TESTIMONY by
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in Opposition
SB 7 "AN ACT CONCERNING PROTECTIONS FOR ACCESS TO HEALTH CARE AND THE EQUITABLE DELIVERY OF HEALTH CARE SERVICES IN THE STATE

PUBLIC HEALTH COMMITTE*E*
Public Hearing
March 24, 2025

The Connecticut Catholic Public Affairs Conference stands strongly in opposition to Section 4 and 19 of SB 7. Section 4, designed to prohibit Catholic hospitals from discipling a provider who violates the ***"Ethical and Religious Directives for Catholic Health Services" (ERDs)*****,** is a blatant and unnecessary backdoor attack on Catholic healthcare and religious freedom in our state. The ERDs set the ethical and moral standard of care for Catholic hospitals, including the prohibition against providing abortions and gender-affirming treatments. Section 19 of the bill will establish a "Safe Harbor Fund," which will pay for "collateral costs" for people coming to Connecticut to get an abortion or gender-affirming care. This fund will use state taxpayers' money for actions many oppose on religious and moral grounds. It will also open the door for the trafficking of minors into our state who may be victims of sexual abuse and exploitation.

<u>Section 4</u>

The true goal of section 4, despite the generality of the language, is to prohibit Catholic hospitals from reprimanding a medical provider for their involvement in providing services related to abortion or gender-affirming care. Whether these services are provided in an office or emergency room setting. This legislation is reflective of a national trend by advocates of abortion and transgender care to attack Catholic healthcare institutions across our country. SB 7 cleverly omits using the term "Catholic" in its wording, but past and current statements by advocates, through their constant use of the word "religious," leaves no doubt as to its intentions. If Catholic hospitals adhering to the ERDs did not exist section 4 of this bill would not even be before this committee.

Although many people may see the ERDs as restrictive, they are the same directives that also stress the quality of care a patient should receive within a Catholic hospital. Catholic hospitals provide quality health care in Connecticut and across our nation. Abortion advocates, who support this type of legislation, fail to recognize the vast number of quality services Catholic hospitals, including a wide array of healthcare services for women. The services not provided by Catholic hospitals and clinics can easily be obtained at other healthcare institutions in our state, who advertise for these services. Section 3 of the bill references the providing of these services in an emergency department. However, the services limited by the ERDs are very rarely, if at all, emergency situations and can be sought at non-Catholic hospitals without any impact on the patient.

Section 4c of SB 7 specifically addresses emergency department procedures. Opponents of Catholic healthcare commonly state that if a pregnant woman appears in an emergency room in a Catholic hospital the Catholic hospital's health care provider would not assist her if it meant that the unborn child would die. *Catholic hospitals will always attempt to save the woman and child in an emergency life-threatening situation*.

The initial response to a pregnant woman in a serious health crisis in an emergency room is that the unborn child and the mother should both be saved if possible. This is common in any emergency room. In instances where the mother is at a serious medical risk, and the standard of care would threaten the pregnancy, it is moral to initiate that procedure, so long as the intent of the procedure was not to directly terminate the pregnancy. In other words, the standard of the Principle of Double Effect holds. The intent is to save the mother, and the death of the child is a very regrettable result.

It should also be noted that all Catholic hospitals adhere to federal emergency room standards under **"The Emergency Medical Treatment and Labor Act" (EMTALA).** Under EMTALA there are three general requirements: screening, stabilization and transfer. The attending physician makes the determination on how to treat the patient and what stabilization procedures should be used. It is extremely rare if an abortion is required to save a woman's life. It would be more common that a procedure or medication provided to the mother would end the life of the unborn child.

See attached excerpt from a Catholic Hospital Association article for more on this topic.

Section 19

This section of SB 7 creates a special "Safe Harbor Account" and allows the money in that account to be passed to nonprofits involved in abortions or gender advocacy to assist the people seeking aid in coming to Connecticut seeking such services. The account would pay for "collateral costs" such as hotel, food and travel expenses and be aimed at states that have restricted abortions or gender-affirming care. Connecticut will become the place to go for abortions and gender surgery, all paid for by Connecticut taxpayers.

It is important to note that most, if not all, of the states that limit gender-affirming care only do so when a minor is involved. Does this mean Connecticut will be the place to go for minors to receive gender-affirming services, when at the same time numerous countries in Europe and the United Kingdom are now banning such services for minors. Recent scientific studies have proven these treatments are more harmful to minors than helpful.

The inclusion of "gender-affirming health care services" in the proposed legislation also creates a serious problem. The language in Section 4 states that a provider is protected for sharing comprehensive medically accurate and appropriate information that conforms to the accepted standard of care. An "accepted standard of care" in this context is debatable and undefined. The treatment of persons' with gender dysphoria is still under dispute in the medical community. Gender-affirming care, which automatically recognizes a person's self-proclaimed gender, is only one approach to treating gender dysphoria and lacks any significant findings as to its effectiveness. Would this protect providers who ignore the ever-increasing evidence against the effectiveness of gender-affirming care for minors.

Additionally, section 19 would force taxpayers to increasingly fund abortion and gender-affirming care which they find immoral and abhorrent. Section 19 should be modified to only allow private funds to be deposited into this account.

The Conference urges the committee to reject Sections 4 and 19 of SB 7.

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Extract From Catholic Hospital Association Article on Catholic Hospitals and Abortion in Emergency Situations

“MEDICAL INTERVENTION

Another issue in this broad social conversation about abortion today is the accusation that Catholic health care, in the pursuit of safeguarding both maternal and prenatal life, restricts clinical care for mothers.[3] Proponents of elective abortion rights conflate the voluntary choice to abort a viable pregnancy with complications in pregnancy, like ectopic pregnancy and premature rupture of membranes. These are not the same.

Ectopic pregnancies and premature deliveries are medical situations that require intervention. Therefore, terminations of pregnancy, per Catholic moral thought, are not all abortions.[4] There are clinical situations where it is medically necessary — and ethically consistent with Catholic ethics — to assist a woman in discontinuing a problem pregnancy.

So, what is considered abortion? There are disparate theological, medical and political answers to this question, which contradict each other. Those differences contribute to misunderstandings and harm for women.

Theologically, the Catholic answer is that abortion is the intentional termination of a pregnancy that could be, or is, viable. If the intention is to make certain that the embryo or fetus is terminated, then we would describe that act as an abortion. It is immoral because the intention is the deliberate act of ending the life of an innocent person in utero.[5]

Medical interventions that address harmful consequences of nonviable pregnancies are not abortions because they are not meant to cause the death of the embryo or fetus. If the pregnancy can never be viable, and symptoms point toward increasingly dangerous conditions for the mother — like sepsis — then it would be moral to address these medical situations, even if we can foresee that the embryo or fetus will die. The standard is whether the pregnancy would be able to reach viability, not whether the pregnancy is before the time of viability.

It is important for some nuance here, for example, when there is an ectopic pregnancy. We may not directly terminate an embryo, which is a human person. If, however, that embryonic person is implanted in a fallopian tube, and that implantation is a threat to the mother, what should be done? The answer is that we should treat the medical problem since this is a nonviable pregnancy. The continued growth of the embryo will result in a rupture of the fallopian tube and the death of the embryo and possibly the mother. It would be moral to either excise the potentially rupturing fallopian tube, or to use a pharmacological response, to resolve this clinical situation if it is clear that using medication (in this case, methotrexate) will not directly lead to ending the embryo's life.[6]

Similarly, if a woman experiences a premature rupture of her uterine membranes or a preterm premature rupture of membranes, the primary questions are whether the embryo — or more likely, the fetus — is viable, and whether the mother is in medical danger. In some well-known cases, clinicians have interpreted Catholic ethics incorrectly.[7] In those cases, septic pregnancies were allowed to continue and threaten the life of the mother because clinicians believed that Catholic ethics required the established death of the embryo or fetus before intervention. That is not correct. In these cases, if the clinical determination is that the pregnancy is not viable, it is moral to assist in managing the medical circumstances of the pregnancy, even if the embryo or fetus will die as an indirect consequence.

Medically, the term "abortion" is confusing. In the Merck Manual, abortion is described as a consequence, rather than an act or a choice. It is the "death of the fetus, sometimes with passage of products of conception (fetus and placenta), before 20 weeks gestation." This definition makes no distinction between elective abortion and miscarriage. Thus, it confuses the consequence of a choice with an intention. The fact that an embryo or a fetus dies as the result of a natural circumstance of a nonviable pregnancy — or, alternatively, as the result of an intentional medical procedure to end a pregnancy — is not significant, according to Merck. What matters is that the pregnancy has ended and the embryo or fetus is dead.[8]

A DUTY TO CARE FOR ALL BEINGS

What about law and politics? In the aftermath of Dobbs, and the patchwork of state laws that will now regulate abortion, it is important to note that there is no common legal and political definition of abortion. Dobbs has left the regulation of abortion to the states, but they disagree on what it actually is. The state definitions are inconsistent. Some state legislatures — in a drastic effort to protect prenatal life — have passed laws that are harsh and misinformed in their understanding of medicine.

It is important to understand that Catholic moral thought does not align completely with the descriptions of "pro-life" or "pro-choice." Instead, we are both "pro-mother" and "pro-child." The line is drawn for us when a woman wants to abort her healthy, nascent child. That choice is not medical, it is personal, and it immorally ends the life of someone who has the right to exist. No child should die because of that choice. Conversely, no mother should die because her pregnancy is not viable."

Extract taken from : https://www.chausa.org/publications/health-progress/archive/article/winter2023/ethics---what-is-abortion .