# REPORT

# OF

# THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION

## SUBMITTED TO THE GOVERNOR AND LEGISLATURE OF SOUTH DAKOTA

## DECEMBER 2005

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## I. INTRODUCTION

During the 2005 legislative session an overwhelming majority of the Legislature voted to create the South Dakota Task Force to Study Abortion. The Act, House Bill 1233, passed by a vote of 63 to 4 in the House and 28 to 6 in the Senate, and was signed into law by Governor Michael Rounds on March 22, 2005.

### A. The Legislative History And The Reasons For The Creation Of The Task Force

The State Affairs Committee of the South Dakota House of Representatives held a public hearing in February, 2005, concerning House Bill 1233. The Committee heard testimony and took evidence relating to the bill and its companion bill, House Bill 1166. HB 1166, which was also passed by large majorities in both chambers, and also signed into law on March 22, 2005, provided for significant amendments to South Dakota's Abortion Informed Consent Statute. The State Affairs Committee of the South Dakota Senate held a single hearing on both bills.

The committees in both the House and Senate heard evidence concerning the magnitude of the interests and rights of pregnant mothers who were adversely affected by abortion. They heard testimony from a number of women who had undergone abortions and who testified how they became depressed and were haunted by suicidal ideation. In every instance they testified about the magnitude of their loss and how that loss adversely affected their lives once they understood that the procedure terminated the life of their existing offspring.

Those who had counseled a large number of women before and after abortions corroborated the testimony of these women. The picture that emerged from the record before both the House and Senate committees was that it was common for women to sign consents for abortion without being truly informed. Many women reported that they were pressured into having an abortion, often by the father of their child, but by others as well. They typically did not understand that the procedure would terminate the life of a human being, and this lack of understanding was further complicated by the fact that abortion providers had misled them at the time of the abortion. The providers told them that there was "nothing but tissue" inside of them. Many of the women testified or reported to post-abortion counselors that if they had been given accurate information, they would not have submitted to the abortion. Their feeling that abortion providers had misled them compounded their sense of loss, adding to their depression, which often followed the mothers' realization that they were implicated in the death of their own child.

One woman testified before the Legislature that by withholding the truth that her abortion terminated the life of a human being:

> "the policy underlying abortion is a lie. First and foremost, because it denies the essential benefit of motherhood. It tells us that we are not forfeiting anything of value for ourselves. We are told we lost nothing, nothing of value. The truth is that the loss is massive. Massive and life altering. Your House Bill 1166 provides

> an important and essential message that the pregnant mother does have a great benefit, that her child already exists and that she has this existing relationship with her child, and that she has a great fundamental and constitutional right to that relationship, all of which she is giving up, all of which is lost as a result of the abortion...If I had been given this information, I would never had had an abortion."

In passing HB 1166 and the companion bill, HB 1233, which created the South Dakota Task Force to Study Abortion, the Legislature made certain findings that are contained in HB 1166. The Legislature found that as a matter of scientific fact an abortion terminates the life of a whole separate unique living human being.

In addition, the Legislature, in explaining the reasons for adopting HB 1166 (reasons which also formed the basis and inspiration for the creation of the Task Force), found:

> Section 3. The Legislature finds that pregnant women contemplating the termination of their right to their relationship with their unborn children, including women contemplating such termination by an abortion procedure, are faced with making a profound decision most often under stress and pressures from circumstances and from other persons, and that there exists a need for special protection of the rights of such pregnant women, and that the State of South Dakota has a compelling interest in providing such protection.

Moved by the testimony that evidenced a need for the Legislature to act to protect the rights, interests, and health of pregnant mothers in South Dakota, the Legislature enacted HB 1233 and created the South Dakota Task Force to Study Abortion.

### B. The Nature And Scope Of The Mandate Of House Bill 1233

The Act creating the Task Force specifically set out the scope of the inquiry to be conducted by the Task Force. It directed the Task Force to study:

A. the practice of abortion since its legalization,

B. the body of knowledge concerning the development and behavior of the unborn child which has developed because of technological advances and medical experience since the legalization of abortion,

C. the societal, economic, and ethical impact and effects of legalized abortion,

D. the degree to which decisions to undergo abortions are voluntary and informed,

E. the effect and health risks that undergoing abortions has on the women, including the effects on the women's physical and mental health, including the delayed onset of cancer, and her subsequent life and socioeconomic experiences,

F. the nature of the relationship between a pregnant woman and her unborn child,

G. whether abortion is a workable method for the pregnant woman to waive her rights to a relationship with the child,

H. whether the unborn child is capable of experiencing physical pain,

I. whether the need exists for additional protections of the rights of pregnant women contemplating abortion, and

J. whether there is any interest of the state or the mother or the child which would justify changing the laws relative to abortion.

The Act stated that the Task Force shall prepare a report detailing its findings, which shall include any proposals for additional legislation that the Task Force deemed advisable.[1]

Pursuant to the Act, Governor Michael Rounds appointed Dr. Marty Allison, Dr. Maria Bell, Mr. Travis Benson, J.D., Dr. Allen Unruh, and Dr. David Wachs to the Task Force; Representative Matt Michels, Speaker of the House, appointed Mr. David Day, J.D., Ms. Linda Holcomb, Representative Roger Hunt, Representative Elizabeth Kraus, Ms. Kate Looby, and Representative Kathy Miles; and Senator Lee Schoenbeck, President Pro Tempore of the Senate, appointed Senator Stanford Adelstein, Senator Julie Bartling, Senator Jay Duenwald, Senator Brock Greenfield, Dr. John Stransky, and Senator Theresa Two Bulls.

## C. Task Force Hearings And Information Gathering

The South Dakota Task Force to Study Abortion (the "Task Force") initially met on August 1, 2005. On that date the Task Force heard a number of presentations and set protocol for scheduling witnesses, receiving written testimony and documents, and scheduling subsequent hearing dates.

Thereafter, the Task Force held four full days of hearings on September 21 and 22, 2005 and October 20 and 21, 2005. The Task Force heard live testimony of approximately fifty-five witnesses, including thirty-two experts, and considered the written reports and testimony from another fifteen experts. In order to achieve a balanced viewpoint and obtain as much information from diverse points of view as possible, live testimony was divided almost equally between

[1] A copy of HB 1233 is attached to this report as Exhibit A.

witnesses who support the position that abortion is harmful to women and should be illegal and those who think it should be legal.

The Task Force also received approximately 3,500 pages of written materials, studies, reports, and testimony, all of which were made part of the record and have been reviewed and considered by the Task Force in reaching its findings, conclusions, and recommendations. Although the Task Force aggressively sought such contributions from all perspectives, this evidence was overwhelmingly in support of protecting life and preventing harm to women caused by abortion.

Of significance, close to 2,000 women who have had abortions provided statements detailing their experiences, trauma, and the impact abortion has had on their lives. Of these post abortive women, over 99% of them testified that abortion is destructive of the rights, interests, and health of women and that abortion should not be legal.

In reviewing this testimony from women who had abortions in South Dakota, as well as in many other parts of the country, a pattern of shared experiences and trauma and a common sense of loss emerge.

## II. FINDINGS OF THE TASK FORCE

### A. The Practice Of Abortion Since Its Legalization

In 1973, the United States Supreme Court issued its opinion in *Roe v. Wade*, 410 U.S. 113, the decision that legalized abortion in our country. At that time, our nation had no experience of any significant duration or extent with legal abortion from which reliable judgments or conclusions could be reached about how legalized abortion would affect the lives, interests, rights, and health of women.

Dr. John Wilke, MD, the former president of National Right to Life, testified before the Task Force and explained how virtually all of the careful analysis and policy-making of the Legislatures in various states was abruptly swept away by the *Roe* decision. In doing so, the *Roe* decision, and many of the subsequent cases following *Roe*, were based on a number of assumptions about the nature of the abortion procedure, the physician-patient relationship, the decisions women seeking abortions made, the safety of the abortion procedure, and other important matters relating to the interests of the women.

At the time the *Roe* Court made these various assumptions, the Court did not have the benefit of the current knowledge of science and medicine or the information obtained from the experience of women who have undergone abortions over the past thirty years. Since *Roe*, approximately 43 to 45 million abortions have taken place throughout the United States, including, in recent years, approximately 820 abortions per year in South Dakota.

Through the knowledge gained from the advances in science and medicine over the past thirty years, and as evidenced in the testimony of women who have experienced legalized abortion, it is clear that the most essential assumptions made by the *Roe* Court are incorrect, to the detriment of the women subjected to the procedure.

#### 1. The Incorrect Assumptions of the *Roe v. Wade* Decision

Specifically, six different assumptions of fact were made that were critical to the *Roe* decision that the states lacked an interest sufficient to prohibit or meaningfully regulate the abortion procedure. We address them one at a time:

First, the Supreme Court assumed that it could not determine the answer to the question of when the life of a human being begins:

> "When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, *at this point in the development of man's knowledge*, is not in a position to speculate as to the answer." (*Roe v. Wade*, 410 U.S. at 159) (emphasis added).

Thus, the Supreme Court did not affirm, but neither did it deny, that the "unborn child" (what embryologists call the "embryo" or "fetus") is a living human being. To understand this point, and to understand the testimony of the witnesses from Planned Parenthood who testified before the Task Force, it is important to distinguish three separate questions.

The first question is a scientific one: is the human being, from the moment of conception, a whole separate living member of the species *Homo sapiens* in the biological sense? The second question is a moral question: assuming that the answer to the first question is yes, should the life of that human being be accorded the same value, worth, and dignity at all stages of development, i.e., as a blastocyst, embryo, fetus, child, adolescent, and adult. And the third question is a legal one: does the Constitution of the United States protect the rights of human beings at all stages of development before birth?

In *Roe v. Wade*, the Supreme Court expressly declined to answer the scientific or moral questions. With regard to the scientific question, the Supreme Court said that at this "point in the development of man's knowledge" it could not say whether a human embryo or fetus is or is not a human being. The Court ruled that the state could not legally prohibit abortion. Whether or not this decision was based upon sound legal analysis has never stopped being the subject of great debate.

Second, the *Roe* Court assumed that there would be a normal healthy physician-patient relationship in which the doctor would impart pertinent information, and that decisions would be made through consultation between the physician and patient. "All these are factors the *woman and her responsible physician necessarily will consider in consultation*." (*Roe v. Wade*, 410 U.S. at 153) (emphasis added).

Third, the Court assumed that motherhood and child-rearing forced "upon the woman a distressful life and future" and that child-rearing could cause "mental and physical" health problems and "distress" of such a nature that abortion had to be available, and that the absence of legalized abortion was a detriment imposed upon the women by the state. (*Roe v. Wade*, 410 U.S. at 153.)

Nowhere in the *Roe* decision did the Court mention the distress due to the pregnant mother losing her child to abortion. In fact, there is no mention of the great benefit and joys that the mother-child relationship brings to the mother, or the devastating loss and distress incurred by the mother who loses her child to abortion. The absence of mention of the nature of this loss and this profound distress is, in all likelihood, attributable to the fact that in 1973 there had not yet been adequate experience with the after-effects of abortion.

Likewise, the Court never mentioned the fact that the pregnant mother possesses a constitutionally protected relationship with her unborn child or the fact that this relationship, protected as a fundamental right, is terminated by the abortion procedure. House Bill 1166 expressly states that this is not only the case, but it required the abortion providers to disclose this information in writing to a woman considering an abortion.

Fourth, the Court's opinion assumed that a decision to have an abortion would be truly voluntary and informed.

Fifth, the Court assumed that the abortion procedure was safe and that the risk to the women's health and life was far greater in carrying the child to full term than in having an abortion. See, e.g. *Roe v. Wade*, at 149 ("consequently, any interest of the state in protecting the woman from an inherently hazardous procedure... has largely disappeared").

Sixth, the Supreme Court assumed that the woman faced significant difficulties as a result of a cultural stigma of unwed motherhood.

As a result of the advances in modern science and medicine, and particularly because of information derived from the practice of abortion since its legalization, the Task Force finds that each of these assumptions has been entirely or largely disproved. The new understanding about these facts, and the new information not previously known concerning them, are important in understanding how abortion affects the lives, rights, interests, and health of women.

**2. What Has Been Learned From the Practice of Abortion Since the *Roe v. Wade* Decision**

It can no longer be doubted that the unborn child from the moment of conception is a whole separate human being. During the 2005 legislative session, the South Dakota Legislature passed HB 1166 that expressly found that "all abortions, whether surgically or chemically induced, terminate the life of a whole, separate, unique, living human being." The Act amends SDCL 34-23A-10.1 to require a physician to disclose in writing to a pregnant mother "that the abortion will terminate the life of a whole, separate, unique, living human being." "Human being" is used in the biological sense as a whole member of the species *Homo sapiens* (SDCL 34-23A-1(4)).[2]

The Task Force received testimony from numerous experts who reiterated this fact. Of significance were detailed affidavits received from nationally and internationally renowned

[2]South Dakota Deputy Attorney General John Guhin addressed the Task Force on August 1, 2005 and reported that a preliminary injunction was entered enjoining the enforcement of HB 1166 in order to preserve the status quo while the case filed by Planned Parenthood challenging the Act is pending in the Federal District Court. Mr. Guhin reported that the state filed an appeal from the entry of the preliminary injunction. Members of the Task Force have subsequently learned that the trial in that case is not yet scheduled and it is anticipated that it will likely be held in the mid to later half of 2006.

It was of some interest to members of the Task Force to learn that while the Federal District Court entered the Order imposing the preliminary injunction, the Court did so on the basis that the Court sought to protect Planned Parenthood's First Amendment right of free speech which they asserted in that case. The Court recognized there was a conflict between these asserted rights of the abortion providers and the interests of the pregnant mothers which were sought to be protected by the Act. We note that the Court attempted to weigh the harm to the personal rights of the abortion providers against the harms to the interests of the pregnant mothers, and the Court chose to protect the interests of the abortion providers as a way to preserve the status quo while the case is litigated in the District Court.

experts from a number of scientific and medical disciplines, who explained the scientific facts and information that establish the fact that abortion terminates the life of a human being. The Task Force concludes that the scientific evidence not only supports the Legislature's finding on this matter, but that it is indisputable.

Dr. David Fu-Chi Mark, a distinguished molecular biologist who has patented certain polymerase chain reaction technologies, provided a declaration (or affidavit) and explained that the new recombinant DNA technologies that have developed over the past twenty years provide scientific evidence about the unborn child's existence and early development and its ability to react to the environment and feel pain prior to birth.

Dr. Mark stated that:

> "[U]ntil the development of molecular biology and modern molecular biological techniques first began in the 1970's and exploding throughout the 1980's and 1990's, most scientific knowledge concerning human identity and human development prior to birth was based solely upon gross morphological observations and biochemical studies....The new techniques developed through the exploding revolution over the past ten to eighteen years permits scientists to observe human existence and development at a molecular level, which is applicable in determining genetic uniqueness, genetic diseases and related information through the analysis of human genes well in advance of the old gross, anatomical observation." (Mark Declaration, P. 5, Par.6.)

Dr. Mark explained nine different DNA technologies that, in essence, have "turned on the lights" for scientists over the past twenty years. (See Section II-B of this Report.)

A number of other nationally and internationally recognized experts also corroborated the findings of the Legislature found in HB 1166. Dr. Bruce Carlson, a renowned human embryologist and professor at University of Michigan Medical School, has published a text on Human Embryology used in medical schools in many nations. Dr. Carlson, Dr. Mark, and the human geneticist, Dr. Marie Peeters-Ney, all emphasized the significance of the way that genetic information is expressed and the manner in which it is "pre-programmed" for life. Dr. Carlson stated, "The wholeness (or completeness) of the human being during the embryonic ages cannot be fully appreciated without an understanding of how the genetic information is packaged, and how the information becomes unfolded and cascades into visible structures." (Carlson Declaration, P. 4, Par. 12.)

The Task Force also reviewed a declaration from Dr. Bernard Nathanson, a board certified obstetrician and gynecologist, a Diplomat of the American Board of Obstetrics and Gynecology, and a Fellow of the American College of Obstetrics and Gynecology. Dr. Nathanson practiced medicine in New York for many decades and was personally responsible for approximately 75,000 abortions. Dr. Nathanson was also one of the founders of the National Association for the Repeal of the Abortion Laws (NARAL) in the United States in

1969. He stated that: "I was active among the pro-abortion community for a number of years, and I was actively involved in attempting, along with other abortion providers, to win public support for all forms of abortion." (Nathanson Declaration, Par. 1 to Par. 5.)

Dr. Nathanson testified that the fact an abortion terminates the life of a living human being is generally known among obstetricians and scientists. However, Dr. Nathanson stated that abortion doctors and operators of abortion clinics often deny this fact for strategic reasons. He testified that he and other strategists for NARAL, for instance, adopted certain tactics to win the public perception that all forms of abortion should be and remain legal. Dr. Nathanson stated that one tactic was to suppress and denigrate all scientific evidence that supported the conclusions that a human embryo or fetus was a separate human being. He stated that he and others denied what they knew was true: "The abortion industry would routinely deny the undeniable, that is, that the human embryo and fetus is, as a matter of biological fact, a human being." (Nathanson Declaration, Par. 14.) Dr. Byron Calhoun, a specialist in internal fetal medicine, also testified that it cannot be denied that the unborn child is a separate human being.

Specifically, Dr. Nathanson stated that:

> "The abortion procedure is an extraordinary one because in it the physician is proposing to terminate the life of one of his patients to whom the physician owes a legal and professional duty. The doctor has no legal authority to do so. Under normal circumstances, if he terminated the life of the unborn child, he would be guilty of a battery upon the mother, and, in fetal homicide states, such as South Dakota, he would be guilty of a homicide. The physician is given his authority to terminate the life of one of his patients only if he receives authority in the form of consent from the pregnant mother.
>
> In order for such a consent to be informed, at a minimum, the physician must be satisfied that the patient understood that the second patient was in existence, and that the procedure would terminate the life of her unborn child. These facts go directly to the risks, and effect the procedure would have on the second patient, but they also explain the nature of the procedure. The nature of the procedure is to terminate the life of the unborn child. Withholding these facts from the pregnant mother deprives her of the ability to make an informed decision for herself. Such informed written consent fails to meet the reasonable patient standard of disclosure and deprives the mother of her rights of self determination." (Nathanson Declaration Par. 10 and 11.)

No credible evidence was presented that challenged these scientific facts. In fact, when witnesses supporting abortion were asked when life begins, not one would answer the question, stating that it would only be their personal opinion.

A number of physicians also testified that it has been recognized for some time that the doctor who has a pregnant mother as a patient has two separate patients – the mother and the

child - to whom he owes a professional and legal duty. Dr. Glenn Ridder, a physician who practices in Sioux Falls, South Dakota, testified that the physician has a duty to both patients, that disclosures about the risks or harms to the child must be made to the pregnant mother and that only she can make the decision for the child. (Ridder Declaration, Par. 9.)

Dr. Yvonne B. Seger, and Dr. Cynthia Davis, both of whom practice obstetrics and gynecology in Sioux Falls, South Dakota, also submitted statements that explained that the physician who has a pregnant woman as a patient has two separate patients - the mother and the child - and that the physician must make disclosures about the risks and effect any procedure would have on each. (Davis Declaration, Par. 5; Seger Declaration, Par. 5.)

Dr. Byron Calhoun, Maternal-Fetal Medical Specialist from Rockford, Illinois, explained that the unborn child is considered a separate patient in his or her own right. Dr. Calhoun also stated that there is no outcome data to support the idea that the mother's life is put at risk by allowing her to carry to term a critically ill baby. See, also Harrison, M.R., Golbus, M.S., Filly, R.A. (Eds), *The Unborn Patient*, 2nd Ed. W.B. Saunders, Phil. 1991; American College of Obstetricians & Gynecologists, *Ethics in Obstetrics and Gynecology*, 34 (2nd Ed. 2004) (The maternal-fetal relationship is unique in medicine...because both the fetus and the woman are regarded as patients of the obstetrician).

Dr. Mark Rosen, a Fetal Anesthesiologist practicing in San Francisco, California, explained that with the advances of modern medical techniques, fetal surgery is now performed on the unborn child *in utero*. The procedures include, among others, inserting fetal shunts, blood transfusions, muscle biopsies, and procedures to repair congenital diaphragmatic hernias.

The Task Force concludes the following:

1. That abortion terminates the life of a unique, whole, living human being;

2. That the physician performing an abortion terminates the life of one of the physician's patients to whom the physician owes a professional and legal duty;

3. That the authority for the physician to terminate the life of his or her patient rests exclusively upon the written consent of the pregnant mother, which, at the time it is signed, terminates the doctor's duty to the child; and

4. That the mother has an existing and important and beneficial relationship with her child that is irrevocably terminated by the abortion procedure.

### 3. The Current Practice of Abortion in South Dakota[3]

Kate Looby, the Director of Planned Parenthood of South Dakota which operates an abortion facility in Sioux Falls, South Dakota, testified before the Task Force.[4] Dr. Carol E. Ball, who performs abortions there, also testified before the Task Force. Both described how Planned Parenthood counsels women about abortions, what kind of information is disclosed, and the interaction between the abortion physician and the pregnant mother.

Based on their testimony, it is admitted that the Planned Parenthood facility in Sioux Falls does not disclose any information about the unborn child and that it does not disclose to the pregnant mother in any way that the child, the second patient, is already in existence. Planned Parenthood only discloses what the state requires them to disclose by statute. This does not adhere to the common law disclosure requirements discussed by Dr. Seger, Dr. Nathanson, Dr. Davis, and Dr. Ridder.

South Dakota Codified Law 34-23A-10.1(2), which appears as Exhibit B, requires that the abortion facility simply inform the women by telephone that they have the right to review printed material prepared by the state that provides information about fetal development.

Ms. Looby testified that their procedure includes having an assistant speak directly to the women over the phone. She states that in this part of the conversation, the woman has an opportunity to ask questions. However, Planned Parenthood still does not volunteer information about the unborn child.

The state's preprinted information does not make it clear that the procedure will terminate the life of a living human being. It only lists aspects of fetal development.

The South Dakota Department of Health publishes statistics about abortions performed at Planned Parenthood, and elsewhere in the State. The latest statistics, as contained in the 2003 report, were made part of the record.

In 2003, there were 819 abortions performed in South Dakota. The law requires the abortion facility to provide a form for the women to fill out concerning the information given to the women. In 819 forms filled out by these women, only five women requested that the written information be mailed to them. (See, 2003 South Dakota Vital Statistics Report, S.D. Department of Health, P. 71.) That means that 814 of the 819 women (99.4%) received no information about the development of the unborn child except the information required by SDCL 34-23A-10.1(1)(c): "The probable gestational age of the unborn child at the time the

[3]One of the primary goals of the Task Force was to gain an understanding of the practice of abortion, and specifically the practice of abortion in our State. Because no other facilities, other than Planned Parenthood of South Dakota, are disclosed as abortion providers in this state, we had no other choice but to gather our information from this organization.

[4]Ms. Looby is a member of the South Dakota Task Force to Study Abortion.

abortion is to be performed." In other words, the woman is only told how far along she is in the pregnancy, a fact she most often already knows from the date she missed her last menstrual period.

Further, the 2003 Vital Statistics Report of the South Dakota Department of Health states that:

> "The data showed that of the 819 forms received, 813 of the patients reported receiving the medial information described in SDCL section 34-23A-10.1 during a telephone conversation and 6 in person." (Report, P. 71.)

The report indicates that in every instance the physician gave the disclosure concerning gestational age. (Report, P. 71.)

Additionally, according to Ms. Looby's testimony, a message given by the physician is pre-recorded. It is a four-minute recording designed to satisfy the statutory requirement of SDCL 34-23A-10.1 that the information contained in that section be imparted by the physician who will perform the abortion.

To summarize, in 814 out of 819 procedures, the only information given to the pregnant mother about the second patient was simply a gestational age. In 813 cases out of the 819, the physician in a taped statement gave resource information. The women had no way of asking the physician any questions since it is a recording.

Based upon the reporting of the women on the forms reviewed by the Department of Health, and the testimony of Ms. Looby and Dr. Ball, it appears that Planned Parenthood does not voluntarily convey other information about the fetus after women listen to the doctor's taped recording.

In fact, what is communicated to the women is misleading. Ms. Looby and Dr. Ball played a video for the Task Force illustrating what may be communicated to women about the abortion procedure. In this video, reference is made to the contents of the woman's uterus in dehumanizing and misleading language. For instance, the video never mentions that an unborn child, embryo, or fetus is even present. It never refers to the unborn child in any way that would imply the existence of a second patient. The language used in the video simply implies that something is removed but does not identify what it is except to claim it is only "tissue:"

1. "The uterus is then *emptied* by a gentle suction."

2. "As the uterus is *emptied*..."

3. "A spoon shaped curette may be used to feel the walls of the uterus to help ensure complete evacuation."

4. "Occasionally the *contents of the uterus* may not be *completely emptied*."

5. "To remove *the tissue* it may be necessary to repeat the vacuum aspiration."

6. "Very infrequently, the early abortion procedure will not end the pregnancy."

7. "If the pregnancy has not been ended, another abortion procedure is recommended."

We find first that Planned Parenthood fails to inform the pregnant mother in any language that her unborn child is in existence. It is impossible for a woman to give informed consent to an abortion if she does not fully understand that her child is in existence and that she is consenting to the termination of the life of her child.

Second, the doctor who in seeking consent to terminate the life of his or her second patient (the child) cannot, in a professional or moral sense, contend that proper authority has been obtained from the mother if she is not fully aware that she is giving such authority.

Dr. Ball and Ms. Looby testified that the women who come to Planned Parenthood sign a "consent" to have an abortion without first speaking to the doctor. These consent forms are filled out before the doctor sees the patient. A person designated as a "counselor" provides whatever information is told to the pregnant mother. However, Ms. Looby admitted that these "counselors" are not licensed and the only training they receive is from Planned Parenthood.

The video played recites:

> "If you have not done so already, you will meet privately with a counselor. The counselor reviews your medical history, answers any questions you have about the abortion procedure, provides after-care instructions and talks with you about your birth control needs. The counselor also talks with you about your decision to have an abortion. It is important that this decision is yours and made of your own free will. *At the end of the counseling session, you are asked to sign an informed consent indicating that you understand the medical risks of the abortion procedure*." (Emphasis added).

Thus, the abortion doctor sees the pregnant mother for the first time in the procedure room, only after the consent form has been signed and the woman has made her commitment to undergo the abortion.

The video, Dr. Ball, and Ms. Looby all verify that the women are told that they may ask questions of the doctor who is to perform the abortion. However, we find that the process which results in the pregnant mother signing the consent form and making her decision *before* ever seeing or speaking to a abortion doctor is incompatible with the principles of a doctor's duty to see that the patient's decision is informed *before* she consents to an operative procedure. We find

that there is no true physician-patient relationship in this process, and once the decision has been made, the woman is seeing the doctor, not for counseling, consultation, or help in reaching a decision, but rather, to submit to the medical procedure that she has already committed to, whether or not it was informed.

The abortion doctor, therefore, provides no counseling unless the pregnant mother initiates a discussion and asks questions in the procedure room. However, we find that even if a woman has the will to press the doctor for answers to questions, the answers that are given at Planned Parenthood concerning the most critical matters will not be helpful to her.

Following her testimony, Dr. Ball was asked what she would tell a woman who asked her "Is this a human life?" or "At what point in the process does human life begin?" or similar questions. Dr. Ball testified that she would refuse to answer these questions. When pressed on this point, Dr. Ball stated that it is a subjective matter for the woman to decide, and an answer from her is nothing but her subjective personal opinion.

Thus, a woman who goes to Planned Parenthood in Sioux Falls is not given scientific and factual information necessary for her to understand that the procedure will terminate the life of a human being, even when the woman asks precisely if the abortion is killing their baby.

We find that Planned Parenthood has confused the objective biological fact that the procedure terminates the life of a live human being with the moral, or value judgment of what respect or value should be placed upon the life of that human being. Under existing law, only the pregnant mother has the right to decide whether she should or should not submit to the abortion. But the pregnant mother can apply her own discrete personal, moral or religious values to her circumstance only after accurate biological facts concerning the existence and nature of her unborn child are disclosed.

By its own admissions, Planned Parenthood makes no such disclosures as required by common medical practice, it uses misleading language such as "contents of the uterus," and it refuses to make accurate disclosure of biological facts even when asked directly about the unborn child.

A policy that requires a patient to research the scientific facts on her own conflicts with all accepted notions of informed consent, and virtually ensures that South Dakota women will submit to a procedure without giving informed consent.

We find that the withholding of the biological information from women has the effect of imposing the personal philosophy of Planned Parenthood and its agents upon these women. To say that a human being, no matter how young or physically immature, is nothing but "tissue" or "contents of the uterus" is to already make and convey the judgment that this human being has less value than others. This precludes the mother from making the decision for herself about whether the life of the human being in question has value.

The testimony of Ms. Looby and Dr. Ball also made it clear that Planned Parenthood does not make accurate disclosures about the risks of abortion. These are discussed more fully in Section II-E. In the Planned Parenthood video referenced in this Report, the following statements were made which we find to be completely inaccurate based on the record and evidence discussed in Section II-E:

1. "Early abortion by vacuum aspiration is one of the safest procedures in all of medicine."

2. "A legal abortion, as it is performed in the United States today, is a very safe procedure and complications are rare."

3. "The emotion most women experience after having had an abortion is relief."

4. "Women may have some mixed feelings at this time but emotional problems after abortion are uncommon, and when they happen, they usually go away quickly."

5. "Serious long-term disturbances after abortion appear to be less frequent than after childbirth."

6. "The risk of dying from a full-term pregnancy and childbirth is at least seven times greater than that from early abortion."

Dr. Ball testified that Minnesota is her state of residence and medical practice. Planned Parenthood of South Dakota schedules abortions about six days a month. On each of these six days, Dr. Ball, or one of three other out-of-state physicians, travels to Sioux Falls to perform, on average, twenty abortions per day, and then leaves the state the same day. One of these four out-of-state abortion doctors has hospital privileges in the Sioux Falls area. Dr. Ball testified: "we have a verbal agreement with an Ob/Gyn group in Sioux Falls who will help us with any complications that occur." Therefore, if any woman has complications, local doctors who are strangers to the patient and were in no way involved in the abortion procedure must see her.

The Task Force concludes that there is no traditional or healthy physician-patient relationship between an abortion doctor at Planned Parenthood in South Dakota and the pregnant mother. The only time the abortion doctor sees the patient is in the room where the procedure is to be performed, after the woman has already committed to submitting to the abortion by signing the consent form.

Further, we seriously question whether the practices of the doctors who provide abortion services at the Sioux Falls facility meet the standards set by the American College of Surgeons, particularly with respect to its principles concerning the relationship of the surgeon to the patient and its proscription against itinerant surgery.[5]

[5]Itinerant surgery involves the practice of a physician outside the physician's normal geographical area of

It must be noted that the information regarding the practice of abortion in South Dakota is based entirely on the practices at Planned Parenthood of South Dakota where almost all abortions are performed. Doneen Hollingsworth, Secretary of the Department of Health, testified that there are four abortion providers in the state, but South Dakota Codified Law prohibits the disclosure and identification of these providers.

There have been two other significant developments in the past twenty years that have resulted in further understanding about the practice of abortion. First, pregnancy help centers have opened all over the country to offer counseling and support to women in crisis pregnancy situations. Second, women have begun to speak out about their abortion experiences.

**4. The Experiences of Pregnancy Help Centers**

Cynthia Collins has been the Executive Director of the Crisis Pregnancy Help Center of Slidell, Louisiana, for the past eighteen years. She explains in her declaration that many of the 3,000 to 4,000 pregnancy help centers around the country are independent of each other, but that there are two national organizations, CARENET and Heartbeat International, that provide training to and certify counselors for women with crisis pregnancies. She affirmed that these centers also provide post-abortion counseling for women traumatized by abortion.

Based upon the information provided by Cynthia Collins; Linda Schlueter of the Justice Foundation in San Antonio, Texas; Stacey A. Wollman, the Director and a licensed counselor at Black Hills Crisis Pregnancy Center in Rapid City; Leslee J. Unruh, Founder and President of the Alpha Center in Sioux Falls; Millie Lace, a licensed professional counselor in Arkansas; and many others, it appears these centers provide help and counseling to about one million or more pregnant mothers each year. In addition, it appears that these centers provide post-abortion counseling to 100,000 to 200,000 women each year.

As a consequence of the rise of these centers, there is now information available that affirms that in a significant portion of abortions, the pregnant mothers' consents are not truly informed or voluntary. This fact is borne out by information received from the counseling of women contemplating abortion and women seeking post-abortion healing.

We find the testimony of these pregnancy help center personnel particularly credible because they are free of any conflict of interest. The pregnancy help centers do not provide abortions and they do not take payment from the women they serve.

With respect to the pre-abortion counseling, Cynthia Collins states that of the 4,400 women who sought help from the center in Slidell in the past four years, 1,860 tested positive for pregnancy. Of these 1,860 women, 560 of them (30.1%) stated that they thought they would have an abortion or that they were seriously considering an abortion. These women were

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practice to perform surgery where the physician is not personally involved in the original diagnosis or preparation of the patient and is not involved in follow-up care.

counseled about the nature of abortion, the risks, and alternatives. In that process, the center provided information about the development of the unborn child.

Ms. Collins explained that when counselors are truthful about this kind of information, the pregnant mothers most often "want to know if the procedure will terminate the life of an existing human being, regardless of his or her age or maturity, and they want candor." She stated that in her experience, this is decisive information for the women and they commonly conclude that a mother should protect, not terminate, the life of her own child.

She stated further that once the women understand that the abortion procedure does not prevent a human being from coming into existence, but instead terminates a life that already exists, they begin to appreciate the benefit and joy the existing child could bring to their lives, and decide not to have an abortion. As a result of the counseling at the Slidell center, Ms. Collins testified that only 45 of the 1,860 pregnant mothers (2%) ultimately had an abortion.

Perhaps most significant, 1,775 of the 1,815 women (about 97%) who carried their children to term raised their children themselves. Of the other 50 women, only twelve are known to have terminated their parental rights through adoption. Thus, 97% or more of the women who carried their children to term raised their children themselves, and at least 95% of all of the women who found out they were pregnant decided to raise their children.

From the information available, it appears that similar statistics and results are found uniformly among the pregnancy care centers. Leslee Unruh, Stacey Wollman, and Eleanor Larsen, a licensed counselor in charge of supervising the counseling at Alpha Center, all provided affidavits in which they relate similar results. In Sioux Falls, of 400 pregnant women seriously considering abortion, about 85% decided to carry their children to full term.

These statistics are startling when compared to those of clinics that provide abortions. It appears that at Planned Parenthood, where women are not informed of information about the child, virtually every woman submits to an abortion.

In the 20 years that the Slidell Center, the Alpha Center, and the CareNet Pregnancy Resource Center have operated, not a single woman ever reported that they regretted their decision to have their child.

At the Slidell Center, Ms. Collins stated that in any given year, 70% to 85% of women seeking post-abortion counseling relate that they made their decision under some form of coercion. More than 80% of these women state that the abortion clinics did not counsel them properly, and that if they had been given accurate information, they would not have submitted to an abortion.

Ms. Unruh stated that among the post-abortive women seeking counseling at the Sioux Falls Alpha Center, 75% to 85% in any given year report that they felt they were misled by the

abortion clinics and that their decisions were uninformed and, in many ways, coerced. Among these women were women who had abortions at Planned Parenthood in Sioux Falls.

Stacey Wollman testified that at the CareNet Pregnancy Center of Rapid City, almost 60% of the post-abortive women receiving counseling stated that their abortions were the result of some form of coercion. The women commonly complain that the pre-abortion counseling they received was either non-existent or inadequate.

Millie Lace, from Arkansas, further testified that as a professional counselor and coordinator for a national helpline, she receives calls from women in South Dakota, and verified much of the above information.

**5. The Experiences of Women Who Have Had Abortions**

We received and reviewed the testimony of more than 1,940 women who have had abortions. This stunning and heart-wrenching testimony reveals that there are common experiences with abortions. Women were not told the truth about abortion, were misled into thinking that nothing but "tissue" was being removed, and relate that they would not have had an abortion if they were told the truth.

They relate that they were coerced into having the abortion by the father of the child or a parent, and that the abortion clinics also apply pressure to have the abortion. They almost uniformly express anger toward the abortion providers, their baby's father, or society in general, which promote abortion as a great right, the exercise of which is good for women. They almost invariably state that they were encouraged to have an abortion by the mere fact that it was legal.

They are stunned by their grief and the negative impact it has had on their lives. Many of these women are angered by grief at the loss of a child they were told never existed. One woman testified before the Task Force about three abortions she was misled into having, only to find that she was rendered infertile by the vacuum aspiration that damaged her fallopian tubes. She was distraught at having to explain to her new husband why they could never have children. Each of these women's stories is powerful.

The overwhelming majority of women testified that they would never have considered an abortion if it were not legal. Their testimony revealed that they feel that the legalization of abortion simply gave a license to others to pressure them into a decision they otherwise would not have made. Most of the women stated that abortion should not be legal.

Ms. Linda Schlueter, Vice President and Senior Staff Attorney of The Justice Foundation, testified that it is particularly significant that both of the plaintiffs in the landmark abortion cases, *Roe v. Wade* and *Doe v. Bolton*, have sought to have the courts overturn the decisions because it is now so clear how abortion violates the rights, interests, and health of women. Norma McCorvey, Jane Roe in *Roe v. Wade*, believed that an abortion would help her, but she was never told about any physical, emotional, or psychological consequences. She actually never had

an abortion herself, but her work in several abortion clinics caused her to see the truth. Sandra Cano, Doe in *Doe v. Bolton*, subsequently told the court that she never even wanted an abortion and her case was a fraud.

A year ago, Judge Edith Jones of the U.S. Court of Appeals for the Fifth Circuit, often mentioned as a candidate for the U.S. Supreme Court, wrote a published opinion in which she referred to the evidence provided by Ms. McCorvey in the *Roe* case, including the sworn affidavits submitted to this Task Force. Judge Jones stated that this evidence provided new and fresh information never before considered by the U.S. Supreme Court.

We find the testimonies of these women an important source of information about the way consents for abortions are taken, as well as many other matters relevant to the mandate given to this Task Force by HB 1233.

## B. The Body Of Knowledge Concerning The Development And Behavior Of The Unborn Child Which Has Developed Because Of Technological Advances And Medical Experience Since The Legalization Of Abortion

The Task Force received scientific information from highly credentialed scientists and medical practitioners. Information about the nature and development of the unborn child is now available that was not in existence at the time of *Roe v. Wade*.

### 1. The Development of the Field of Molecular Biology and Other Sciences

It has been known for the past five decades that human beings are biologically made up of molecular building blocks. The development of these building blocks is controlled by genetic material known as deoxyribonucleic acids (DNA) and ribonucleic acids (RNA). DNA contains genetic information, and RNA contains instructions for the synthesis of proteins.

The Task Force received a declaration prepared by Dr. David Fu-Chi Mark, who explained the modern developments in molecular biology, the information it has recently revealed, and the significance of that information. Dr. Mark is a nationally celebrated molecular biologist who has patented various polymerase chain reaction (PCR) techniques. In 1986, Dr. Mark was given the award of *Inventor of the Year*, which is a single award given across all disciplines of science and technology. That particular award was given to Dr. Mark for his work in obtaining a patent for Human Recombinant Interleukin-2 Muteins, which is used to treat cancer of the kidney and skin, and is still marketed internationally. He also obtained a patent for Human Recombinant Cysteine Depleted Interferon - B Muteins, which is a drug that is used to treat Multiple Sclerosis, and is also marketed internationally. These two drugs were developed by employment of new molecular biological techniques: DNA cloning, in vitro modification of DNA, and DNA sequencing.

Dr. Mark observed that until the development of molecular biology and modern molecular biological techniques,

> "most scientific knowledge concerning human identity and human development prior to birth was based solely upon gross morphological observations and biochemical studies. Over the past [twenty] years there have been extraordinary scientific, medical and technological advances and discoveries which expose the rather rudimentary level of knowledge and ignorance of science, errors of fact and judgment concerning past scientific understanding of the child's existence as a human being, the child's early development and ability to react to the child's environment and feel pain prior to birth. The new techniques developed through the exploding revolution over the past [twenty years] permits scientists to observe human existence and development at a molecular level, which is applicable in determining genetic uniqueness, genetic diseases and related information through the analysis of human genes well in advance of the old gross, anatomical observation." (Mark Declaration, P. 5, Par. 6.)

Dr. Mark described and explained in technical detail, with full citations to the relevant literature, nine of the many new major molecular biological technologies, and how they have been used to discover information about the unborn child:

1. Use of Restriction Endonuclease Enzymes: a technique discovered early in molecular biology that allowed scientists to use enzymes to cut pieces of DNA so that DNA can be manipulated in a test tube. This technique has had great practical application. (Mark P. 5-7, Par. 7A.)

2. DNA Cloning: a technique first achieved in 1974 which allows a scientist to take a portion of DNA from a single cell, reproduce it, and make copies of it, allowing for the modern study of DNA and its reproduction. It was with the advent of development of DNA cloning in 1974 that molecular biology began in 1974. (Mark, P. 7-8, Par. 7B.)

3. DNA Probe: a technology, first developed in 1979, that allows scientists to determine whether information contained in a certain gene is being expressed; study genome structure and identify sites of cytosine methylation (discussed below); and facilitate the development of DNA fingerprinting technology. (Mark, P. 8-9 Par. 7C.)

4. Southern Blot: a technique that permits the study of a single gene fragment. The importance of Southern Blot is the new ability to visualize the DNA of specific interest to the scientist, and it has led to the discovery and use of DNA fragmentation patterns visualized by Southern Blot as DNA fingerprints. DNA fingerprints, as discussed below, allows for the identification of DNA fragments

both specific to the species *Homo sapiens*, and the specific individual member of the species. (Mark, P. 10, Par. 7D.)

5. Northern Blot: a technique that permits detection of messenger RNA (mRNA) in extremely small quantities of material. The importance of Northern Blot is the new ability of science to determine whether a specific gene is expressed in a particular tissue, which led to an understanding of the role of DNA methylation in regulating gene expression. (Mark, P. 11, Par. 7E.)

6. DNA Mapping: an important technique that allows scientists to determine if there are differences in DNA sequences, which provide science with the ability to detect abnormalities due to mutations in DNA, and to identify sites of DNA methylation. (Mark, P. 11-12, Par. 7F.)

7. DNA Fingerprinting: a technique first discovered in the mid-1980s by Alec Jeffries in Great Britain which gained wide application in the early to mid-1990s being introduced as evidence in American courts. It was learned by DNA mapping and Southern Blot analysis that the human genome contains many repetitive DNA sequences. Jeffries and his colleagues discussed in 1985 that, with the combined use of DNA mapping and Southern Blot, that a highly polymorphic DNA fragmentation pattern can be visualized. It was discovered that the highly variable DNA fragmentation patterns are characteristic of each individual human being, and the same pattern is found in all the cells of an individual. The significance of DNA fingerprinting is that it demonstrates the uniqueness of each human being, even at the first cell stage. (Mark, P.12, Par. 7G.)

8. DNA Sequencing: the currently used rapid sequencing techniques were first developed in 1997. The importance of DNA sequencing is that from the gene code, science can better understand the functioning and development of the human being, including the ability to identify potential sites for DNA methylation. It also helps science determine the difference in genes in order to identify the nature of mutations. (Mark, P. 12-14, Par. 7H.)

9. Polymerase Chain Reaction (PCR): without PCR, DNA could not be analyzed from a single cell. The PCR technique was first invented in 1985 to rapidly amplify a segment of DNA up to a million fold from a very small amount of material. PCR greatly enhanced the ability of science to understand the uniqueness of each human being. (Mark, P. 14, Par. 7I.)

## 2. Science Now Explains The Wholeness and Uniqueness of Every Human Being From Conception

DNA fingerprinting and the refinement of it by polymerase chain reaction (PCR) techniques developed in the mid-1990s have proven that each human being is totally unique immediately at fertilization. Dr. Mark explained that the invention and widespread use of the DNA techniques such as restriction enzymes, DNA cloning, DNA sequencing, and Southern Blotting provided scientists with the ability to clone human DNA and study the organization of the genes encoded by DNA. This resulted in many discoveries in the mid-1980s leading to the finding that individual species DNA bands can be observed as a fingerprint of an individual human being. A child's DNA fingerprint is completely unique.

The invention of the PCR techniques has led to further refinements of the DNA fingerprinting techniques, which has given science the ability to obtain a human being's DNA fingerprinting – and therefore his or her identity – from a single cell.

There can no longer be any doubt that each human being is totally unique from the very beginning of his or her life at fertilization. (Mark, P. 19-21.)

The significance of methylation of cytosine was unknown until 1985. It has a profound significance in understanding the wholeness or completeness of a human being immediately following conception. Cytosine is one of the four base components of DNA. Methylation of cytosine, just as other methods of gene regulation, is a natural method by which genetic information is periodically silenced or activated for purposes of human development. Understanding how the genetic information contained in each human being's DNA is activated and how that information is programmed for life is essential to understanding that the human being is whole and complete at fertilization.

A human being at an embryonic age and that human being at an adult age are naturally the same, the biological differences are due only to the differences in maturity. Changes in methylation of cytosine demonstrate that the human being is fully programmed for human growth and development for his or her entire life at the one cell age. (Mark, P. 21-25.)

Although the material messenger RNA initially present in the fertilized egg can provide the basic functions necessary to transcribe the child's DNA in the initial one or two cell divisions immediately following fertilization, these messenger RNAs are quickly degraded and lost after the first two rounds of cell division, and the housekeeping genes in the child's own DNA are transcribed into messenger RNA at that point. This newly synthesized RNA directs the program of global demethylation of genes so that they can be activated to replenish the functions lost after the degradation of the maternal RNA. Modern molecular biology has discovered that by the third cell division (long before implantation) all control of growth and development are established by the child's DNA. This means that immediately after conception, all programming for growth of the human being is self-contained. (Mark, P. 26.)

At the pre-implantation age, the child synthesizes a platelet activating factor (PAF) (discovered by O'Neil in 1991), beginning at the one cell age, that enhances the child's ability to implant into his or her mother's uterine wall; and at 7.5 days old, before implantation into the uterus, the child begins to produce an enzyme (IDO) that inhibits the mother's immune system from attacking and rejecting the child (discovered by Mann, et al in 1998). (Mark, P. 25-26.)

Molecular biology has also revealed information about chemical reactions within the unborn child that assist the child to adjust to its environment and defend itself from painful stimuli. The role of substance P in pain transmission through activation of a sub-population of the primary afferent c nerve fibers has been recently understood and documented in the 1990s. The presence of substance P, known to be a pain transmitter, was not observed in the human being during gestation until the late 1980s. The discoveries concerning neuropeptides, enkephalin and beta-endorphin, pain modulators, natural pain inhibitors, as found in the unborn child, is discussed in Section II-H of this Report, along with studies done in the 1990s that measured fetal plasma cortical and beta endorphin responses to painful stimuli given to the fetus in utero. (Mark, P. 27, 28, Par. 9 to 11.)

### 3. Developments in Modern Medicine Allow for the Diagnosis and Treatment of the Unborn Child

At the time of *Roe v. Wade*, and for twelve to fifteen years thereafter, it was erroneously believed that neonates, newborn full-term infants, were incapable of feeling pain. (Porter, F. "Pain in a Newborn," *Neonatal Neurology, Clinics in Neonatology*, 16(2) P. 549 et siq (1989). Today modern medicine not only understands that neonates feel pain, but also that the child can feel pain *in utero*.

Likewise, the unborn child today is treated as a separate patient in his or her own right, not only during child birth and delivery, but from the earliest ages of gestation. Today conditions are diagnosed as early as eight weeks post-conception, and surgery is performed on the child at the fetal age of sixteen weeks post-conception, long before the age of so-called "viability", which is generally regarded as 21 to 23 weeks post-conception.

Dr. Mark Rosen, a fetal anesthesiologist, was invited to testify by phone before the Task Force on September 21, 2005. Dr. Rosen is a member of a surgical team headed by Dr. Michael Harrison, who is recognized as the pioneer of modern fetal surgery.

Dr. Rosen explained some of the procedures that are currently performed on the child in utero. He identified procedures installing shunts, blood transfusions, muscle biopsies, and congenital diaphragmatic hernias. We find this new branch of medicine of significance to the undertaking of this Task Force.

Dr. Rosen is also a contributor to Dr. Harrison's pioneering textbook on fetal surgery. ("*The Unborn Patient*", Harrison, M.R., Golbus, M.S., Filly, R.A. (Eds), 2nd Ed. W.B. Saunders,

Phil. 1991.) He wrote a chapter in "*The Unborn Patient"* concerning anesthesiology during fetal surgery. In pertinent part, Dr. Rosen wrote:

> "For fetal surgery, unlike maternal surgery, the fetus is not an innocent bystander for whom we attempt the least anesthetic interference. Instead, the fetus is the primary patient, requiring safe administration of anesthesia and close monitoring of anesthetic effects to ensure well-being."
>
> "A variety of benefits and risks characterize the techniques involved in fetal surgery. For example, the necessity or benefit of fetal anesthesia for surgical intervention is not documented. However, it has been shown that surgical manipulation of an unanesthetized fetus results in various degrees of autonomic nervous system stimulation, variations in heart rate, increased hormonal activity, and increased motor activity. It is also known that later in gestation a fetus will respond to environmental stimuli, such as noises, light, music, pressure, touch, and cold. The presence of fetal anesthesia therefore suggests some benefits and, in conjunction with fetal immobility during a surgical procedure, may be an important goal of fetal anesthesia."[6] ("*The Unborn Patient"*, supra, P. 175-176.)

Harrison's text "*The Unborn Patient"*, is a monument to the reality that the unborn human being is indeed a separate patient in his or her own right. The text devotes eleven chapters to diagnosis of fetal defects before birth. Of interest is the fact that DNA-based tests taken at early ages in utero have been discovered to disclose numerous abnormalities. The DNA analysis has been well-received, for multiple reasons. The DNA analysis can be done from fetal or embryonic samples by amniocentesis or by *first-trimester* chorionic villus sampling, and this testing can be done with any nucleated cell type in any stage of differentiation. ("*The Unborn Patient"*, supra, Chapter 12, P. 82 (citations omitted).)

"*The Unborn Patient"* details numerous conditions of the unborn child that can benefit from surgical intervention. During the procedure, both the mother and fetus are anesthetized, the mother's abdomen is surgically opened, and the uterus incised. While still attached to the umbilical cord, amniotic fluid is drained off the child, and "the surgeon removes the fetus' left arm from the uterus and attaches specially designed fetal monitors."[7] These fetal monitors are for ECG, transcutaneous oxygenation, and temperature readings. The baby is incised surgically, repaired, and placed back into the mother's uterus. The uterus is then filled with warm lactated Ringer's solution and prophylactic antibiotics to replace any lost amniotic fluid.[8]

Fetal heart rate and oxygen saturation monitoring is a norm in these procedures.[9] Some defects that might require this type of surgery include urethral obstruction, congenital

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[6]Section II-H exclusively addresses the ability of the fetus to experience pain.

[7]Levine, A.H. "Fetal Surgery" Aorn, 54 (1991): 17-19, 22-27, 30-32, at P. 30.

[8]Levine, A.H. "Fetal Surgery" Aorn, 54 (1991): 17-19, 22-27, 30-32, at P. 30.

[9]Harrison, M.R.; Langer, J.C.; Adzick, N.S.; Golbus, M.S.; Filly, R.A.; Anderson, R.L.: Rosen, M.A.; Callen, P.W.; Goldstein, R.G.; and deLorimier, A.A. "Correction of Congenital Diaphragmatic Hernia In Utero, v.

diaphragmatic hernia, fetal chylothorax, and sacrococcygeal teratoma (a fetal tumor).[10] After surgery, the child can go on to be delivered at or near full-term.[11]

**4. Children are Surviving Premature Deliveries at Younger Ages**

Dr. Ola Didrik Saugstad, a world renowned neonatologist, submitted a declaration. Dr. Saugstad was honored as the recipient of the Yippo Award, which is given to only one neonatologist in the world, once every five years. He was also selected President of the European Congress of Perinatal Medicine in 2001 and given the prestigious Versinie Apgar prize from the World Perinatal Association. He has treated babies as young as twenty-one weeks post-conception and only one pound in weight.

Dr. Saugstad stated that the field of neonatology has had enormous development in the last two decades. One of the most important advances was the introduction of surfactant therapy. The injection of surfactant into the lungs of premature infants has resulted in improved survival rates of the tiniest infants. In the US, approximately 50% to 60% of infants with gestational post-conception ages of 21 and 22 weeks respectively now survive.

Dr. Saugstad has provided vital testimony in his declaration. We especially find merit in his testimony from pages 7-14. Some of his testimony follows:

> "The anatomical, biochemical, and physiological development of a human being also starts early in fetal life and continues long after birth. Although the fetus is wholly dependent on the mother in order to survive, the extremely premature infant is wholly dependent on its surroundings. Even a term baby is dependent on its surroundings in order to survive. The concept of viability is therefore not as interesting as it seemed only some years ago. It is the same human being whether it is an early embryo, a fetus around midterm (20 weeks) or pre-term born after 23-25 weeks of gestation. The human subject is completely helpless and dependent on its care givers for a long time – from conception until late childhood. The child is a whole separate human being from conception and throughout the full gestational period, whether entirely spent in utero or not."
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> "Suggestions or implications that a woman considering an abortion should be told anything about whether or not the fetus is a human being based upon whether the child is or is not of "viable" age would be misleading. The child is a human being before viability just as well as after viability and, as I previously indicated, viability is irrelevant to that question. There is absolutely nothing that can be told to the woman that is different about a child that is a so called "post

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Initial Clinical Experience" J Pediatric Surg 25 (1990): 47-57, at P. 49.

[10]Harris, M.R.; and Adzick, N.S. "The Fetus as a Patient" *Ann Sur* 213 (1991): 279-291, at P. 281.

[11]Strickland, R.A.; Oliver, W.C.; Chantigian, R.C.; Ney, J.A.; and Davidson, G.K. "Anesthesia, Cardiopulmonary Bypass, and the Pregnant Patient" *Mayo Clin Proc* 66 (1991): 411-429, at P. 413.

viable" age as opposed to one that is "pre viable" age with reference to the pure question of whether as a matter of biological fact, the fetus is a human being."

"I have traveled all around the world and have lectured in many different countries. The laws of those countries vary widely in how those countries view human beings both born and unborn. Whether a particular adult person holds legal or moral beliefs that individual human beings should be treated with equal respect and dignity, or whether there are justifications for treating them differently or be accorded degrees of respect may reflect the culture, but those individual beliefs are totally irrelevant to whether or not it is a human being. Just because in one culture some adult human beings are not treated equally or not even given legal rights, does not mean they are not human beings. Science is oblivious to such concepts."

"It defies all reason to suppose that the relative abilities of the adults or medical professionals at any one point in history or at any one place on earth - external to the child - determines if the child is a member of the human race. If adult care givers are inadequate, their failings do not render one child not human, but another, at the exact same age of gestation, human beings because he or she received proper care. At any one time, children in one part of the world will survive at younger gestational ages than children in other parts of the world because of the difference in the quality of medical services. Those services, administered differently, don't define the humanity of the children. An unborn child in Africa, twenty-one weeks post-conception is just as much a human being as a twenty-one week post-conception child in the United States despite the fact that the African child may not be able to receive the kind of medical services the child in the United States may receive. The African child is not "viable". The American child is. Both are human beings."

"The point at which professionals can provide sufficient medical assistance to help a pre-term baby to survive outside the mother's womb is essentially a study in the abilities of those in medicine, not a statement of the essence or nature of the patient."

"The history of newborn medicine teaches us that the prognosis of sick newborn infants and especially pre-term infants has been dramatically improved over the past century and even in recent decades. It is impossible to know the extent of future developments that might lead to a human being able to live its entire post-conception life apart from the mother."

(Excerpts from Saugstad Declaration, P. 7 to P. 14.)

## 5. Human Embryology

A declaration from the nationally recognized human embryologist, Dr. Bruce Carlson, MD, Ph.D., was made part of the record. Dr. Byron C. Calhoun, a specialist in internal fetal medicine, and President of the American Association of Pro-Life Obstetricians also testified before the Task Force. Both experts provided evidence concerning the gross morphological appearance and functions of the unborn child during the embryonic and early fetal ages of the child.

Dr. Carlson is widely recognized as one of the leading experts in the nation in the field of human embryology. He taught human embryology and anatomy continuously from 1966 to 2004 at the University of Michigan Medical School. He is the author of a text on human embryology (*Human Embryology and Developmental Biology*) that is used in medical schools throughout the United States and many other parts of the world. He has conducted embryology research over the years in different parts of the world including periods in Moscow, Russia, Czechoslovakia, The Netherlands, and Helsinki, Finland.

Dr. Carlson set forth facts about what can be observed about the unborn child from fertilization to 12 weeks post-conception. He testified that it is a scientific fact that an abortion at any age of gestation terminates the life of a living human being.

He stated: "The post implantation human embryo is a distinct human being, a complete separate member of the species *Homo sapiens*, and is recognizable as such." (Carlson, P. 3, Par. 5.) He stated that this statement of biological fact is indisputable, and cautioned that this biological fact should not be confused with moral or philosophical considerations. Dr. Marie Peeters-Ney, an accomplished human geneticist, Dr. Saugstad, and Dr. Mark, also cautioned against this confusion. The Task Force also received the official report of the U.S. Senate Judiciary Subcommittee on Separation of Power after hearing testimony from 24 prominent scientists. That report stated that: "Those witnesses who testified that science cannot say whether unborn children are human beings were speaking in every instance to the value question rather than the scientific question." (Report to the Committee on the Judiciary, United States Senate, made by its Subcommittee on Separation of Power, U.S. Government Printing Office, Washington, D.C. 1981, P. 11.)

Dr. Carlson submitted with his declaration a nine page attachment that sets forth a list of structures from three systems found in the adult human being, the nervous, circulatory, and digestive/respiratory systems, as they have been observed and described in 10 millimeter human embryos, the size of the unborn child at five weeks post-conception. Dr. Carlson's attachment lists approximately 106 components of the nervous system, 63 components of the circulatory system, and about 40 components of the digestive and respiratory systems.

It is noted that the unborn child's heart is beating at three weeks old. The 2003 South Dakota Vital Statistics Report published by the Department of Health reports that in 2003 and 2002, 92% and 95% of all abortions performed in South Dakota were from 5 weeks to fourteen

weeks post-conception. That means that in each of these abortions, the unborn child had 210 components of these three systems visibly in place.

Both Dr. Carlson and Dr. Calhoun explained how the child functions and interacts with his or her environment in utero. The child's heart typically starts to beat at 21 to 22 days old. Soon the baby's heart starts to fold into a structure in preparation of its subdivision into the familiar four chambers of the mature heart. At this age of 22 days, the major blood vessels that enter and leave the heart are visualized. The gut tract is visible by the end of the fourth week, and a recognizable mouth is visible. The brain is forming at a rapid rate. In the fourth week cells of the neural crest migrate throughout the body and form an astounding array of structures, including the sensory and autonomic nerves, pigment cells, and most of the bones and connective tissue of the face and neck. In the head, the earliest recognizable traces of the future eyes and inner ear are readily distinguishable. (Carlson, P. 10-11.)

By the end of the fourth week the unborn child has a highly functional circulation with three sets of blood vessels. The fifth week is characterized by profound changes in almost all organ systems of the human being. The brain becomes subdivided in 5 parts, corresponding to the major divisions of the adult brain, and nerve cells are forming. The eyes have formed a lens, and the nerves in the retina are taking shape. An olfactory placode, the precursor of the organ of smell in the nose is prominent. By the end of the fifth week, the 210 components of the three systems of the human body are observable.

On the first day following fertilization, the human embryo is identifiable as a specific individual human being on a molecular level. At the end of the sixth week, the unborn child is clearly recognizable as a human being even by gross morphological observation.

The sex of the child is also determined at fertilization. During the sixth week after fertilization the unborn child can respond to local tactile stimulation by reflex movements. Spontaneous movements are seen shortly after the completion of the seventh week. During the eighth week the heartbeat is approximately 160 beats per minute. (Carlson, P. 13-19.) A detailed discussion of the neurological development of the unborn child is found in Section II-H dealing with fetal pain.

The Task Force finds that the new recombinant DNA technologies indisputably prove that the unborn child is a whole human being from the moment of fertilization, that all abortions terminate the life of a living human being, and that the unborn child is a separate human patient under the care of modern medicine.

### C. The Societal, Economic, And Ethical Impact And Effects Of Legalized Abortion

The substantial negative impact legalized abortion has had on our society and culture is almost incalculable. In many ways it has deformed our nation. It has created a unique and especially painful exploitation of women. It has subjected women to the unjust and selfish

demands of male sexual partners. It has subjected women to unnecessary risks of psychological and physical injury. It has denigrated the role of a mother as a unique individual because of the unique person she carries. It isolates a woman in her painful loss of her child. It has deprived our country of millions of children.

**1. Societal Effects: Rape Abortions**

Since abortion advocates so often explain the need for legalized abortion by pointing to the pregnancies that result from rape and incest, the Task Force finds that it is appropriate to address this issue.

Dr. J. C. Willke, founder of the Right to Life organization and President of the International Right to Life, testified before the Task Force on September 21, 2005. Dr. Willke noted that only approximately 0.1% of rapes result in a pregnancy. In his book, he writes:

> "We must approach this with great compassion. The woman has been subjected to an ugly trauma, and she needs love, support and help. But she has been the victim of one violent act. Should we now ask her to be a party to a second violent act - that of abortion? Reporting the rape to a law enforcement agency is needed." (Willke, *Why Can't We Love Them Both*, p. 263, 2003). (See Section III of this report for suggested legislation regarding reporting illegal sexual activity.)

Dr. Donald Oliver is a pediatrician who has practiced in Rapid City, South Dakota, for 25 years and who is board certified with the National Board of Medical Examiners and American Board of Pediatrics. In testimony to the Task Force, Dr. Oliver said:

> "I was asked to share some genetic information with you regarding the issue of incest. As many of you are aware, the union of two closely related people may result in an infant with genetic deformities or retardation. That is why in the United States we have laws against close relatives marrying. What you may not be aware of is that deformities and/or retardation occur in the smallest minorities of these instances. Ninety-seven percent of the time, these children are normal."
>
> "Just two months ago, I personally took care of a baby boy born to a very young teenage mother who was allegedly raped by her brother. So here we have the two scenarios brought forth most often by those on the pro-abortion side, rape and incest. This brave young lady carried her child to term and delivered a healthy normal boy. Here is an interesting fact that you may not be aware of. Just as two bad genes might pair up and lead to an unfortunate outcome, two good genes can pair up, and the infant of this incestuous relationship, may become the brightest person in the family—sometimes in the genius range of intellect. They are normal children at least 97 to 98 percent of the time. This young teenage mother that I just spoke of, when she found out she was pregnant, felt that besides herself, the only other really innocent person in this sad situation was her baby, and he

certainly didn't deserve capital punishment for her brother's sins. What great insight for someone so young! I wonder how many employees of Planned Parenthood would have encouraged and supported this young lady's courage to choose life for her newborn son."

**2. General Societal Effects**

It is difficult to comprehend the damage done to a society that so wounds its women, but we can refer to some of the testimonies of women who have been subjected to abortion – not to quantify this damage – but to comprehend its qualities. In doing so, we are compelled to witness their guilt, a guilt they are forced to endure because most of them trusted an abortion provider who told them that their only emotion following an abortion would be "relief."

The nearly 2,000 post-abortive women who provided testimony to the Task Force described this damage to themselves. We find all of these testimonies moving and the following are examples of their expressions of guilt, sadness, and depression:

"It has deeply wounded my spirit; it's murder." (Bate record 1500).

"I grieve the loss of my daughter to the point of almost being suicidal...it has caused emptiness in my life." (Bate record 1502).

"I carry the guilt and shame with me every day." (Bate record 1518).

The impact this pain, sadness, and anger has on our society is difficult to measure. We know it results in parenting problems, substance abuse, problems with relationships and personal issues, and sexual dysfunction. (See Section II-E.) The focus we place on the experiences of women harmed by abortion is appropriate because in many ways it is only now that we are realizing in an appropriate way, the magnitude of the injustice of abortion. For most of us, the injustice to the child has long been apparent; but we have never before seen the magnitude of the injustice to the mothers as witnessed from their personal testimonies.

We do not know the cost of abortion to our society, in the form of the lack of productivity of the women, but we fear it is far greater than we can imagine.

We do not know the cost to our society of losing the children who die in abortions, but we fear that the loss of their talent, productivity, and their love for their families and companionship with their mothers is far too great for us to imagine.

We do not know the cost to our society by the shattered and broken relationships caused by abortion, and the anger and pain resulting from abortion, but we fear it is far worse than what we are able to comprehend.

What we do know, and what we can say, is that abortion is unethical and immoral and our support of it as a society wounds all of us. It exploits the mother, destroys her rights, destroys her interests, and damages her health, and does so by killing her child. It isolates her in her pain by placing all of the blame for the loss of her child upon her. It kills an innocent human being, and in the process creates the illusion that a mother and her child – who in reality have interests in harmony with each other – are somehow enemies. It portrays life, the greatest of gifts, as an intruder of no worth. It portrays the role of mother as valueless.

### 3. Economic Effects

Former South Dakota State Representative Matt McCaulley, an attorney in Sioux Falls, presented graphs to the Task Force that showed the decrease in the number of school-age children in the state as a result of legalized abortion from 1973. By 1996, the cumulative effect of legalized abortion in the state was the loss of over 13,000 annually in the South Dakota K-12 school systems, and this number has remained at over 13,000 fewer students annually for the period 1996-2003. Declining enrollment is a major problem for our K-12 school system. We cannot begin to estimate the earnings and other contributions that these citizens would have made to our State.

### 4. Ethical Impact

Perhaps the greatest cost to society, and our state, is that of our slide into a culture of neglect and abuse of our role as protectors of the natural and intrinsic right of our citizens. We are a nation founded upon principles of equal rights for all and the recognition that the role of government is to protect all human beings in their natural rights.

Legal abortion – as the embodiment of the assertion that the constitution provides protection for a doctor who performs an abortion – has transformed our nation to one that subjects its mothers and children to the pain and injustice of abortion. This Task Force is unable to quantify the cost of this transformation in terms of measure. We can only try to understand its nature and we find that the tears of the women who have given us their testimonies best help us to understand.

## D. The Degree To Which Decisions To Undergo Abortions Are Voluntary And Informed

The pregnant mother, in virtually every instance, considers having an abortion because she, or others in her life, believes that her circumstances render the *timing* of motherhood – *not motherhood itself* – inconvenient or undesirable.[12] And while an abortion succeeds in

[12]The 2003 South Dakota Vital Statistics Report of the South Dakota Department of Health reports that among the 819 abortions performed in South Dakota in 2003, in only 16 cases (2%) was it reported that a reason for the abortion was because the mother "would suffer substantial and irrevocable impairment of a major bodily function if the pregnancy continued." Since no description of what condition was asserted, it is impossible to know

postponing motherhood, it also, as discussed above, destroys the already existing relationship the mother has with her child. That interest enjoys substantial legal protections in other contexts and our public policy is based upon the recognition that this interest of a mother is fundamental in nature and involves an intrinsic natural right. Both South Dakota Law[13] and Federal Constitutional Law[14] recognize this right of the mother.

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whether such a threat actually existed in any of these 16 cases. (Report P. 70.) In 525 cases the box checked on the state-provided reporting form stated "The mother did not desire to have the child." The underlying reasons are not recorded. In 366 cases the box checked stated "The mother could not afford the child." Combined, these two reasons appear a total of 891 times. The 891 entries are greater than the total number of abortions because the women are permitted to list more than one reason for submitting to an abortion. However, the information on these forms is, in some ways, incomplete. For instance, there is no box that offers the woman the opportunity to explain that the reason she submitted to an abortion was because the baby's father or someone else placed demands upon her. Likewise, there is no box that indicates she has reached her decision because she feels she does not have enough time to explore other options.

[13]South Dakota law has strong policies to protect against uninformed or involuntary waivers or surrenders of a pregnant mother's relationship with her child. For instance, under South Dakota's adoption statutory scheme, the petition which represents the waiver by a mother of her rights cannot be filed, at the earliest, until five days after the birth of her child. S.D.C.L. 25-5A-4. The petition must set forth the reasons why the mother wants to give up her rights, and an express written consent to the termination of her rights. S.D.C.L. 25-5A-6 (5) & (7). To help insure that her decision is informed, the law requires that the mother receive counseling from an adoption agency, South Dakota Department of Social Services, or a private counselor before she consents to terminate the rights. S.D.C.L. 25-5A-22. The counselor must determine that the waiver of rights is voluntary without undue influence of others; that all other alternatives were examined; must explain likely emotional losses involved; must disclose the legal right to counsel; must discuss the permanent consequences of the decision; and must make an assessment of the ability of the parent to understand the consequences. S.D.C.L. 25-5A-23. This counseling must take place at least fifteen days before the mother petitions the court. A report must be submitted to the court certifying that all of these matters were discussed with the mother and the mother must sign a statement verifying that she understood the counseling. S.D.C.L. 25-5A-24. The court must then hold a hearing before it can terminate the mother's rights. S.D.C.L. 25-5A-9. Although the statute does not expressly set out the requirement, the Supreme Court of South Dakota has consistently recognized that the court must determine that the consent is knowing, informed and voluntary. *See, e.g., Matter of D.D.D.*, 294 N.W.2d 423, 426 (1980). *In the Matter of J.M.J.* 368 N.W. 2d 602 (S.D. 1985), the S.D. Supreme Court ruled that a judgment terminating a mother's rights should be vacated, even if the court held that her decision was informed and voluntary, if the record does not support the court's finding. The mother's rights are further protected by law which allows the mother under certain circumstances to withdraw her consent. In *Matter of Everett*, 286 N.W.2d 810 (1979). Thus, in the adoption context a mother must be fully counseled about other alternatives, can not terminate her rights until after the birth of her child, and her rights cannot be terminated except by a court order entered by a judge following a hearing in which the court concludes, upon an adequate record, that the mother's waiver of her rights was informed, knowing and voluntary.

[14]The relationship between a mother and her child is a fundamental liberty interest protected by the United States Constitution. *Santoski v. Kramer*, 455 U.S. 745 (1982). It is perhaps the oldest of the fundamental liberty interests. See, *Trowel v. Granville*, 530 U.S. 57 (2000); *Meyer v. Nebraska*, 262 U.S. 390, (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). This liberty interest has its source "in intrinsic human rights, as they have been understood in 'this Nation's history and tradition.'" *Smith v. Organization of Foster Families*, 431 U.S. 816 (1977) (quoting *Moore v. City of East Cleveland*, 431 U.S.494 (1977)). The interest protected is the interest in the existing relationship. *Compare Stanley v. Illinois*, 405 U.S. 645 (1972); *Caban v. Mohammed*, 441 U.S. 380 (1979) with *Quilloin v. Alcott*, 434 U.S. 246 (1978); *Lehr v. Robertson*, 463 U.S. 248 (1983). In contrast to the cases involving fathers, the mother's interest in her relationship with her child has always been protected as fundamental. This is because "the mother carries and bears the child, and in this sense her parental relationship is clear." *Lehr, supra*, 463 U.S. at 260 & n.16 (quoting *Caban, supra*, 441 U.S. at 397 (dissent by Stewart, J.)).

In making a decision of whether to undergo or forego an abortion procedure, the mother must also make a decision about the welfare of her child. The right to do so has been recognized as a constitutionally protected fundamental right. (*Meyer v. Nebraska*, 262 U.S. 390 (1923); *Troxel v. Granville*, 530 U.S. 57 (2000); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925).)

Informed consent disclosures about the existence of the child are key because they not only establish the right of the pregnant mother in her relationship with her child, but also her right to protect the child's welfare.

And while the primary purpose of abortion is not medical in nature (the mother does not have an adverse medical condition that requires treatment), it requires a medical procedure. Dr. Stanley Henshaw, Ph.D., a science fellow at the Alan Guttmacher Institute (long associated with Planned Parenthood Federation of America), testified that an abortion provides no medical benefits for the woman who submits to one.

However, because a medical procedure is involved, the policies and laws dealing with informed consent to medical treatment and procedures are directly implicated and applicable. South Dakota employs the common law "Reasonable Patient Standard" of disclosure, under which a physician has a duty to disclose all facts about the nature of the procedure, the risks of the procedure, and the alternatives to the procedure. (See, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (explaining the Reasonable Patient Standard of disclosure); *Weeldon v. Madison*, 274 N.W. 2d 367, 374 (S.D. 1985) (South Dakota Common Law adopts the *Canterbury* standard); see also *Savold v. Johnson*, 443 N.W. 2d 656 (S.D. 1989) (applying *Weeldon*, and *Canterbury*).)

Usually, where a medical procedure is performed, the disclosures about the alternatives relate to alternative medical treatment. However, since in at least 98% of the cases there is no underlying medical condition in need of treatment, the alternatives are non-medical in nature. Essentially, the alternatives for the pregnant mother are to (1) exercise her right to keep her child and raise her child herself or (2) to delay the decision of whether to keep the child by carrying the child to term, gather information about what is best, and decide whether adoption is a better choice for her and her child.

Gail Dirckson, Social Worker with Bethany Christian Services of Sioux Falls, South Dakota, and Sister Mary Carole Curran, Ph.D., ABPP, Executive Director of Catholic Family Services of Sioux Falls, South Dakota, provided extensive testimony of the opportunity for, and merits of, both open and closed adoptions in South Dakota as a healthy and rewarding alternative.

Therefore, in determining whether decisions to undergo abortions are voluntary and informed, we must consider whether adequate information is given and procedures carried out to protect the right of the pregnant mother in her relationship with her child, her right to protect the child's welfare, and her right to protect her own health.

## 1. The Mother's Decisions to Give Up Her Right to Her Relationship with Her Child and Her Right to Protect Her Child's Life are Often Not Informed and/or Voluntary

Both Ms. Looby and Dr. Ball testified that abortions in South Dakota are voluntary and informed. Lynn Paltrow, an attorney and Executive Director of National Advocates for Pregnant Women, testified before the Task Force. Ms. Paltrow contended that South Dakota's 1994 abortion informed consent statute, and the informed consent statutes of other states, impose counseling and informational requirements "far beyond those required prior to other medical procedures." She believes that these statutes result in a "super" or "ultra" voluntary decision. Their reasoning and conclusions were unsupported by the objective evidence before the Task Force.

In fact, we find that an examination of the facts supported by virtually all of the credible objective evidence, compels the opposite conclusion. In the overwhelming majority of cases, the decision to submit to an abortion is uninformed. Further, there are many pressures and coercive forces and elements, including some that are hidden and inherent in the nature of the procedure, that render most abortions not truly voluntary.

The total record reflects the following:

a. The abortion providers fail to disclose the essential nature of the procedure – that it terminates the life of the woman's existing child;

b. When they do discuss the procedure, they provide misleading information in misleading terms, as previously discussed in this Report;

c. The abortion providers give misleading information about the psychological and physical risks to the mother, and do not disclose the direct injury to the child that leads to its death;

d. The abortion providers assume the women have made their decisions before they reach the facility;

e. The abortion providers place the burden upon the mothers to discover material facts on their own;

f. The abortion doctor's only contact with the mother prior to the abortion surgery consists of a pre-recorded audio tape, and the first face-to-face meeting of the doctor and pregnant patient is after she has signed the consent forms, paid for the surgery, and is on the procedure table (See Section II-A);

g. The pregnant mothers are often pressured into having an abortion by outside forces;

h. The contact and procedures by the facility personnel prior to the abortion are inherently coercive and force a quick decision; and

i. The fatal and irrevocable nature of the decision is not made known to the mother and adequate time for reflection is not provided.

As was detailed in Section II-A of this report, abortion providers in South Dakota fail to disclose anything at all about the unborn child. The only information given to 814 out of 819 pregnant women who were subjected to an abortion at the Planned Parenthood facility in 2003 was the age of the pregnancy. Women are not told that the procedure kills their already existing child. In fact, Dr. Ball stated that at Planned Parenthood, *even if a woman asks* whether the child exists or not, she will not answer her.

This failure is critical to the women's decision, because when information about the child is given to women at pregnancy help centers, it is reported that 85% to 98% of the women decide to not have an abortion.[15] If given, the disclosures would protect the mother's interest in her relationship with her child and her right to protect her child's life.

The Task Force also received powerful oral and written testimony from about 1,950 women who underwent abortions. Virtually all of them stated they thought their abortions were uninformed or coerced or both. They gave many different reasons, but there were also some common reasons. A majority of these women stated that they were not told the truth that the abortion would terminate the life of a living human being, and if they had been, they would not have submitted to the procedure because of their sense of duty and their relationship with the child.

Examples of this kind of testimony are found throughout the record. Lisa Strafford testified:

> "If I had known that there was an existing living human being whose life would be terminated, I would have factored that into my considerations, and I surely would not have submitted to the procedure, and I would not have consented to it." (Strafford Declaration, Par. 8.)

Ms. Strafford stated the reasons for her having her abortion would not have been sufficient to outweigh other considerations if she had known the procedure would terminate the life of an existing human being. This assertion was proven true when Ms. Strafford became pregnant a second time while still in college. The circumstances that led her to seek an abortion when she discovered her first pregnancy were exactly the same with the second: she was a college student,

[15]It appears that, in contrast to the pregnancy help centers, virtually every pregnant woman who arrives at an abortion clinic submits to an abortion. Unfortunately, there are no record-keeping requirements with respect to the number of women who decide not to have an abortion at an abortion facility. There is a need for reporting requirements in this regard.

unmarried, and having a child would have interfered with her studies. However, with her second child, she obtained information about her unborn child from a pregnancy help center before she went to the abortion clinic, and she decided against an abortion. She stated:

> "The most critical and important fact was the information I was given indicated that the child was already in existence and that the procedure wasn't going to somehow prevent a human being from coming into existence." (Strafford Declaration, Par. 12.)

Ms. Strafford explained that she then carefully examined the possibility of giving up her rights to adoption, but at the end of the pregnancy – having been given five or six months to examine all of the options and her feelings about them – she decided to exercise her right to keep her child and raise her son who is now 12 years old.

The testimony of the nearly two thousand women who had abortions is replete with references to how they were left to fend for themselves and allowed to make decisions based upon false assumptions of biological fact. The abortion providers wanted the women to make decisions about those biological facts themselves even though they had no expertise. Dr. Ball repeatedly stated that she wouldn't disclose biological facts about the fetus even if the women asked about them.

In addition, the doctor who proposes to terminate the life of a woman's child has authority to do so only after obtaining the consent from the child's mother. For that authority to be valid, the mother must understand exactly what the doctor is proposing to do.

The Task Force therefore finds that the deliberate avoidance of a candid understandable disclosure that the child already exists and that the procedure will terminate the child's life, precludes an informed decision with regard to the woman's right to a relationship with her child and right to protect her child's life.

With regard to whether a woman's decision to have an abortion is voluntary, women have reported that they have submitted to abortions against their own desires because they felt pressured into the decision by the father of the child, or their parents, or other family members. Some studies demonstrate that more than half of the fathers of aborted children urged the mother to have an abortion upon first learning of the pregnancy. (Shostak, A. Et al, *Men and Abortion, Lessons, Losses and Love*, New York, Proejer (1981); Lien-Mak, F., et al, "Husbands of Abortion Applicants: A Comparison with Husbands of Women Who Complete Their Pregnancies" in *Social Psychiatry*, 14: 59-64 (1979). See also, Rue, V., "Abortion in Relationship Context" in *International Review of Natural Family Planning*, 9: 95-121 (1985).)

The process that takes place immediately before the abortion procedure also creates a coercive environment. The record reflects that women are pressured into making the decision

quickly. And once they arrive the day of the scheduled abortion, the process moves ahead without time to reflect.[16]

Another substantial problem is the fatal nature of the procedure. It is completely irreversible. The record is replete with women describing how they wanted to change their mind once the procedure was started. In some cases they begged the abortion doctor to stop, but they were told it was too late. The totally irreversible nature of the decision requires the need for complete and candid disclosures.

The Task Force finds that women are often subjected to coercion in the form of overt and subtle pressures from outside sources and from the abortion procedure itself that render their decision involuntary.

**2. The Mother's Decision To Submit To A Medical Procedure That Puts Her Health At Risk Is Often Not Informed**

The pregnant mother has an interest in her own health, and thus has a substantial interest in receiving accurate and full disclosure about the psychological and physical risks of abortion. This interest enjoys constitutional protection. (*Doe v. Bolton*, 440 U.S. 179 (1973).)

The substantial mental and physical health risks of the abortion procedure are discussed in Section II-E of this Report. We find that virtually none of the risks are disclosed to the pregnant mother. In fact, in South Dakota, based upon the admissions of Dr. Ball, Ms. Looby, and the agents of Planned Parenthood, the abortion providers make misrepresentations of fact to the women. Among these misrepresentations are the following:

1. "Early abortion by vacuum aspiration is one of the safest procedures in all of medicine."

2. "A legal abortion, as it is performed in the United States today, is a very safe procedure and complications are rare."

3. "The emotion most women experience after having had an abortion is relief."

4. "Women may have some mixed feelings at this time but emotional problems after abortion are uncommon, and when they happen, they usually go away quickly."

5. "Serious long-term disturbances after abortion appear to be less frequent than after childbirth."

[16] In contrast, with adoptions, the mother does not make a decision until after birth when she has had an opportunity to see and hold her child and the reality of what she is giving up is concrete. And special court proceedings are mandatory to ensure that her decision is voluntary and informed.

6. "The risk of dying from a full-term pregnancy and childbirth is at least seven times greater than that from early abortion."

The Task Force finds that the abortion providers fail to make disclosures they should make, make affirmative representations that are inaccurate, and misrepresent the risks of pregnancy and childbirth, all to the detriment of the pregnant woman and her ability to reach an informed decision.

## E. The Effect And Health Risks That Undergoing Abortions Has On The Women, Including The Effects On The Women's Physical And Mental Health, Including The Delayed Onset Of Cancer, And Her Subsequent Life And Socioeconomic Experiences

The Task Force received and reviewed testimony from a number of distinguished experts in the field of obstetrics and gynecology (Dr. Elizabeth Shadigian and Dr. Ann Davis), sociology (Dr. Stanley Henshaw), psychiatry (Dr. Martha Shupping), psychology and human relations (Dr. Priscilla Coleman and Dr. Vincent Rue), medical ethics (Dr. David Reardon), public health (Marie Harvey), and human biology (Dr. Joel Brind). Most powerful, however, was the vast amount of testimony received into the record from post-abortive women who were willing to publicly share their experiences. After reviewing the lengthy and considerably referenced materials and testimony presented, the Task Force finds that there is a substantial discrepancy between current medical and psychological information and the medical and psychological information conveyed by abortion facilities (including Planned Parenthood of South Dakota) to their abortion patients.

### 1. Mental Health Effects

Dr. Priscilla Coleman is an Associate Professor of Human Development & Family Studies at Bowling Green State University in Ohio. She is a nationally and internationally recognized expert in the mental health risks of induced abortion, having conducted numerous scientific studies on this issue. The Task force finds the testimony she provided informative, comprehensive, and credible.

Dr. Coleman noted that many women have difficulty making a reasoned decision of whether or not to submit to an abortion. This ambivalence affects post-abortion adjustment. Studies she cited indicated that 1/3 to 1/2 of women considering abortion experience decision-making difficulty. (Husfeldt, 1995; Kero, 2001.) The decision conflict experienced by many women contemplating abortion is likely based on interpersonal, biological, moral, and spiritual factors. The ambivalence is often due to competing considerations and the fact that others are urging her to have an abortion she would prefer not to have. According to her and her colleagues' research, guilt is a commonly identified problem after an abortion, with estimates of half of the women experiencing this feeling. Thus, the choice to abort may frequently conflict

with firmly held beliefs and values and result in conflicted decision-making, as well as difficulties coping after the abortion.

When a decision involves a violation of one's conscience, regression in cognitive functioning enables women to cope with the decision. Coleman cited studies indicating that abortion-related reasoning in young women is significantly lower than their general reasoning abilities. There can be no doubt that a pregnant mother considering an abortion is under stress, in crisis, and is vulnerable to the suggestions of others. However, after the stressfulness of the decision and the procedure have ended, women's cognitive abilities return to normal, often ushering in feelings of pronounced guilt, sadness, and regret.

Dr. Coleman noted that the literature on the psychological effects of abortion conducted over the last several decades indicates that a minimum of 10-20% of women experience adverse, prolonged, post-abortion reactions. This translates into at least 130,000 to 260,000 new cases of serious mental health problems each year in the U.S.

In conducting research on the adverse mental health effects of abortion, Dr. Coleman emphasized to the Task Force that methodological weaknesses have been common in the body of post-abortion literature. Newer studies improve on the research defects seen in these older studies and are more methodologically rigorous.

In her testimony, Dr. Coleman provided a table summarizing 12 studies she and colleagues have published since 2002. She emphasized the fact that these studies were designed to address the shortcomings of earlier research in order to provide more reliable and valid results. Among the collective strengths of the studies are: (a) the use of an appropriate control group (unintended pregnancy carried to term); (b) controls for pre-existing psychological problems; (c) controls for third variables associated with the choice to abort; (d) use of prospective (as opposed to retrospective) data collection strategies; (e) use of medical claims data (with diagnostic codes assigned by trained professionals); and (f) use of large samples (most in the thousanda and many nationally representative).

Dr. Coleman highlighted key results of these studies and the Task Force finds the following mental health outcomes:

1. Based on methodological improvements characterizing these studies, prior works indicating that abortion is an emotionally benign medical procedure for most women are invalid and little reliance can be placed upon them;

2. In all the analyses conducted, women with a history of abortion were never found to be at a lower risk for mental health problems than their peers with no abortion experience;

3. Women with a history of induced abortion are at a significantly higher risk for the following problems: a) inpatient and outpatient psychiatric claims, particularly

adjustment disorders, bipolar disorder, depressive psychosis, neurotic depression, and schizophrenia; b) substance use generally, and specifically during a subsequent pregnancy; and c) clinically significant levels of depression, anxiety, and parenting difficulties;

4. When compared to unintended pregnancies carried to term and other forms of perinatal loss, abortion poses more significant mental health risks; and

5. Cross-cultural data call into question the often-voiced view that psychological problems associated with abortion are socially constructed, as women living in a culture where abortion is normative and a much less volatile social issue, have been found to also suffer psychological effects of abortion.

The results of the four largest record based studies in the world have consistently revealed that women with a known history of abortion experience higher rates of mental health problems of various forms when compared to women without a known abortion history. (Coleman et al., 2002a: David et al., 1981; Ostbye et al., 2001; Reardon et al., 2003.) The two studies conducted in the U.S. (Coleman et al., 2002a; Reardon et al., 2003) used data from over 54,000 low-income women on state medical assistance in California. Women who had an abortion in 1989 with possible subsequent pregnancies had significantly higher rates of outpatient psychiatric diagnoses than women who gave birth. This difference was apparent when data for the full time period were examined (17% higher) and when only data from women with claims filed on their behalf within 90 days (63% higher), 180 days (42% higher), 1 year (30% higher), and 2 years (16% higher) of the pregnancy event were considered. Data using the same sample and focusing on inpatient claims revealed similar findings.

Specific negative effects of abortion reported include the following:

1. **Guilt**. For women who believe that they have consented to killing a human being, the burden of guilt can be unbearable. The percentage of women reporting guilt associated with an abortion has been found to range from 29.7% to over 75%.

2. **Post-abortion anger and resentment.** Self-directed anger is a logical consequence if abortion violates an individual's conscience. Externally projected anger often results from an abortion decision that is the product of coercion from others, or a decision based upon misinformation by the abortion provider. In a study by Kero (2004), abortion-related anger was reported by 13% of a sample as they faced the abortion, and 14% one year later.

3. **Anxiety.** Women who submitted to an abortion experienced anxiety in various ways, including feelings of tension, physical responses (dizziness, pounding heart, upset stomach, headaches), worry about the future, difficulty concentrating, and disturbed sleep.

Dr. Coleman cited an extensive review by Bradshaw and Slade (2003), wherein the authors concluded that 30% of women who abort experienced clinical levels of anxiety and/or high levels of general stress.

In a study by Cougle, Reardon, and Coleman (2005) using data from the 1995 National Survey of Family Growth, women who aborted an unintended pregnancy, when compared to women who carried an unintended pregnancy to term, were 34% more likely to experience Generalized Anxiety Disorder. This study is particularly noteworthy because women who reported a period of anxiety before their first pregnancy were excluded from the analyses.

4. **Posttraumatic Stress Disorder (PTSD).** Individuals with PTSD experience symptoms of avoidance (efforts to escape from reminders of the event), intrusion (unwanted thoughts, nightmares, and flashbacks related to the event), and arousal (exaggerated startle reflex, sleep disturbance, irritability) for a month or more following exposure to a traumatic event.

   In a study led by Rue, 14.3% of Americans sampled, and just under 1% of the Russian women sampled, met the full diagnostic criteria for PTSD.

5. **Psychological numbing.** People who experience extreme psychological distress will sometimes respond by avoiding future situations likely to cause emotional upset, and they experience a restricted range of emotions.

   Rue and colleagues (2004) found that 12% of the American women and 3% of the Russian women reported feeling emotionally numb as a direct result of the abortion.

6. **Depression.** Many women with a history of abortion will experience symptoms of depression including the following: sad moods, sudden and uncontrollable crying episodes, low self-esteem, sleep, appetite, and sexual disturbances, reduced motivation, and disruption in interpersonal relationships.

   In a recent study led by Reardon (2003), employing a nationally representative, racially diverse sample, controlling for prior psychological state and several other variables, as well as an extended time frame, women whose first pregnancies ended in abortion were 65% more likely to score in the "high risk" range for clinical depression, compared to women whose first pregnancy resulted in a live birth.

7. **Suicidal ideation.**

8. **Substance abuse.** Accumulating evidence indicates that abortion increases the risk for substance use post-dating the procedure. Dr. Coleman cited several

studies, which are also summarized in a review paper she recently published in *Current Women'sHealth Reviews.* A few examples are provided below.

Reardon and Ney (2000) found that among women with no prior history of substance abuse, those who aborted, when compared to those who continued to term, were 4.5 times more likely to report subsequent substance abuse. Eighty-nine percent of the women reported the onset of substance use to be within three years of the abortion.

Using data from a nationally representative sample, Coleman and colleagues (2002) published a study in the *American Journal of Obstetrics and Gynecology* indicating that pregnant women with a prior history of abortion, compared to women without a history, were 10 times more likely to use marijuana, 5 times more likely to use various illicit drugs, and twice as likely to use alcohol.

In a paper published in the *American Journal of Drug and Alcohol Abuse,*using data from the National Longitudinal Survey of Youth, Reardon, Coleman, and Cougle (2004) found that women who aborted were twice as likely to use marijuana, and reported more frequent use of alcohol, after controlling for age, race, marital status, income, education, and prior psychological health.

9. **Relationship problems.** The stress associated with an abortion can cause strain on intimate relationships. Studies have specifically found that abortion is related to an increased likelihood of sexual dysfunction, communication problems, and other relationship difficulties, including separation or divorce. For example, Rue et al. (2004), found that 6.2% of the Russian women and 24% of the American women sampled reported sexual problems that they directly attributed to a prior abortion. In a review, Bradshaw and Slade (2003) concluded that 10-20% of women experience sexual problems in the early weeks and months after an abortion, while 5-20% of women report sexual difficulties a year later.

10. **Parenting**. Research suggests that emotional difficulties and unresolved grief responses associated with perinatal loss may hinder effective parenting by reducing parental responsiveness to child needs, interfering with attachment processes, instilling anger, which is a common component of grief, or by increasing parental anxiety about child well-being. A study recently published in Thailand revealed that 43.2% of the women sampled experienced moderate to severe grief 2 weeks post-abortion.

In a study published by Coleman and colleagues (2002) in the *Journal of Child Psychology and Psychiatry and Allied Disciplines*, using a nationally representative sampling, the results indicated lower emotional support in the home among first-born children ages 1-4 of mothers with a history of abortion, and second- and third-born children ages 1-4 of divorced mothers experienced

lower levels of emotional support than children of non-divorced women. Decreased emotional support was not observed among children of divorced women with no history of abortion.

In a second study published in *Acta Pediatrica*, Coleman and colleagues (2005) found that compared to women with no history of induced abortion, those with one prior abortion had a 144% higher risk for physical child abuse, but a history of one miscarriage/stillbirth was not associated with increased risk of child abuse.

Dr. Marie Harvey testified before the Task Force. She is a professor of Public Health at Oregon State University and Director of the Research Program on Women's Health at the University of Oregon. She has worked in the area of reproductive health for women for over 25 years, including providing abortion counseling. Dr. Harvey is an active proponent of the view that abortion does not cause psychological harm in women. Dr. Harvey expressed the view that "deliberate disinformation" is spread for ideological reasons, though she cited no research to corroborate her opinion. Dr. Harvey also testified that (1) early in pregnancy maternal fetal attachment is not relevant and (2) maternal fetal attachment is not a reality because studies have not been able to measure it, despite widespread personal experiences of mothers.

With respect to informed consent, Dr. Harvey testified: "Because the decision to continue or to terminate the pregnancy is a very complex one, it's critical that women be provided comprehensive and accurate information about their options. Information should be consistent with current medical and psychological science and based on findings from the most rigorous and objective studies. It is critical that women not be given misinformation about the mental health consequences of having an abortion."

Dr. Harvey testified, as well, that major medical and mental health professional organizations support her belief that post-abortion depression is without foundation in scientific studies. Her belief is that if the American Psychological Association (APA), for example, concludes that abortion has no lasting or significant health risks, that this determination is made by an objective scientific organization of psychologists.

The Task Force is aware that the APA has submitted various amicus briefs before the U.S. Supreme Court supporting abortion rights and in opposition to any abortion regulations, including parental involvement in a minor child's abortion decision making. Further, the APA's position does not represent that, of the majority of its membership, but rather, the opinions of a group of members on various committees of interest. It has also advocated and supported other controversial positions on homosexuality and redefining child sexual abuse.

Dr. Harvey also believes that in post-abortion research, association does not mean causation and that women should therefore not be advised of any possible adverse emotional outcomes. We do not find this position credible, as it contradicts her earlier opinion. Clearly in the public interest, consistent association, controlling for associated variables, and time order preceding the outcome, all suggest a strong likelihood of harm. The Task Force recognizes and

takes notice that other public health interests, such as smoking and cancer, are based upon correlational data and that the correlative studies are considered predictive of adverse outcome. The Task Force, based on other evidence and testimony, fails to concur with Dr. Harvey's conclusions.

Dr. Martha Shuping is a psychiatrist and conveyed the wealth of many years of clinical experience treating patients suffering from negative effects of abortion. The Task Force finds her testimony persuasive due to her training, psychiatric practice, and research. Her experiences are consistent with the broad range of adverse psychological symptoms described by Dr. Coleman in her review of the literature. Dr. Shuping contended that the source of much of the psychological suffering evidenced in the lives of women who have aborted can be traced to the biologically based attachment processes that occur during pregnancy.

Further, the Task Force finds that the pre-abortion counseling provided often does not prepare women who have abortions for the psychological outcomes they may experience after their abortions. In addition, women who receive little or no information about possible emotional health risks of this procedure may significantly compromise their mental health and the quality of their lives for years to come. Due to the very limited information disclosed by abortion providers, women are not fully aware that abortion carries with it the potential to damage their physical, emotional, interpersonal, and spiritual well-being.

Perhaps worse, the pregnant mother is not told prior to her abortion that the procedure will terminate the life of a human being. The psychological consequences can be devastating when that woman learns, subsequent to the abortion, that this information was withheld – information that would have resulted in her declining to submit to an abortion. Her anger at being deceived and being prevented from making an informed decision for herself is exacerbated by her realization that she was implicated in the killing of her own child in utero. Aside from the injustice of her being deprived of making her own informed decision (see Section II-D), the psychological harm of knowing she killed her child is often devastating.

This very phenomena was recognized and acknowledged by the U.S. Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992):

> "Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman appreciates the full consequences of her decision, (by requiring the doctor's disclosure) the state furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."

The Task Force finds that it is simply unrealistic to expect that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering

significant psychological trauma and distress. To do so is beyond the normal, natural, and healthy capability of a woman whose natural instincts are to protect and nurture her child.

**2. Physical Health Risks**

The record reflects that abortion places women at increased risk of physical injury including the risk of: infection, fever, abdominal pain and cramping, bleeding, hemorrhage, blood transfusion with its subsequent risks, deep vein thrombosis, pulmonary or amniotic fluid embolism, injury to the cervix, vagina, uterus, Fallopian tubes and ovaries, bowel, bladder, and other internal organs, anesthesia complications (which are higher with general anesthesia), failure to remove all the contents of the uterus (leaving behind parts of the fetus/baby or placenta), need to repeat the surgery, possible hospitalization, risk of more surgery such as laparoscopy or exploratory laparotomy, possible hysterectomy (loss of the uterus and subsequent infertility), allergic reactions to medicines, mis-diagnosis of an intrauterine pregnancy with a tubal or abdominal pregnancy being present (which necessitates different treatment with medicines or more extensive surgery), possible molar pregnancy with the need for further treatment), emotional reactions (including but not limited to depression, guilt, relief, anxiety, etc.) death of the woman, and risk of a living, injured baby.

The record reflects that abortion places women at increased risk of other long term physical injury including placenta previa (a condition that necessitates a c-section and has higher rates of complications) and pre-term birth in subsequent pregnancies (births before 37 weeks gestation, many of which require neonatal intensive care unit stays for babies and higher rates of death).

Dr. Elizabeth Shadigian is an associate professor of Obstetrics and Gynecology at the University of Michigan Medical School. She presented testimony that addressed physical complications associated with abortion, noting that approximately 10% of women undergoing induced abortion will suffer immediate complications, of which approximately one fifth (or 2%) are considered life threatening. Rates of complications increase with greater gestational age of the pregnancy.

In the most recent edition of medical opinions set forth by the American College of Obstetricians and Gynecologists (Compendium of Selected Publications, 2005, Practice Bulletin #26), ACOG states: "Long-term risks sometimes attributed to surgical abortion include potential effects on reproductive functions, cancer incidence, and psychological sequella. However, the medical literature, when carefully evaluated, clearly demonstrates no significant negative impact on any of these factors with surgical abortion." The Task Force disagrees with this statement due to other testimony and materials.

The National Center for Health Statistics provides maternal mortality information and the Center for Disease Control provides abortion mortality statistics. Planned Parenthood continues

to cite statistics issued by the CDC to claim that "the risk of dying from a full-term pregnancy and childbirth is at least seven times greater than that from early abortion."

The Task Force finds this statistic to be false and very dangerous for women who rely upon it. The CDC statistics are not a reliable basis for determining death rates due to abortion, and the U.S. Department of Health and Human Services has expressly stated that their statistics should not be used for that purpose. These statistics grossly understate death due to abortion for a variety of reasons. Although the fact that it is a department of federal government implies an aura of authenticity, the CDC is not funded, or under any mandate, to obtain comprehensive and accurate data on deaths due to abortion. The limited data it does supply is not intended to be used the way Planned Parenthood uses it.

Second, the statistics for maternal mortality rates issued by the National Center for Health Statistics cannot be compared with the incomplete statistics for death due to abortion issued by the CDC because the standards and methods of data collection used by these two systems are very different. The Department of Health considers the data on death due to maternity as highly reliable, while the data from the CDC concerning death due to abortion is unreliable and grossly understated.

Specifically, when a death is violent, a recent abortion is virtually never mentioned. The CDC confines the definition of maternal death to those occurring during pregnancy or within 6 weeks of the termination of pregnancy. In addition, coding rule 12 of the ICD-9 requires deaths due to medical and surgical treatments be reported under the complication of the procedure (e.g., infection) rather than the treatment (e.g., elective abortion). Thus, complications from abortion that result in death – even though the abortion was a competent and significant contributing factor, are not included in the statistics relating to death due to abortion.

Third, the number of maternal deaths is substantially underestimated if death certificates alone are used to identify deaths, as is usually the case in reporting to the CDC. The Department of Health issued a public letter. In it, the CDC admits that death certificates that they rely upon do not usually give the cause of death, and it is clear that when abortion causes death, it is virtually never on a death certificate. A research study from Finland revealed that death certificates revealed only 6% of all abortion-related deaths. Based upon that study, deaths due to abortion may be 16 times greater than deaths reported based upon death certificates.

Finally, it is clear that the CDC statistics do not include the vast majority of deaths due to abortions because they do not include deaths from suicide, deaths from physical complications from abortions, and deaths due to any of the cancers in which abortions may be a significant contributing factor.

In fact, studies not relying on the above sources of data, have shown a higher risk of death associated with abortion compared to childbirth:

1. Gissler and colleagues (1997) reported post-pregnancy death rates within one year that were nearly 4 times greater among women who aborted their pregnancies than among women who delivered their babies. The suicide rate was nearly 6 times greater.

2. Reardon and colleagues (2002) found that women who aborted when compared to women who delivered, were 62% more likely to die from any cause. Increased risk estimates associated with specific causes of death were also identified in the study: violent causes - 81%, suicide - 154%, and accidents - 82%.

3. A study by Gissler and colleagues (2004) indicated the mortality rate was lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000).

4. In Gissler and colleagues' (2005) most recent publication, an age-adjusted induced abortion related mortality rate from all external causes (homicide, suicide, and unintentional injuries) of 60.3 per 100,000 was observed in comparison to a 10.2 age-adjusted mortality rate per 100,000 for pregnancy or birth. For suicide, the age–adjusted mortality rate for abortion was 33.8, compared to 5.5 for pregnancy or birth.

Dr. Shadigian noted that physicians, policy makers, medical governing bodies, and society in general, should be informed of the inadequate manner in which maternal death and pregnancy-associated death are reported, thus grossly underestimating the risk of death from abortion.

The Task Force finds that the above identified physical health risks are significant and important for women in considering whether or not to obtain an abortion. Dr. Shadigian's testimony is credible and comprehensively reports current physical health risks that are not included in pre-abortion informed consent materials for South Dakota women.

Dr. Stanley Henshaw also provided testimony on the physical and mental health effects of abortion. He is an advocate for reproductive choice. He has been Deputy Director of Research for the Alan Guttmacher Institute, a Planned Parenthood special affiliate which is partially funded by Planned Parenthood Federation of America.

Dr. Henshaw read several excerpts from papers published by Coleman and her colleagues suggesting that the authors themselves claimed causality that could not be determined by the evidence in their studies. He further noted that in order to determine cause and effect, researchers need to control for confounding variables associated with the choice to abort.

Dr. Coleman provided testimony that the issue of causality cannot be resolved in the context of a single study, necessitating review of the accumulated evidence. She further noted that the question of causality is often complex in the social/psychological sciences when the

focus of one's investigation involves human behavior. Manipulation of variables is not possible for obvious ethical reasons. In the studies she has conducted with colleagues in recent years, many controls for pre-existing psychological problems, intendedness of pregnancy, and demographic, personal, and situational factors predictive of the choice to abort have been implemented. Prospective or longitudinal data collection methods, which enable demonstration of the time sequence between the cause and the effect, also help to build the case for causality, and 9 of the 12 studies in Dr. Coleman's table of recent publications were prospective, as opposed to retrospective, in nature.

Dr. Henshaw provided basic descriptive data pertaining to abortion rates, indicating that poor, never married, and adolescent women choose abortion most frequently. He also provided information regarding the percentage of abortions according to weeks of gestation in 2001. Nearly 11%, or 143,000 of the 1.3 million abortions performed annually in the U.S. occur in the second and third trimesters.

Dr. Henshaw made the claim that the availability of abortion services in the U.S. has had positive effects on children. He specifically made assertions indicating that since *Roe v. Wade*, lower rates of neonatal mortality, low birth weight, pre-term delivery, abandoned infants, infant homicide, birth defects (including Down syndrome), and children unwanted by their parents have been observed. Several Committee members challenged these assertions, pressing Dr. Henshaw to explain how causality could possibly be determined when examining broad societal trends like these. Dr. Henshaw was not able to provide substantiation, that the Task Force found convincing, for his claims.

Numerous cultural factors are implicated in gains observed in children's health over the past three decades, including improvements in medicine, educational interventions, and prevention programs. Given the scientific impossibility of drawing causal conclusions from general trend data, Dr. Henshaw's credibility is called into question by his efforts to infer that abortion has played a causal role in any beneficial improvements in children's health, let alone implying that the elimination of children with fetal defects or anomalies is somehow beneficial to society.

One memorable moment in the hearings before the Task Force occurred on September 21, 2005, the first day of public hearings. Dr. Henshaw displayed a chart entitled "Healthier Children." It stated that because of abortion there are "fewer abandoned infants." This was advanced as a reason to support legal abortion. The Task Force concludes that this logic is emblematic of some of the reasoning advanced by the pro-abortion advocates that testified before the Task Force, even some of those who testified as experts.

Likewise, Dr. Henshaw's chart listed as an improvement to the health of children that it is suspected that there are "fewer infant homicide victims." Thus, Dr. Henshaw argues that it is better for the health of children that the lives of 1.3 million children be terminated each year because he suspects that a very small number of them may have died from other means. Rather

than belabor the illogical nature of this abortion advocacy reasoning, we include Dr. Henshaw's "Healthier Children" chart as Exhibit C to this report.

Dr. Henshaw's charts merit one last comment from the Task Force. He argues that because of abortion, there are "fewer children with the handicaps of being unwanted by their parents." The Task Force record is replete with evidence that in the overwhelming majority of cases when women are given an informed and voluntary choice, they raise the children themselves. The mere fact that a pregnancy was unplanned does not mean that the child will be unwanted after birth.

Although we received compelling evidence that large percentages of women wished they did not have their abortion, we found no evidence that women who decided to keep the children ever regretted it. There is simply no evidence that the parenting of children who are "unwanted" is any way affected by the availability of legal abortion.

### 3. Breast Cancer

The question concerning whether abortion causes an increased risk for breast cancer cannot be answered by this Task Force based on the record. However, the subject is of vital importance and the reasons to suspect such a connection sufficiently sound. We conclude that further study of this topic is justified and needed. Sorting out the science and truth of this matter is of the utmost importance so that relevant informed consent information can be provided to women considering an abortion.

## F. The Nature Of The Relationship Between A Pregnant Woman And Her Unborn Child

The Task Force received testimony and submissions concerning the relationship between a pregnant mother and her child during pregnancy. Of all human relationships, the relationship between a mother and her unborn child is unique in both its biological and psychological nature.

Biologically, as has already been noted, the mother detects the presence of the child at the end of its first week of life when it prepares for attachment to the mother's uterine wall. As Dr. Mark stated, at the pre-implantation age, the child synthesizes a platelet activating factor (PAF) (discovered by O'Neil in 1991), beginning at the one cell age, that enhances the child's ability to implant into his or her mother's uterine wall; and at 7.5 days old, before implantation into the uterus, the child begins to produce an enzyme (IDO) that inhibits the mother's immune system from attacking and rejecting the child (discovered by Mann, et al in 1998). (Mark Declaration, P. 25-26.) The mother often experiences symptoms of "morning sickness" shortly thereafter, trumpeting the arrival of her child.

Psychologically, Dr. Anne C. Speckhard, a professor of psychiatry at Georgetown University Medical School in Washington, D.C., contributed to Chapter 4 of the comprehensive

work *Death and Trauma, The Traumatology of Grieving*, Figley, C.R., Bride, B.E. & Mazza, N. (Eds.), Taylor & Francis (1996). Chapter 4, entitled "Traumatic Death in Pregnancy: The Significance of Meaning and Attachment," addresses the nature of attachment between the mother and the child in utero. Dr. Speckhard observes:

> "Leifer's research, as well as other clinical and small research studies of the psychological processes of parental attachment in pregnancy (Borg & Lasken, 1989: Conden, 1986; Gilbert & Smart, 1992; Klauss & Kennel, 1976; Peppers & Knopp, 1980; Speckhard, 1985; 1987), have consistently reported that for the pregnant woman, attachment often begins *shortly after conception*; but far before birth..." (*Id*, at P. 74 (emphasis added)).

Other studies also demonstrate that a mother's bond with her child (and the child's attachment to her) begins during pregnancy and even at its early stages: Klaus and Kennel, "The Family During Pregnancy,"in *Parent Infant Bonding*, 1-2 (1982); Lumely, "Attitudes to the Fetus Among Primigravidae," *Australian Pediatric J.*, 106, 108 (1982); Leister, *Psychological Effects of Motherhood*, at 76 (1980); 1&2, J. Bowlby, *Attachment & Loss*, (1969, 1973); M. Mahler, *The Psychological Birth of the Human Infant*, (1975); Sugarman, "Parental Influences in Maternal Infant Attachment," 47 *Am. J. Ortho – Psychiatry* (1977).

Dr. Martha Shuping also testified about this relationship and referred to Dr. Speckhard's above-referenced book in her testimony. Dr. Shuping holds an MD from Wake Forest University School of Medicine and completed her psychiatric residency at North Carolina Baptist Hospital in 1988. She also has an MA in Pastoral Ministry from the University of Dayton.

Dr. Shuping testified that biological, psychological, and emotional attachments occur early in the pregnancy, as evidenced by intuitive responses in the mother, such as cravings, nausea, changes in the woman's breasts, and aversions to certain foods and other substances. Further, when a mother has an ultrasound and sees the child on the screen, she instinctively puts her hand on her belly to touch her child.

Dr. Vincent Rue, Ph.D., Institute of Pregnancy Loss, Jacksonville, Florida, also addressed certain aspects of the relationship between mother and child in utero in his testimony. Dr. Rue received his Ph.D. in Family Relations from the University of North Carolina in 1975. For 27 years, Dr. Rue has been a practicing psychotherapist and has served on the faculty of California State University at Los Angeles and United States International University in San Diego. In 1981, Dr. Rue provided the first clinical evidence of post-abortion trauma, identifying this psychological condition as "Post-abortion Syndrome" in testimony before the U.S. Congress. During the Reagan Administration, he was a special consultant to the U.S. Surgeon General, Dr. C. Everett Koop on abortion morbidity.

Again, the conclusions reached by Dr. Speckhard, Dr. Shuping, and Dr. Rue are: the attachment between mother and child begins almost immediately after conception and the basis of maternal attachment is both psychological and physical, and this process, and the natural protective urges of maternal attachment, often form irrespective of whether the pregnancy was intended or wanted.

This unique mother-child relationship, with the developing bond and attachment, benefits both the child and mother. (Klaus and Kennell, *supra*. at 3.) At the same time the bond helps the mother to transfer her interest from herself to her child, and to prepare her for her unique role in the child's life. (Sugarman, "Parental Influences in Maternal Infant Attachment," 47 *Am. J. Orthopsychiatry* 407 (1977).) This accounts for the fact that a mother is the principle attachment figure for a child. (Bowlby, "Attachment and Loss," Vol. I *Attachment*, at 304 (1969).)

Studies have demonstrated the subjective and conscious awareness that mothers have concerning their bonding with their children during pregnancy. In the second trimester, 63% of women expressed attachment with the child and 92% expressed such attachment during the third trimester. Bonding even occurs in a large percentage of cases in the first trimester. (Lumely, "Attitudes to the Fetus Among Primigravides" *Australian Pediatric J.*, 106, 108 (1982).) Mothers talk to the fetus and stroke it. (*Id.* at 109.) Increased sensitivity to the child follows the experience of "quickening" when women can feel the baby move. (Klaus and Kennell, *supra*, at 13; Leister, "Physiological Effects of Motherhood," at 76 (1980).)

Most noteworthy are the conclusions of many researchers, as discussed in Section II-E of this Report, that the traumatic disruption of this attachment bond is capable of causing enduring psychological damage. Specifically, breaking this bond by abortion is detrimental to the health of the mother (*See*, Ortof, "Psychological Aspects of Abortion" in B. Blum, *Psychological Aspects of Pregnancy, Birthing and Bonding* (1980)) even when the termination of pregnancy is the presumptive desired result. (Speckhard, 1985, 1987a, 1987b; Speckhard & Rue, 1992, 1993.) (See, Speckhard, "Traumatic Death in Pregnancy" in *Trauma and Death*, Figley, et al, P. 75.)

Dr. Shuping also related that her seventeen years of clinical practice experience as a psychiatrist in Winston-Salem, NC, and numerous published studies, confirm that trauma is evident within the mother when these attachments are broken. Grief or posttraumatic stress after abortion is common. Dr. Shuping also testified that just because a woman considers an abortion does not mean that she has not bonded with the child.

It should also be noted that in South Dakota the law recognizes the fact that the child is a separate human being. Under South Dakota criminal law, criminal conduct that results in the death of the unborn child, at any age of gestation, is a homicide. (SDCL 22-16-1.) The tortious death of an unborn child, at any age, gives rise in South Dakota to a claim for wrongful death. (*Wiersma v. Mapleleaf Farms*, 543 N.W. 2d 787 (SD 1996).) The wrongful death damages are awarded based upon the loss of the relationship a mother has with her unborn child. The loss is

measured over the natural life span of the relationship, as it would have otherwise continued to exist throughout the lives of mother and child. (*Id*.)

The Task Force therefore finds that a mother's unique relationship with her child during pregnancy is one of the most intimate and important relationships, worthy of protection. The history and tradition of our nation has recognized this relationship as one that has intrinsic beauty and benefit to both the mother and the child, and it is recognized as one of the touchstones, and at the core, of all civilized society.

### G. Whether Abortion Is A Workable Method For The Pregnant Woman To Waive Her Rights To A Relationship With The Child

The Task Force finds, based upon all of the evidence presented, that an abortion is a completely unworkable method for a pregnant mother to waive her fundamental right to her relationship with her child.

Abortion, as we have discussed, is almost always not a procedure to treat a medical condition, but rather a method for the mother to postpone child-rearing, and is therefore, a method for a woman to give up her right to her relationship with her child.

A mother's unique relationship with her child during pregnancy is one of the most intimate and important of relationships, and worthy of protection. The unique bond between mother and child creates a human relationship that may be the most rewarding in all of the human experience.

It is for these reasons that our laws have traditionally protected the mother. Our laws dealing with surrender of the mother's rights in the context of adoption, for example, are based upon the premise that the mother's intrinsic natural right is fundamental, and its termination is a great loss to the mother.

The unworkable nature of using abortion to waive a woman's right to her relationship with her child is manifest in numerous ways.

First, as previously noted, in the abortion procedure, the woman is not told that her child already exists. However, even if it were to be disclosed, such oral representations are not an effective substitute for the mother seeing her child through ultrasound or holding her child in her arms before making such a life-changing decision.

Second, this method of waiver is completely fatal and irreversible. In the context of adoption, the mother can change her mind on numerous occasions before the child is born, and even after she files a petition in court expressing her intent to give up her rights, she can revoke that petition. In addition, her decision must be certified to the court, and her rights cannot be

terminated if the court record does not support the finding that her decision was informed. *J.M.J.*, 368 N.W. 2d 602 (S.D. 1985).

Third, it is unworkable that a matter of such importance is entirely entrusted to abortion providers whose interests and philosophies are in direct conflict with the interests of the mother in her relationship with her child. As Dr. Willke testified, the abortion providers are in the business of terminating the mother's relationship. Even when the pregnant mother has the entire nine months of pregnancy to investigate her options and reach a reasoned decision about whether to parent her child, the law does not entrust the termination of the mother's rights to an adoption agency. Only a court of law, after a hearing, can terminate the mother's rights.

Fourth, the procedure is, as has been seen, inherently coercive. The inherent coercion precludes this method from being an appropriate way for the mother to give up her right.

Fifth, this method of waiver of the mother's rights expects far too much of the mother. It is so far outside the normal conduct of a mother to implicate herself in the killing of her own child. Either the abortion provider must deceive the mother into thinking the unborn child does not yet exist, and thereby induce her consent without being informed, or the abortion provider must encourage her to defy her very nature as a mother to protect her child. Either way, this method of waiver denigrates her rights to reach a decision for herself.

Sixth, this method of waiver unnecessarily subjects women to physical and psychological injury.

Seventh, unlike the adoption procedure, it is difficult for the state to supervise the abortion process to insure that the mother is not exploited and her rights are adequately protected.

The price to society to permit this injustice to women is too great. Our state must not overlook the harm to the mother and the fact that her fundamental rights are often terminated without informed or voluntary consent, and we must not overlook the injustice of the loss of life that results from abortion.

### H. Whether The Unborn Child Is Capable Of Experiencing Physical Pain

The Task Force received a substantial amount of technical evidence concerning the question of whether an unborn child is capable of experiencing pain. Dr. Mark Rosen, an obstetrical anesthesiologist, testified by telephone, and Dr. Byron C. Calhoun, who appeared before the Task Force, both addressed this topic. The Task Force also received substantial written submissions and reports on this topic which we found important and helpful.

Since the time of *Roe v. Wade*, a number of generally accepted assumptions about human neurological development and our ability to feel pain have been refuted. The first assumption was that neonates were incapable of feeling pain.[17] The second assumption was that myelinated nerve fibers were necessary for pain perception, and since they did not form completely until after birth, pain perception was a late developmental event. The third assumption was that pain experience required pain-detecting nerves connected to the thalamus and then to the brain cortex; furthermore, there was presumed to be a period of cortical maturation necessary before pain could be experienced. All of these assumptions were based upon gross histological observations.

It was only in the last 20 years that the traditional concept accepted at the time of *Roe*, that even normal neonates cannot feel pain, was first challenged.[18] It had been assumed by the medical community that a fully developed and mature cortical brain region was necessary for pain perception. This assumption, it became clear, was inconsistent with the observations of caregivers for premature infants.[19]

Biochemical studies have supported the observations of caregivers concerning pain experiences. Studies on unborn and premature infants have demonstrated that the developmental time when pain is experienced was earlier than had been previously understood. Detailed hormonal studies in pre-term neonates undergoing surgery under minimal anesthesia have shown marked release of catecholamines, as well as autonomic nervous stimulation, heart rate changes, increased hormonal activity and increase motor activity. These activities are consistent with stress experienced with pain.[20] It has been documented that endocrine and metabolic responses associated with pain are abolished by giving anesthesia to pre-term neonates[21] and to the fetus.[22]

Based upon these and other studies, standard medical practice has changed. A New England Journal of Medicine editorial stated:

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[17]Porter, F. "Pain in a Newborn," *Neonatal Neurology, Clinics in Neonatology*, 16 (2) p. 549 et seq. (1989).

[18]Fitzgerald, M; and McIntosh, N. "Pain and Analgesia in the Newborn." *Arch Dis Child* 64 (1989): 441-443, at p. 441.

[19]One of whom stated eloquently:

"It has generally been assumed that the ability of a child to feel pain increases with age and that neonates may not perceive pain or may perceive it only minimally. Assumed by whom? Certainly not by those of us at the bedside of critically ill infants, who see them flinch from procedures, startle in response to loud noises, and turn from bright lights and various other forms of stimulation. Not by those who have heard infants' anguished cries and seen their vigorous withdrawals from painful stimuli. Not by those who have observed their increased heart and respiratory rates and profuse sweating in response to heel sticks or circumcision. And finally, not by those who have seen babies gasp for every breath as they die from incurable lung disease."

Fletcher, A.B. "Pain in the Neonate." *N Eng J Med* 317 (1987): 1347-1348, at p. 1347.

[20]Rosen, M.A., *Anesthesia for Procedures Involving the Fetus* (1991), Seminars in Perinatology 15:410-417.

[21]Levine, A.H. (1991), Fetal Surgery, Aorn J, V54 (1): 16-19, 22-27, 30-32, at p. 27. Rosen, M., " Anesthesia and Monitoring for Fetal Intervention" In *The Unborn Patient* 2nd ed., (1991), Harrison (editors), W.B. Saunders Co. P. 176, at p. 176.

[22]Fletcher, A.B. "Pain in the Neonate." *N Eng J Med* 317 (1987): 1347-1348, at p. 1348.

> "Any decision to withhold anesthetic agents ought not to be based on the infant's age or *perceived degree of cortical maturity*; it should be based upon the same criteria used in older patients."[23] (Emphasis added).

In the current state of medicine, with operative procedures being performed on premature babies as early as four months, it is a standard medical practice to anesthetize the child (at any age).[24] Thus, as of 1989, it was known that premature babies could experience pain, and the standard practice of medicine came to require anesthetizing all neonates and all pre-term infants. The more difficult question was at what age did the unborn child first have the ability to feel pain? Virtually all questions surrounding the unborn child, and how he or she should be treated, or viewed, evince disagreement. The question concerning the ability of an unborn child to experience pain is no different.

There are today, however, areas of agreement. We find that it is generally accepted that the unborn child can experience pain beginning at 23 or 24 weeks post-conception. This fact seems to be generally accepted by both proponents and opponents of abortion. Dr. Mark Rosen, an obstetrical anesthesiologist, was invited to testify by members of the Task Force who support abortion. Dr. Rosen acknowledged that the unborn child can experience pain beginning somewhere between 23 and 29 weeks post-conception. Dr. Byron Calhoun testified that the evidence supports the conclusion that the unborn can feel pain much earlier than 24 weeks. There are some scientists who suggest that there is evidence which cannot be ignored, that the unborn child can experience pain perhaps as early as 7 to 8 weeks post-conception, and others who do not rule out pain perception at 5½ weeks post-conception.

In order to provide guidance to the Legislature, we examined the evidence and literature and we find that:

a. It is almost universally accepted that the unborn child can experience pain by 24 weeks after conception.

b. The evidence supports the conclusion that the unborn child experiences pain by 20 weeks post-conception, at the latest.

c. That there is a considerable body of evidence, increasing in recent years, that the unborn child may experience pain as early as 11 weeks post-conception.

d. It is possible that the unborn child experiences pain as early as 7 weeks post-conception.

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[23] *Id*

[24] Porter, F. "Pain in a Newborn," *Neonatal Neurology, Clinics in Neonatology,* 16 (2) p. 549 et seq. (1989). For general discussion of medical practice for pain relief for neonates see: Choonara, I., *Management of Pain in Newborn Infants*, in Seminars on Perinatology, 16(I): 32040 (1992); Malhortora, N., L. Han, *Privilege of Analgesia in the Neonate*, in Seminars in Perinatology, 15 (5): 418-422 (1991).

## 1. The Nature of Pain and Pain Transmission

The main issue of contention is whether it is necessary for the unborn child to have a functioning cerebral cortex in order to have pain experiences. It is Dr. Rosen's contention that it is necessary. He and all of current modern science recognize that all other neurological functioning for pain transmission is in place early in gestation. The question, therefore, is whether: (1) is the presence of consciousness necessary in order to experience pain; and if so, (2) is the cerebral cortex the only site of consciousness at a level necessary for pain experience?

To answer these questions, an understanding of what pain transmission capabilities are found in the early embryo and fetus and how pain is transmitted and experienced in the human being is necessary.

The neuropeptide, Substance P, was first discovered in mammalian brain and intestine by Euler and Gaddum (J. Physiolo. 72:74, 1931). The presence of Substance P, known to be a pain transmitter, was not observed in the human being during the gestational period until the late 1980s. Since then, its role in pain transmission through activation of a subpopulation of the primary afferent C nerve fibers has been well-documented (Masanori et al., Cell. Mol. Neurobiol. 10:293, 1990; Mantyh et al., Science 278:275, 1997). The Substance P releasing primary efferent C fibers terminate in the superficial layers of the spinal dorsal horn (Cuello et al., Lancet 1:1054, 1976) and form synapses with second-order neurons in the dorsal horn of the spinal cord (DiFiglia et al., Neuroscience (7:1127, 1982). Many of these second-order neurons in this region of the spinal cord express the Substance P receptor (Marshall et al. Neuroscience 72:255, 1996) and transmit the nociceptive information up to the brain. The role of Substance P in transmitting a highly noxious stimulus was clearly demonstrated in 1997 by the work of Mantyh et al., in which they selectively ablated the neurons in lamina I of the spinal cord in mice and thus attenuated the responses of the animals to highly noxious mechanical and thermal hyperalgesia.

The neuropeptides, enkephalin (Konshi et al., Nature 294:80, 1981) and beta-endorphin (Hosobuchi et al., Commun. Psychopharmacol. 2:33, 1978), are endogenous analgesics that can modulate pain transmission at the spinal cord (Jessel et al., Nature 268:549, 1977). That is they are natural pain inhibitors. Enkephalinergic neurons and opiate receptors can be found in the superficial layers of the dorsal horn (Horfelt et al., PNAS 74:081, 1977), and stimulation of these neurons result in an opiod peptide mediated inhibition of the Substance P containing C-type fibers (Woolf & Fitzgerald, Neurosci. Lett. 29:67, 1982). Furthermore, administration of enkephalim and beta-endorphin to the spinal cord can depress nociceptive pain transmission responses (Otsuka & Yanagisawa, J. Physiol. 395:255, 1988).

In human beings, Substance P and enkephalin containing neurons can be detected in the dorsal horn of the spinal cord as early as five weeks following conception, using the technique of immunohistochemical staining (Luo et al., Neuroscience 27:989, 1988). High density of Substance P containing neurons can also be found in areas of the fetal brain that are associated

with pain perception (Picket et al., J. Comp Neurol 193:805, 1980; Nomura et al., Brain Res. 252:315, 1982. See also, Yew, D.T. et al., Neuroscience, 34:491, 1990). Therefore, the basic mechanisms for transmission of pain signals and the natural analgesics for the attenuation of pain signal transmission from the periphery to the brain are in place early during fetal development. This is confirmed by the study of Giannakoulopoulos et al., (Lancet 344:77, 1994), in which they measured the fetal plasma cortisol and beta-endorphin response to intrauterine needling. In this study it was shown that the fetal plasma concentrations of cortisol and beta-endorphin both increased significantly following fetal blood sampling or intrauterine blood transfusions by needling the fetal intra-abdominal portion of the umbilical vein.

In contrast, in cases where the needling was performed into the umbilical vein at the placental cord insertion outside of the baby's abdomen, no increase in cortisol of beta-endorphin was detected in the baby's plasma. Since the elevation of plasma cortisol and Beta-endorphin are known to correlate to the body's stress response to painful stimuli in adults (Lacoumenta et al., B. R., Jr., Anaesth. 59:713, 1987), the hormonal changes in the fetus are thought to be a response caused by the stress of a painful stimulus.

The morphological substrate (the necessary pieces) for pain detection in the spinal cord exists at very early developmental stages.[25] At twelve weeks gestation, the thalamus, third ventricle, midbrain, brain stem, and cerebellar hemispheres are developed and basic structure, apart from changes in physical size, will go unchanged throughout the rest of fetal and post-natal development.[26] At seven weeks, cutaneous sensory nerve fibers and interneurons of the spinal cord[27] are present.

Neuronal multiplication occurs mainly from the tenth to twentieth gestational weeks, after which no new nerve cells are formed, though neuronal arborization and the information and reorganization of synapses continues until adulthood. Somatosensory functions are developed at an early stage. The pain threshold is assumed to be lower in the fetus than in the adult. In man, general fetal movements appear from the eighth gestational week and more complex movements, such as sucking, swallowing, and breathing during the tenth to twelfth gestational weeks. These movements are generated by neuronal networks.[28]

The unborn child has the ability to open his jaw, move his tongue and even hiccup at 8 to 10 weeks.[29] Movement by the fetus away from cutaneous stimulation,[30] and brain activity,[31] has

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[25]Rizvi, T.; Wadhwa, S.; and Bijiani, V. "Development of Spinal Substrate for Nociception" *Pain* 4 (1987 - suppl.); S195.

[26]Filly, R.A. "Sonographic Anatomy of the Normal Fetus" In *The Unborn Patient* 2nd ed., ed. Harrison et al., 92-130, Phila.: W.B. Saunders Co., 1991, at 122.

[27]Anand, K.J.S.; and Hickey, P.R. "Pain and Its Effects in the Human Neonate and Fetus," *N Engl J Med* 317 (1987); 1321-1329, at p. 1322.

[28]Lagercrantz, H., et als. "Functional Development of the Brain in the Fetus and the Infant" *Lakartidningen* 88 (1991): 1880-1885.

[29]deVries, J.I.P., Visser, G.H.A., and Prechtl, H.F.R., "The Emergence of Fetal Behavior. I Qualitative Aspects," *Early Human Development*, 7 (1982), 301-322. "In this pattern of movement the hand slowly touches the

been observed by the eighth week. At 8 weeks, local stimuli may elicit the following movements: squinting, opening the mouth, partial finger closure, and plantar flexion of the toes.[32] The first detectable brain activity in response to noxious, or pain, stimuli is elicited in the thalamus of the brain between the ninth and tenth weeks.[33] A basic sensory response loop is clearly present by about eight weeks of gestation. There are particular neurological structures that are necessary for the sensation of pain, the thalamus, bundles of nerve pathways within the brain stem, pain receptive nerve cells, and neural pathways. These structures are at least partially in place during the time period between 8 and 13½ weeks. Doctors V.J. Collins, S.R. Zielinski, and T.J. Marzen have written that, "...it may be concluded with reasonable medical certainty that the fetus can sense pain at least by 13½ weeks."[34]

Nature prepares the nervous system first so that all other systems can develop and function properly.[35]

Many behaviors characteristic of newborns are clearly present in children with anencephaly[36](children born without a developed cerebral cortex).[37] Prior to this observation, these behaviors had erroneously been ascribed to cerebral cortex activity.[38] After birth, anencephalic newborns breathe spontaneously, exhibit a grasp response,[39] and respond to

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face, the fingers frequently extend and flex. Insertion of the fingers into the mouth can only vary rarely be seen accurately." (Hand-face contact firs occurs 10 to 12 postmenstrual weeks, Fig. 9, p. 311)

[30]Flower, M.J. "Neuromaturation of the Human Fetus," *J Med Philos* 10(1988): 237-351.

[31]Goldenring, J.M., "Development of the Fetal Brain," *N Engl J Med* 307 (1982); 564; Flower, M.J. *supra*.

[32]Cunningham, F.G., et al., *Williams Obstetrics*, 19th ed. (Norwalk, CT: Appleton & Lange, 1993), 1982. "At 10 weeks [postmenstrual-Ed.], local stimuli may evoke squinting, opening the mouth, partial finger closure, and plantar flexion of the toes."

[33]Cunningham, F.G., et al., *Williams Obstetrics*, 19th ed. (Norwalk, CT: Appleton & Lange, 1993), 193. "Movements of the fetal chest wall have been detected by ultrasonic techniques as early as 11 weeks gestation [postmenstrual-Ed.]. From the beginning of the fourth month, the fetus is capable of respiratory movement sufficiently intense to move amniotic fluid in and out of the respiratory tract."

[34]Collins, V.J., M.D., Zielinski, S.R., M.D., and Marzen, T.J.M., "Fetal Pain and Abortion; The Medical Evidence," *Studies in Law & Medicine*, No. 18. (1984) [See also: A.C. Guyton, *Textbook of Medical Physiology* (Philadelphia; W.B. Saunders Company, 1976), 666; and H.D. Patton, J.W. Sundsten, W.E. Crill, P.D. Swanson, eds. *Introduction to Basic Neurology* (Philadelphia; W.B. Saunders Company, 1976), 198.] "Certain neurological strictures are necessary to pain sensation; pain receptive nerve cells, neural pathways, and the thalamus [two egg-shaped masses of nerve tissue located deep within the brain at the top of the brain-stem]...the neurological structures are at least partially in place between 8 and 13½ weeks, it seems probable that some pain can also be felt during this time of gestation... as evidenced by the aversive response of the human fetus, it may be concluded with reasonable medical certainty that the fetus can sense pain at least by 13½ weeks."

[35]Kalvger, G., and Kalvger, M.F., Human Development: *The Span of Life*, St. Louis: The C.V. Mosby Company, 1974, at p. 35.

[36]The Medical Task Force on Anencephaly, (Stumph, D.A., et al.) "The Infant with Anencephaly" *N Eng J Med* 322 (1990): 669-674.

[37]Shewmon, D.A., et als., "The Use of Anencephalic Infants as Organ Sources: A Critique," *JAMA*261 (1989): 1773-1781.

[38]The Medical Task Force on Anencephaly, supra.

[39]Ashwal, S., et als., "Anencephaly: Clinical Determination of Brain Death and Neuropathologic Studies," *Pediatr Neurol* 6(1990); 233-239.

noxious stimuli known to cause pain by avoidance, withdrawal and crying.[40] They also breathe, cough, hiccup, smile, grimace, yawn, and suck. In a recent study of twelve anencephalic infants, all twelve responded to pain, had an exaggerated sustained response to touch, evidenced spontaneous movement, and breathed spontaneously.[41] Seven of the twelve responded to a stimulation of their mouth area by turning towards the stimulus and sucking.[42] These behaviors are also present in the normal fetus between 6 to 11 weeks gestation. Spontaneous movement in the normal fetus begins between six and seven and one-half weeks gestation.[43] Stimulation of the mouth area resulting in a response towards the stimulus is seen at 9 weeks gestation and sucking at 11 weeks.[44] The fetus of 6 to 11 weeks gestation is neurologically developed at least equivalent to the twelve anencephalic children described above which are capable of experiencing pain.

Thus, it is clear that the neurological structure necessary for pain detection is in place very early (between 6 to 11 weeks post-conception) and neuropeptides, which both transmit and suppress pain, are present as early as five or six weeks post-conception. The question is essentially reduced to whether it is necessary to have a functioning cerebral cortex in order to "experience" or be aware of the pain transmission.

**2. Whether a Functional Cortex Is Necessary for the Unborn Child to Experience Pain**

It is clear that the unborn child reacts to his or her environment and reacts to painful stimuli during the first trimester. However, it is thought that simple reflex reactions can occur without conscious awareness and involvement of the brain. A noxious stimulus would cause a signal to be sent to the spinal cord via a sensory nerve. This signal can be relayed to the muscle that responds without the transmission traveling beyond the spinal cord. Some describe this as a "knee jerk" reaction because no high cerebral functioning is involved. There is no question that in the first trimester everything is in place for the unborn child to have single reflex responses to stimuli including stimuli that are ordinarily painful.

There are more complex reflex reactions. These involve situations in which the spinal cord sends nerve signals to the brain stem and structures in the lower brain. These low brain areas organize a different kind of response that is more sophisticated and coordinated, such as crying. Many scientists maintain that this kind of complex "reflex" is not evidence, standing

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[40]Stumpf, D.A., Med Task Force on Anencephaly, "The Infant with Anencephaly," *N Eng J Med* 322(1990): 669-674. Shewmon, D.A., et als., "The Use of Anencephalic Infants as Organ Sources: A Critique," *JAMA*261 (1989): 1773-1781. Van Assche, F.A. "Anencephalics as Organ Donors," *Am J Obstet Gynecol* 163(1990): 599-600; Ashwal, S., et als., "Anencephaly: Clinical Determination of Brain Death and Neuropathologic Studies," *Pediatr Neurol* 6(1990); 233-239.

[41]Ashwal, supra.

[42]*Ibid*

[43]deVries, J.I.P., Visser, G.H.A., and Prechtl, H.F.R., "The Emergence of Fetal Behavior. I Qualitative Aspects," *Early Human Development*, 7 (1982), 301-322. Flower, M.J. "Neuromaturation of the Human Fetus," *J Med Philos* 10(1988): 237-351.

[44]Giannakoulopoulos, X., Sepulveda, W., Kourtis, P., Glover, V., and Fisk, N.M., "Fetal Plasma Cortiso and B-Endorphin Response to Intrauterine Needling," *Lancet* 1994; 344:77-81.

alone, that the human being experienced pain. However, it has been suggested that if aspects of awareness are located in these lower structures of the brain in children in early utero, some form of perception occurs and a pain experience can occur. Since there is disagreement on this, it is necessary to examine the evidence. In reviewing this question, the Task Force reviewed the work, published by a Royal Commission of the British House of Lords, "Human Sentience Before Birth," issued in 1999. That commission heard evidence from renowned experts in the field.

We are struck by the fact that doctors and scientists draw a distinction between "feeling" painful stimuli and "conscious" awareness of it. It is the "consciousness" of pain that some experts, like Dr. Rosen, hypothesize requires upper brain and cortex functioning. For policy considerations, the Legislature may not be willing to draw such a distinction, but since some of the medical experts attach such significance to it, we review the question of a need for a functioning cortex in order for an unborn child to experience pain.

Once a human being has a functioning cortex, the nervous system carries messages to the cortex and the human being is capable of being aware of the pain and can organize deliberate actions in response to the stimulus.

The report issued by the Commission of the British House of Lords concluded that evidence from hydranencephalic children (cerebral hemispheres of the brain are missing) and anencephalic babies (babies with little or no hypothalamohypopophyseal systems) showed that while the children with these conditions do not have a functioning cortex, they demonstrate a wide range of complex behaviors associated with the cortex, including conditioning, ability to be consoled, and associative learning.[45]

In one case, a 21-month-old child with hydranencephaly developed behavior and learning normal for a child that age.[46] He spoke, played with toys, was potty trained, etc. The literature concerning anencephalic babies with functioning hypothalamohypopophyseal systems indicates they have reactions to painful stimuli.[47] This indicates that a human being can make responses to noxious stimuli even without a functioning cortex. There is also evidence from experience with anencephalic children that some of the functions of the cortex are performed by the lower centers of the brain in the absence of the cortex. A noted British scientist testified before the Royal Commission that this evidence may well disprove the latest in a long line of disproven assumptions about pain and that even the fetus at the earliest ages may experience pain. There is evidence that the thalamus, an area of the lower brain, may "support a form of awareness and consciousness." (Mense, S. (1983) "Basic Neurobiologic Mechanisms of Pain and Analgesia," *Amer J of Med*, 75, 4-14.)

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[45]Shewmon, D.A., et al., "The Use of Anencephalic Infants as Organ Sources: A Critique," *JAMA*261 (1989): 1773-1781.

[46]Lorler, J. (1965) "Hydanencephaly with Normal Development," *Developmental Medicine and Child Neurology* 7, 628-633.

[47]Van Assche, F.A. "Anencephalics as Organ Donors," *Am J Obstet Gynecol* 163(1990): 599-600.

In a paper that Dr. Rosen coauthored (Lee, S.J., et al., "Fetal Pain, a Systemic Multi disciplinary Review of the Evidence," *JAMA*, Vol. 294, 8 Aug. 2005), that recognizes that brain activity is detected at 8 to 10 weeks post-conception, it states: "The histological presence of thalamocortical fibers (from which EEG readings can be obtained) is insufficient to establish capacity for pain perception. These anatomical structures must also be functional." This hypothesis is, however, a bit circular in reasoning. Dr. Rosen, et al. assumes the need for cortical functioning and then says that the evidence of brain functioning associated with consciousness cannot be significant because it is in a child without a functioning cortex.

We find it more persuasive that the unequivocal reactions to painful stimuli and the learning capabilities of the hydranencephalic and anencephalic babies indicate that lower brain centers – in the absence of a functioning cortex – have a capacity to function in a more complex fashion, and that these children possess the capacity for awareness and experiencing pain.

Based upon the comprehensive analysis contained in the report by the Commission of Inquiry into Fetal Sentience, our review of the literature, the testimony before the Task Force, and other evidence received, we conclude:

1. Concerning physical neurological development:

    a. Beginning at 5 weeks post-conception the unborn child responds to touch and the development of the brain is well under way;

    b. Brain activity can be detected at 7 weeks post-conception;

    c. The lower brain begins activity around 10 weeks post-conception; and

    d. The higher areas of the brain are active at 23 weeks post-conception, and at 24 weeks the neurological signals can be processed from the thalamus to the cortex.

2. Concerning the child's ability to experience pain:

    a. It is virtually universally accepted by science and medicine that the unborn child can experience pain by 24 weeks post-conception;

    b. It is probable that the unborn child can experience pain at least by 20 weeks post-conception;

    c. It is more likely than not that the unborn child can experience pain without a functioning cortex, as long as the lower brain is developed to the same extent as that of hydranencephalic babies, which is around eleven weeks

post-conception. There is a significant and growing body of evidence that the unborn child experiences pain as early as 11 weeks post-conception;

d. Some scientists contend, although it has not been proven, that the unborn child may be able to experience pain as early as 7 weeks post-conception; and

e. The fact the unborn child can "feel" painful stimuli before the ability to be conscious of that pain is relevant to matters of public policy.

## I. Whether The Need Exists For Additional Protections Of The Rights Of Pregnant Women Contemplating Abortion

Considering the scope of the record, especially the powerful and moving testimonies of the almost two thousand women, there is no question that there is need for additional protections of the rights of pregnant women.

The Task Force has found that abortion adversely affects the rights, interests, and health of women. It involves the irrevocable termination of one of a woman's most important fundamental liberties protected by the United States Constitution, her fundamental right to her relationship with her child. The fact that some women may feel that their circumstance prevents them from exercising this right must not be allowed to obscure the fact that this fundamental right demands respect and the greatest legal protections. It is only by these protections that the pregnant mother can realize and freely exercise her right to have a relationship with her child. Likewise, these protections are necessary to ensure that any decision to give up her fundamental right is an informed and voluntary decision.

Any policies implemented by this, or any other state, must begin with the recognition that human life has intrinsic value. We find it to be self-evident (and supported by the record) that a mother's relationship with her child, at every moment of life, has intrinsic worth and beauty for the mother and child alike. It must be with these truths in mind, that our state, or any state, must act to guarantee that the pregnant mother's fundamental right to her relationship with her child enjoys strong legal protections.

For too many women, abortions are the result of uninformed consent. The mother's ability to freely exercise her right to her relationship with her child depends upon new legal protections to ensure that if a woman wants to relinquish her right, it is done under circumstances that are unequivocally informed.

The mother, of course, has a duty and a right to make decisions about the welfare of her child at every age. We find it untenable that the law allows a mother to be implicated in the termination of the life of her own child. Since the abortion providers repress information

necessary for a full disclosure of this circumstance, there is a clear need for additional protections of the mother, not just to assist in helping make that decision better informed, but to prevent her short- and long-term suffering.

The ability of a pregnant mother to freely exercise her right to keep her relationship with her child depends entirely upon the laws protecting her right. This is so regardless of the source of such pressures, whether it be from the father of the child, a family member of the pregnant woman, an abortion provider, or from a culture that promotes abortion and the termination of the mother's rights because it is easier than assisting her in her time of need. We find that there is a clear need for additional protection of the mother's fundamental rights to her relationship with her child against pressures of third parties.

As we have seen, the abortion procedure is inherently dangerous to the psychological and physical health of the pregnant mother. There is a need for better protection of the mother's health.

The current legal policy found in our country today, that protects the destruction of her relationship with her child (i.e., abortion) instead of her relationship with her child is a denigration of women. We find that we should, as state policy, promote motherhood and counter the claim that the exclusive "right" to abortion liberates women.

The sad and compelling testimonies of the women who have informed us of the reality of their experiences must not be ignored. Their courage in stepping forward to educate us on their suffering must be given meaning. The additional protections discussed above would have protected them, and will help protect other women from similar harm.

We recognize that legislative action short of a ban on all abortions[48] will be insufficient to prevent all harm from abortion. However, the protections listed above have the potential to reduce the number of abortion decisions by as much as 98%. (See Section II-A of this Report.)

### J. Whether There Is Any Interest Of The State Or The Mother Or The Child Which Would Justify Changing The Laws Relative To Abortion

The testimony presented to this Task Force demonstrates the need to change laws relative to abortion. As stated previously, the current laws do not adequately protect the mother or child, and have resulted in great harm to women and the deaths of thousands of South Dakota children.

We conclude that the most fundamental assertions made by the U.S. Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973), upon which its decision was based, are now known to be false or inaccurate. Of these, none are more damning than the position that it could not be

[48] The Task Force has not examined the question of whether any exceptions are necessary – i.e., whether an abortion is ever medically necessary, even to save the life of the mother.

determined when life begins. This statement of *Roe* has caused confusion in the lives of women and has destroyed the lives of their children. Because of this statement, Planned Parenthood tells women that there is only "tissue" inside a pregnant mother and refuses to inform women of the biological fact that an abortion will terminate the life of a human being.

It is now clear that the mother's unborn child is a whole human being throughout gestation and that she has an existing relationship with her child.

Our nation was founded both on the proposition that human life is a gift of immeasurable worth and on the precept of equal rights for all human beings. The Declaration of Independence put this message in words that stir the heart:

> "We hold these truths to be self-evident: that all men are created equal; that they are endowed by their creator with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness..."

The fact that the unborn child is a whole separate unique living human being is not without significance for our culture and our state. The right to live does not derive from government. If it is truly, as we know it to be, an intrinsic natural right, it is enjoyed by every single human being, no matter how poor or wealthy, strong or weak, age of maturity, or state of dependence. We find that the unborn child possesses intrinsic rights that are in perfect harmony with and equal to the intrinsic rights of that child's mother.

As for the sovereign state of South Dakota, we recognize that the State has both the right and the unqualified duty to protect every human being and their personal intrinsic rights, including the pregnant mother's natural intrinsic right to her relationship with her child, and the child's intrinsic right to life. These cherished rights are compatible and harmonious, regardless of the unfortunate circumstances that sadly invoke thoughts that she may not be able to avail herself of her great rights.

It is the law, as it represents the collective interests of the individuals for whom the law exists, that must protect life. Long ago, our law protected life and the mother's beautiful interest in her child's life. It protected innocent children over the misguided philosophies and trends in social thought, which come and go.

If there are any self-evident and universal truths that can act for the human race as a guide or light in which social and human justice can be grounded, they are these: that life has intrinsic value; that each individual human being is unique and irreplaceable; that the cherished role of a mother and her relationship with her child, at every moment of life, has intrinsic worth and beauty; that the intrinsic beauty of womanhood is inseparable from the beauty of motherhood; and that this relationship, in its unselfish nature, and, in its role in the survival of the human race, is the touchstone and core of all civilized society. This relationship, its beauty, its survival, its benefits to the mother and child, and its benefits to the State of South Dakota, and society as a whole, all rest in the self-evident truth that a mother is not the owner of her child's life, she is the trustee of it.

The state, the mother, and the child all have interests that justify changing the laws of the state of South Dakota to protect the child's life, first and foremost, to protect the mother-child relationship, and to protect the mother's health. In fact, the state not only has an interest, it has a duty to change the law. Because of this duty, the state cannot continue to protect the abortion practice, for the right and duty to preserve life cannot co-exist with a right to destroy it. Likewise, the right and duty to preserve and protect the cherished relationship between mother and child cannot co-exist with a right to destroy it.

## III. PROPOSALS FOR ADDITIONAL LEGISLATION

The State of South Dakota has an interest and a duty to protect every citizen's intrinsic rights, most importantly the right to life. This duty includes protecting an unborn child's intrinsic right to life and the mother's natural intrinsic right to a relationship with her child, along with the protection of the mother's health.

The Task Force concludes that to fully protect the rights, interests, and health of the mother and the life of her unborn child, a ban on abortions is required. [49] We recommend that the Legislature examine the method and timing of such a ban.

The Task Force is aware of the arguments by which *Roe v. Wade* and related decisions of the U.S. Supreme Court have determined that the Constitution prohibits a state from banning abortion. However, it is clear to us that abortion terminates the life of a child and the relationship with his or her mother and is an unsafe procedure that places women at significant risk for psychological and physical harm. In fact, this decision has already allowed the termination of the lives of well over 40 million children and has harmed women and families across our state and nation.

Further, there are new facts and appreciations of those facts, as discussed in this Report, that disprove many factual assumptions made by the Court in *Roe v. Wade,* requiring that the Supreme Court reconsider its *Roe* decision.

Thus, while we recommend, and even urge, a legal ban on abortion, we nonetheless propose the following additional legislation in an effort to lessen the loss of life and harm caused by abortion until such a ban can be implemented:

1. Amend the State Constitution to include provisions that provide the unborn child, from the moment of conception, with the same protection of the law that the child receives after birth and also provide protections for the mother-child relationship.

2. Require the abortion doctor to personally complete, while questioning the woman in confidence, a written form provided by the State that specifically asks the woman if she is being pressured into having the abortion. If she indicates that she is being pressured, require that the abortion shall not be performed.

3. Require the abortion doctor to verify the age of the patient and the father of the unborn child, and require the abortion doctor to report to the appropriate authorities any sexual activity that is contrary to South Dakota law.

[49] The Task Force has not examined the question of whether any exceptions are necessary – i.e., whether an abortion is ever medically necessary, even to save the life of the mother.

4. Require strict reporting requirements concerning the reasons a woman is seeking an abortion. The report must contain a written disclosure by the doctor as to whether or not continuing the pregnancy threatens the health or life of the woman. If the threat exists, the doctor must detail the nature of the threat.

5. Require that the State create a written disclosure form that requires the abortion doctor to provide the mother, in person, with all of the risks of abortion to the mother and her unborn child. Require that this disclosure take place before the woman pays for the abortion and before she is taken to the procedure room. Require that the mother must also be provided sufficient time for personal review and discernment.

6. Require that no abortion can be performed unless the pregnant mother, prior to making an appointment for an abortion, receives counseling and disclosures about the nature of the risks and the alternatives to abortion by a pregnancy care center that does not perform abortions.

7. Require that the abortion doctor show the pregnant mother a quality ultrasound image of her unborn child before the procedure is performed and prior to her signing the consent form on which she indicates that she viewed the ultrasound.

8. Require the abortion doctor to have hospital privileges at a hospital within 30 miles of the location where the abortion is performed.

9. Require that the South Dakota Vital Statistics include disclosure of all facilities that perform abortions in South Dakota as well as the number of abortions performed per year at each facility.

10. Strengthen laws so that abortion facilities are thoroughly regulated and regularly inspected by the South Dakota Department of Health or other proper authority.

11. Strengthen the child support laws, including the requirement that the father of an unborn child support the mother and their unborn child during the pregnancy and thereafter.

12. Strengthen laws that provide financial and other support to pregnant women so that lack of support no longer compels a woman to seek an abortion.

13. Strengthen and clarify existing public policy regarding character development education pursuant to SDCL 13-33-6.1. Such clarifications should include a

definition of sexual abstinence and a statement that abstinence education in South Dakota is to exclude contraceptive-based sexuality education.[50]

14. Any other legislation that has as its goal to decrease the number of abortions in our State.

[50] Although the Task Force was not mandated to discuss and make recommendations regarding sexuality education, this issue was brought to the attention of the Task Force throughout the testimony, and was discussed extensively. It is clear that sexuality education and abortion are undoubtedly connected. We find that abstinence until marriage education based upon character development is foundational in decreasing unplanned pregnancies and sexually transmitted diseases including HIV/AIDS.

The state of South Dakota through its various entities has campaigned to educate our youth to "Just Say No" to harmful activities, such as smoking and drugs, and if the minor is participating in such a harmful activity to simply stop. This message given to our youth is clear, concise, and without contradictions.

We find that almost everyone can agree that sexual activity for minors is harmful. To promote a message of "comprehensive sex education" (i.e. sex education based upon the promotion of contraception) is confusing and dangerous. It is inconsistent with the message of "Just Say No" since abstinence from sexual activity is the only completely reliable means of preventing pregnancy and disease. The message communicated to youth by contraceptive-based sex education is that they are not capable of controlling their emotions and instincts, thus the need for contraception. Further, contraceptive sex education instills a mentality that abortion is a "back up" for failed contraception, thus the promotion of "emergency contraception" drugs which can act as early abortifacients. No objective studies of contraceptive sex education programs have proven to result in the reduction of unplanned pregnancies and abortions. Conversely, studies have shown that contraceptive sex education results in an increase in sexual activity.