www.karger.com/Article/Abstract/48022 (last viewed January 22, 2018) (mother recovered under broad-spectrum antibiotherapy).

[93] Supra note 79.

[94] *Id.*

[95] *Id.* ("The Society of Family Planning 2010 Clinical Guideline reviewed these data and concluded that there was inadequate evidence to recommend inducing fetal demise to increase the safety of D&E, although they did not recommend against it; the American College of Obstetricians and Gynecologists, in its 2013 Practice Bulletin on Second-Trimester Abortion, likewise merely reiterates the absence of supporting evidence.")

[96] Supra note 90.

[97] *Id.*

[98] A study performed in 2001 determined that 91% of test subjects preferred fetal demise prior to abortion. *Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo-Controlled Trial*, R. Jackson, V. Teplin, E. Drey and P. Darney, Obstet Gynecol. 2001 Mar; 97(3):471-6, https://www.ncbi.nlm.nih.gov/pubmed/11239659 (last viewed on January 22, 2018).

[99] Alabama, Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas and West Virginia.

Legal challenges to these laws have been brought in six states.[100] A temporary injunction has been issued prohibiting the enforcement of these laws in each of those states. Each state has filed an appeal which are currently pending in various federal and state courts. The laws were not challenged in two states, Mississippi and West Virginia, so the prohibition remains in effect in those states.

Effect of Proposed Changes

HB 1429 prohibits a physician from knowingly performing a dismemberment abortion while performing a D&E. The bill defines a dismemberment abortion as:

> An abortion in which a person, with the purpose of causing the death of an fetus, dismembers the living fetus and extracts the fetus one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or a similar instrument that, through the convergence of two rigid levers, slices, crushes, or grasps, or performs any combination of those actions on, a piece of the fetus' body to cut or rip the piece from the body.

The bill provides an exception to this prohibition under certain conditions if a dismemberment abortion is necessary to save the life of a mother if no other medical procedure would suffice for that purpose.

Any person who knowingly performs or actively participates in a dismemberment abortion commits a third degree felony[101]. The bill exempts a woman upon whom a dismemberment abortion has been performed from prosecution for a conspiracy to violate this provision.

The bill does not prohibit an abortion that exclusively uses suction to dismember the body of a fetus by sucking pieces of the fetus into a collection container. The bill also does not prohibit a D&E in which fetal demise is accomplished prior to the dismemberment of the fetus.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 390.011, F.S., relating to definitions.
Section 2: Amends s. 390.0111, F.S., relating to termination of pregnancies.
Section 3: Provides for an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[100] Legal challenges have been filed in Alabama - *West Alabama Women's Center v. Miller*; Arkansas - *Hopkins, M.D., M.P.H. v. Jegley*; Kansas - *Hodes v. Schmidt*; Louisiana - *June Medical Services, LLC et al. v. Gee*; Oklahoma - *Nova Health Systems v. Pruitt*; and, Texas - *Whole Woman's Health v. Paxton*.

[101] A third degree felony is punishable by up to 5 years in prison and up to a $5,000 fine. Sections 775.082-.083, F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have indeterminate, negative fiscal impact on women seeking abortions if the physician performs a D&E with fetal demise prior to evacuation as an alternative to the dismemberment abortion. The particular method of fetal demise selected by the abortion provider could result in the woman having to visit the abortion clinic on more than one occasion. For example, fetal demise by injection of digoxin into the amniotic sac may potentially require one visit for the injection (fetal death usually occurs within 24 hours) and a second visit for the abortion provider to evacuate the fetus from the woman's uterus. Alternatively, fetal demise by injection into the fetal heart could potentially require only a single visit (fetal death usually occurs within a few minutes of the injection). However, currently a D&E without fetal demise can require the woman to visit the abortion provider more than once (one trip to dilate and one to evacuate) so a cost increase seems unlikely.

The fetal demise procedure itself may also increase the cost of the abortion.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA currently has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES