Mary Lazich

President
Wisconsin State Senate

Senate Committee on Health and Human Services
Senate Bill 179 Testimony
Assembly Committee on Health
Assembly Bill 237 Testimony
June 2, 2015

Thank you for a public hearing about Senate Bill 179 (SB 179) and Assembly Bill 237 (AB 237). SB 179 & AB 237, named the Pain-Capable Unborn Child Protection Act, prohibits the abortion of an unborn baby capable of feeling pain.

The state has a compelling interest in preventing an unborn child from experiencing pain. Recent advances in medical research inform us that by the fifth month of pregnancy, an unborn baby is able to sense and feel pain. Consequently, unimaginable and excruciating pain via dismembering a child should not be allowed.

At 20 weeks postfertilization, or five and one-half months into pregnancy, all of the physical components necessary for the body to experience pain developed. The baby makes movements in response to touching after eight weeks and a motor response is seen as early as seven and one-half weeks postfertilization. 20 weeks after fertilization an unborn baby reacts to stimuli that's recognized as painful while recoiling. Medical facts offer profound new insights into providing compelling grounds to extend protection to this specific class of human beings.

Furthermore, surgeons performing corrective procedures on unborn children observe unborn children flinch and jerk away from incisions. In addition, painful stimuli application is associated with significant increases in stress hormones. Stress responses may be observed during fetal surgery at the time anesthesia is administered. With anesthesia, an unborn child releases reduced amounts of stress hormones compared to the level released during a painful stimuli application without anesthesia.

The most important point is there is nothing in the text or tradition of the U.S. Constitution that precludes Wisconsin from extending the most basic protections of the law to five-month unborn babies experiencing significant pain. The pain the child experiences is the constitutional basis to enact protections for a child.

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Technology affords the public information that requires us to confront the fact an unborn baby is in fact human, and that while small and defenseless, the human baby experiences pain. The information offers new and overwhelming reasons to prohibit abortions at 20 weeks postfertilization.

The Pain-Capable Unborn Child Protection Act is a rational, thoughtful, and compelling state interest to regulate the practice of abortion. The legislation prevents unborn human babies from experiencing pain and death.

Again, thank you for the public hearing, and thank you for your consideration of SB 179 and AB 237.

JESSE KREMER
STATE REPRESENTATIVE • 59TH ASSEMBLY DISTRICT

Senate Committee on Health and Human Services
Senate Bill 179
Assembly Committee on Health
Assembly Bill 237
June 2, 2015

Committee Chairs, members of the Senate and Assembly Committees; thank you for being here today to hear testimony on SB 179/AB 237, the Pain Capable Unborn Child Protection Act. I am thankful for the opportunity to testify before you today.

As a state and nation, we are outraged when someone causes harm to an animal or treats an enemy combatant inhumanely. As Wisconsinites, we also have a compelling moral and civic duty to ensure that our unborn children are protected from the tortures of painful stimuli leading up to their eventual and intentional death. The "Pain Capable Unborn Child Protection Act" will prevent Wisconsin's unborn babies from extreme torture and pain. These protections will exist for a child who has developed to the point that he, or she, can experience and sense painful stimuli.

Recent scientific research has demonstrated that unborn babies can feel pain as early as twenty weeks, or five months, after conception. This bill seeks to protect babies who are capable of feeling pain from the torture of late term abortion procedures.

Evidence from objective experts in the fields of anesthesia and fetal surgery have documented that when a child is subjected to painful stimuli in the womb, chemical changes occur independent of the mother. Endorphin levels rise, cortisone levels fluctuate and the child thrashes around. It is for this reason that fetal surgeons administer anesthesia to an unborn child during a surgery. Many of these same physicians have demonstrated when a perfectly healthy baby and one with Hydranencephaly, no cerebral cortex, are placed side by side and subjected to painful stimuli - such as a pinch on the bottom of the foot - both will react to the pain in the same fashion.

Current law requires facilities that perform abortions to report socioeconomic and geographic data annually to the Department of Health Services (DHS). This bill requires the additional reporting of the probable post-fertilization age of the child for purposes of determining pain capability. A doctor will also be required to inform the mother seeking an abortion of the numerical odds of survival if the child were to be delivered at that gestational stage. If the child is found to be capable of experiencing pain, the DHS report must also contain the nature of any medical emergency that causes a doctor to terminate the pregnancy and the manner of termination that gave the child the best opportunity for survival. At the late stage of five plus

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months of pregnancy, there is no abortion as defined in Wisconsin statutes that an unborn child could survive. Thus, *intent* to end the life of the child would not be allowed.

The Pain Capable Unborn Child Protection Act will also require the oral and written provision of information on perinatal hospice to a mother considering abortion. Sadly, some mothers who receive a fetal abnormality prognosis are often directed towards abortion as their only real option. Many are unaware of their options should they decide to carry their child to term. Perinatal hospice is a support network of specially trained psychologists, doctors and clergy who provide physical and emotional help to the mother, father and terminally ill child from the initial diagnosis until probable, natural death occurs.

Today you will hear a variety of testimony addressing scientific documentation on both sides of this issue; but first, let me ask one simple question. If there is *any* chance that a five month old baby who is systematically dismembered in the womb can feel her body being torn apart, will you be content to sit idly by?

Wisconsinites have long since abandoned the death penalty on the grounds of cruel and unusual punishment. This bill would mark another such positive step for the moral and ethical direction of our state and ensure that citizens of Wisconsin do not have to tolerate the scientifically proven, brutal and painful killing of our innocents. I implore each of you today to join us in support of this legislation.

TO: Senate Committee on Health and Human Services and Assembly Committee on Health
FROM: Paula Cody, MD, MPH
RE: Testimony for in Opposition to SB 179/AB 237
Date: June 2, 2015

Chairwoman Vukmir and Chairman Sanfelippo, thank you for the opportunity to share my testimony in opposition to SB 179 and AB 237, which would prohibit almost all women from accessing abortion services after 20 weeks gestation. As a physician with extensive training in reproductive health of adolescents, including an Adolescent Medicine fellowship and a Master of Science degree in Public Health, I find myself unqualified to tell an Obstetrician how to do his/her job. I cannot tell him/her when it's appropriate to use a laparoscopic approach vs a vaginal approach in a hysterectomy. I'm not sure the proper position of the ports in a minimally invasive myomectomy. I am definitely not qualified to tell an OB how or when to do the medical procedure referred to in SB179, and I do not feel that anyone in the Wisconsin Senate or Assembly is qualified to do so either.

Who does this legislation benefit? It certainly doesn't benefit my 11 year old patient who became pregnant as a result of incest and didn't know her body well enough to realize that she was pregnant. It also doesn't benefit my 20 year old college student patient who found out after a date rape that her contraception isn't 100% effective at preventing pregnancy, although it continued to stop her periods so she didn't take a pregnancy test until past 20 weeks.

It's not in the best interest for the fetus who has a fatal anomaly that was discovered after 20 weeks, who would be forced to endure several days of excruciating pain after birth until finally finding peace; because under this legislation, the so-called pain of a fetus (which has no basis in actual science, as evidenced by a rigorous scientific review of the available evidence on fetal pain in Journal of the American Medical Association in 2005[i]) matters more than the pain of a newborn. It's not in the best interest of the parents of that newborn, who had to continue with that pregnancy, endure a labor, and then watch that child suffer for a days.

I think that this legislation has the potential to benefit very few and harm many.

Thank you for taking the time to consider my testimony. I strongly urge you to do the right thing for Wisconsin's women and medical community by opposing SB 179/AB 237. I would be happy to answer any questions you may have.

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[i] Lee SJ, Ralston HJP, Drey EA, Partridge JC, Rosen MA. Fetal pain: A systematic multidisciplinary review of the evidence. *JAMA* 2005; 294: 947-954.

Jeff Wenzler

Mequon, WI

June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

One afternoon I was speaking with a doctor that I was calling on while I was working in the pharmaceutical field. The clinic I was in was in one of Milwaukee's most impoverished communities on the south side. The clinic served a heavily Hispanic population. Many had little education, little English, and sparse resources at best. I was dropping off free samples for an STD medicine I sold.

The doctor asked how I was doing and I took the opportunity to say proudly, "not bad considering I am juggling a new job, a 1 year old at home, and pregnant wife on long-term bed rest due to a complicated pregnancy." After asking a few casual questions, he very quickly advised my wife and I to "cut our losses"- to abort our unborn child, Jonah - "because it will slow your family down," he said.

I will never forget those words. I had told him that our perinatologist said for us to "expect a second trimester event," which would be a miscarriage because of pre-term labor. Then he said that IF our child survived, he would not be a "tax payer," meaning he would have significant disabilities and therefore would never have gainful employment requiring him to pay taxes.

If that alone wasn't hard enough for us as parents to process, here I was in front of another doctor giving me very pointed advice on why to seek an abortion. He personally had a brother that was cognitively and physically disabled and, although the family hoped for a miracle, it never happened and it "slowed his parents down."

At that moment, his next patient came down the same hall where we were talking. She was a Hispanic, teenage mother who could not speak English, pushing a stroller with a child with significant disabilities. The doctor continued his lecture knowing she could not understand him saying, "See, here is an example now," referring to the disabled child.

I was stunned as he spoke. I could not believe this doctor could give such one-sided advice, and I could not believe that he was dismissing not only my child's life, but also the life of the precious but differently-abled child right before him.

Because I have never walked a day in someone else's shoes I have tried to stay out of the business of telling someone what to do. However, these exchanges with those doctors, and their disregard for both my son's and that child's life, convinced me to speak out for him and all other babies who receive a prenatal diagnosis or are living with a disability.

No life is ordinary. Just as each child's fingerprint formed inside the womb is unique, so is each child's mark on the world.

Two highly trained medical professionals, with years of practice under their belts, both bet against Jonah either surviving, or being a productive "normal, ordinary" citizen. Their advice was scary, deeply personal, and filled with assumptions on all that "could" go wrong.

Well, their advice was wrong. Jonah survived a full term and an ultimately healthy pregnancy.

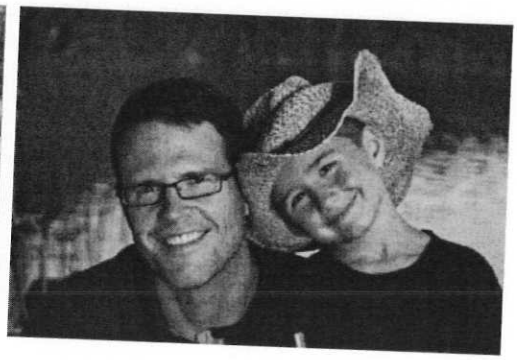
When did the doctors I spoke with lose the ability to provide hope?

Last year, Jonah won his chess tournament at his school against students two years older than him. This year he made a select baseball team as the youngest player. Jonah is head and shoulders physically above his peers. He is far from ordinary, he is extraordinary – just like the young Hispanic girl's physically and mentally impaired child. Both of our children are loved in an extraordinary way, and both deserve a chance at life.

Today, I call on the Wisconsin State Legislature to protect all extraordinary lives with the *Pain-Capable Unborn Child Protection Act*. Not only does it save babies who feel pain regardless of ability, but it also ensures parents like me receive information on all the resources available in the case of a prenatal diagnosis of disability.

Jonah would not be alive today if I took the limited and unfortunate advice provided to me. I sincerely hope the legislature empowers doctors to ensure parents like me receive all the resources we need to support our extraordinary children – no matter their condition. I also hope other parents who face a prenatal diagnosis can receive the hope they so desperately need to spare not only themselves, but also their child, from the pain of abortion.

-Jeff Wenzler, Father of Jonah



Cori Salchert

Sheboygan, WI

June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

My name is Cori Salchert. I am almost 50 years old and 27 years ago, I graduated from nursing school here in Madison. And I'm a wife and mother of eight biological children.

Being an RN led me down several paths in my nursing career. Hospice was one of them. Twelve years ago, after having taken ten years off to be with my kids at home, I decided to return to work at my local hospital and work on the maternity floor. I had loved working with hospice, but wanted to help at the other end of the spectrum of life, where I thought all was sweetness and light. This rosy picture was quickly changed after seeing so many women come to the OB floor with miscarriages, stillbirths, and babies who would die shortly after birth.

It wasn't very long before I was once again working in a hospice role, only I was providing this kind of care to obstetric patients and their babies, not to the ill, elderly, and their loved ones.

After these experiences, a number of years ago I began a program at St. Nicholas Hospital in Sheboygan, WI called HALO, or the Hope After Loss Organization. What I offered through that program was the same support and comfort to infants and their parents that older hospice patients and their families would receive.

Any loss should be validated, and treated as worthy of the grief it caused. The length of the pregnancy, be it 8 weeks, 18 weeks, or full term wasn't the point of HALO's work. There was a baby, the baby had died, and the family was grieving. How could we best come alongside and support the grieving family?

It's with a great deal of heaviness I think back to how many horrible situations I dealt with during my time with HALO. Babies born without a brain or skull, abdominal contents floating in a bubble outside their bellies, no limbs, decayed and skin sloughing off because the baby died in the womb weeks before being discovered...

So much pain.

So much darkness in those rooms. I would stand outside the door and pray from someplace deep in my gut for the grace to walk in, with kindness and a steady, gentle confidence, and assure that the whole deal was difficult but it was possible - with TLC, some clothing, blankets, etc. - to make

something. *Something* to help families remember their baby, without anything that would add to the grief.

Once, I was having a difficult time not vomiting while preparing one baby who was falling apart in my hands as I tried to dress her. I needed to remember that what is here, right here in my hands, is not the end - she's not forever going to look like she does at this moment. And she is still the beautiful daughter of her parents. I got her dressed, wrapped up in soft blankets, and her family held her for hours.

Nothing about perinatal hospice is easy. Nothing takes the searing pain away.

All I'm saying is that the pain doesn't have to be the only emotion ruling, or remembered.

I have a number of autoimmune diseases, and 5 years ago my health started to decline and eventually I completely crashed. I spent more than a year in and out of the best hospitals in the area, to no avail. Hundreds of thousands of dollars spent, seemingly thrown away, for what? To have me still bedridden, unable to do anything for myself. Eventually we found a hospital and some doctors who found a way to help get me back on my feet again. But it wasn't without a lot of struggles.

During my time of bad health, I felt that all my work with HALO, all of my nursing education, all the countless hours spent reading, listening to seminars, and attending conferences to enhance my role as a Bereavement Specialist, appeared to have been for nothing.

Until August of 2012. A call came. A baby, without the right or left hemisphere of her brain, needed a home. Would we take her. She had a life limiting diagnosis, and we no idea how long she'd live or if she did, what her life would be like. With a resounding "yes!" our family opened our home to receive this baby, without a name, without anyone who loved and cared for her. She'd been left at the hospital under the Safe Haven Law. And we were there to bring her - Emmalynn - home.

We brought Emmalynn Rae Salchert home to *live*. She could have died in the hospital. Wrapped in a blanket, off to the side, not even held while she was fed.

We brought this 6 pound, 16 inch babe home. Her body was deformed but very quickly, we managed to see past her physical issues and only saw the precious soul encased in her faulty body.

50 days she lived. We took her to the beach, and the bank, and the Bookmobile. She was held almost non-stop. We'd been told she was a "vegetable," limited in her "capabilites" - but we proceeded to treat her like any of our other kiddos, and lavished affection towards her.

Before Emmalynn came, because of how devastating my illness had been, my family was in recovery mode. My son described it as, "going through the motions, just surviving day by day." After Emmalyn came, I personally found a purposefulness, and our family had a common goal to make

whatever days she had with us nothing short of crazy amazing. It was as if our home came alive and was thrown into HD Color.

What I'd like you to know is that I know how hellish it is to hear, "There's nothing that can be done. The baby is going to die." And, I want you to know that there are families like mine out there who still want to give these little babies every ounce of love possible before they leave this earth - whether these children are biologically "ours" or not.

Bringing Emmalynn home to live with us, and having her die in my arms, was the hardest thing we've ever done, but it was so worth every sacrifice. She was snuggled against my breast. Tucked close to my heart. The last thing this precious baby girl experienced was her enveloped in love and physical comfort - with no pain.

Nothing about perinatal hospice and palliative care is easy. But it means so much. And my family has no regrets.

In fact, right now my family has taken another baby who received a life-limiting diagnosis, Charlie, who is now 15 months old:

We care. We really mean it. We're not asking everyone to be just like us. We just want parents to know both they and their child can be spared the pain of abortion. We're there, arms open, officially licensed to take in kiddos whom no one else wants to take in because of their "flaws." We love them.

Words can't express how happy I am that the *Pain-Capable Unborn Child Protection Act* provides families with more information about perinatal hospice. Losing a child doesn't have to be all about the pain, and perinatal hospice helps give families the opportunity to make some good memories.

We know unborn babies feel pain from abortion. And so do their families. But the *Pain-Capable Unborn Child Protection Act* gives babies and families the opportunity for not only avoiding some pain,

Katy Zerkel
Kaukauna, WI
June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

My husband and I were at our 20 week prenatal appointment, the week we receive our first ultrasound. Our ultrasound technician went from happy and joyful at the beginning of the appointment, to being quietly concerned. We asked her if something was wrong, and she explained that our baby's lateral ventricles in her brain were wider than usual, and that I would have to see a neonatologist.

During our next appointment, the neonatologist informed us that we would have to do regular ultrasounds to keep an eye on the growth of her lateral ventricles in her brain to make sure that they were not becoming too wide. It was likely that we would have to wait until our daughter's birth to better test what was happening in her brain. She explained that the worst case scenario would be that our baby would have to be flown to Children's Hospital after her birth and have a shunt placed in her brain, which could lead to our baby being mentally handicapped. Never was abortion an option for us - no matter what happened, she was our daughter, and deserved the right to life.

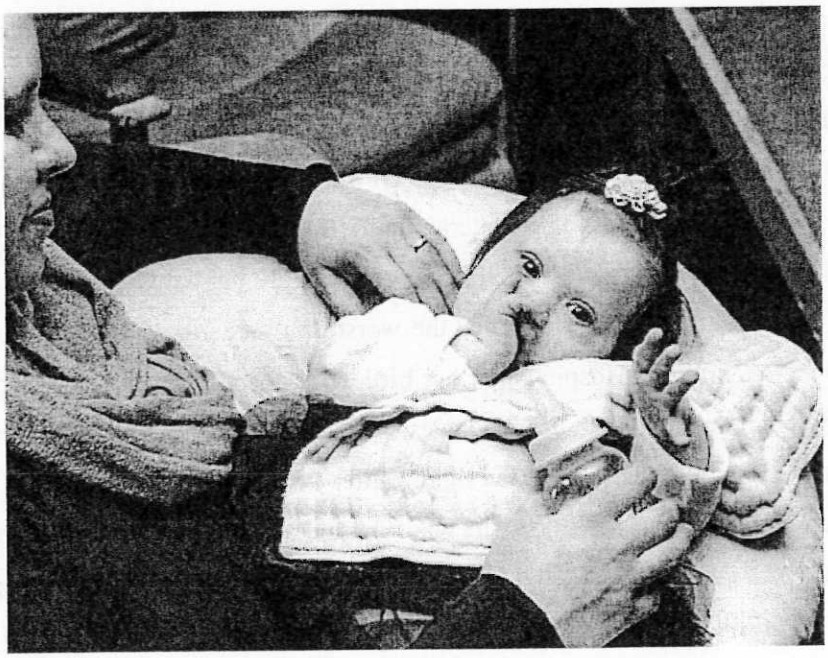
Upon our daughter's birth via c-section, she was whisked away to the NICU immediately so that they could check the lateral ventricles in her brain. Back in my recovery room, three hours passed since she had been born and I still had not seen my husband, baby, or any doctors telling me how our Gabriella was doing.

Finally, the door opened, and I was asked, "Would you like to hold your baby?" I replied excitedly with a loud, "Yes, oh yes I would!" As they lowered my daughter into my arms, the doctor said, "Katy, your baby has Down Syndrome." I gazed into my baby's sweet face and said, "Oh you do, don't you my sweetheart!" I covered her face with kisses and nuzzled her warm body close to me.

The doctor, looking bewildered, repeated slowly, "Um, Katy, your daughter has Down Syndrome." I looked up at her smiling, "Yes, I know, I heard you." Sheepishly she replied, "Okay, I wasn't sure. After being in this profession for over 30 years, I have never heard a mother respond so joyfully upon first hearing the diagnosis." I explained to her, "Gabriella is a gift, and I feel honored to be her Mommy." It didn't matter her physical condition - she was my child, deserving of all of the love and life I could give her.

Gabby had to spend 21 long days in the NICU, needing assistance breathing and with feeding. But, her lateral ventricles in her brain were completely healed upon the first test they took in the NICU.

Our dear Gabby is and always will be a treasure in our family. I call her my 'sunshine baby' because she radiates so much beauty. Her siblings, Noah & Grace, think the absolute world of their baby sister and love her tremendously. People who are born with Down Syndrome as a true gift to this earth. I can't believe that more than 90% of babies diagnosed with Down Syndrome in the womb are aborted - especially at an age when they can feel pain from abortion. Everyone who knows and loves my daughter can see that Gabriella is truly a gift, and I hope with the *Pain-Capable Unborn Child Protection Act* that more babies just like Gabriella can live and be a gift to others as well.



Thank you for your time,

Katy Zerkel

Chairwoman Vukmir, and members of the committee, thank you for allowing me to speak today. My name is Dr. Joanna Bisgrove, and I am a family physician in Oregon, Wisconsin. I am here to speak today about grave concerns I have regarding Senate bill 179/Assembly Bill 237, which proposes strict restrictions on pregnancy termination beyond 20 weeks post-fertilization.

I would like to first give you a glimpse of the perspective from which I speak. I have been practicing family medicine for 12 years, in both Chicago IL and here in Wisconsin. As part of my practice, I provide full spectrum maternal child care. Many family physicians like to say that we provide care "from cradle to grave." I am someone who proudly provides care, as a colleague once said, "from womb to tomb." I take care of women from the time they are planning their families, through their pregnancies and birth of their babies, and then care for their families while their children grow up and someday have children of their own. As part of my practice, I deliver babies AND see women and their newborns in the hospital in the few days after the child is born. In fact, that's exactly what I did this morning prior to coming here to the Capitol. It is my favorite part of being a family physician.

With that said, I do understand and appreciate the core argument of the authors of this proposed legislation. However, it is my professional and personal opinion that the intent, while well-intentioned, is severely misguided.

I have several concerns regarding this legislation. My first concern is the interference in the doctor-patient relationship. One of the primary tenants of medicine is "Primum non nocere," or "first do no harm." It is a philosophy I strongly believe in, and it is inscribed on this bracelet I wear today. However, it is a tenant that is often fraught with contradictions, and the decision on what is the best course of action in a given patient circumstance is often a mixture of the available medical evidence, the patient's situation, and the patient's beliefs. Our oath is to the patient who sits before us, and the harm which we are trying to avoid may be physical, psychological, or a combination of both. This proposed legislation effectively ties our hands in our ability to provide the best, patient centered care possible for our pregnant women who are facing an agonizing decision.

My second concern is the stated definition in the bill of when fetuses feel pain. There is incredibly solid scientific evidence that pain cannot be felt unless the entire neuro-cortical pathway is intact. For instance, a diabetic who has lost all nerve function in their lower legs cannot feel what would otherwise be a painful foot ulcer, putting them in danger of developing a life threatening infection. Likewise, a quadriplegic individual would not feel the pain of clothes burning on their skin. There is also solid evidence that the neuro-cortical pathway of a developing fetus is not complete and intact until between 29 and 30 weeks gestation. To arbitrarily dismiss methodically researched information is both foolhardy and dangerous.

My third concern is the lack of exceptions in which termination restrictions would apply. The statement "except in a medical emergency" is extremely vague, and creates a slippery slope regarding providing appropriate medical care. What, then, constitutes an emergency? Is it a pregnant woman who has been beaten so severely by her partner that she is experiencing vaginal hemorrhaging? Is it one whose has suffered an early breaking of her water, known as premature rupture of membranes, who is at high risk of life-threatening infection unless the very premature child is delivered in an timely fashion? Or is it the couple who, after years of trying to conceive, is faced with the heartbreaking news that their child has a lethal genetic defect and will not survive beyond birth? To me, these are all medical emergencies which should be accorded the best, most thoughtful care and counseling to these women and their families. However, someone else may disagree, putting these women's lives at risk. Is it fair to also put their families at risk of greater heartbreak should they lose not only an expected addition to the family, but their wife and mother as well?

My fourth and final concern lies with the underpinning moral argument of this bill: whose rights should carry – mother or child? I am concerned because of an assumption this argument makes: that the mother making the decision to terminate her pregnancy does not love the child inside her. In my 12 years caring for women during their pregnancies, I have never seen a decision to terminate a pregnancy taken lightly. By 20 weeks, which is halfway through a woman's pregnancy, every woman whom I have cared for has wanted their pregnancy. The decision to terminate a pregnancy after 20 weeks is NEVER an asked for choice, and never an easy decision. It is a decision made because of medical factors, be they genetic, infectious, traumatic or otherwise, which are outside of our control. These medical events are often cruel twists of fate, and the mother choosing to terminate her pregnancy does so with the understanding that the alternative is either certain death or lifelong pain and disability of their child. The women making these decisions choose termination because they love their child so much they do not want to see them suffer. They are also women who often have other children, and want to preserve their own health so their older children won't grow up without a mother. I have cried with these women, counseled them, and given them the information they need to make an informed decision. To take that decision away helps no one. Rather, it hurts everyone.

In conclusion, I strongly urge all of you to reject this bill and its provisions. The families of Wisconsin deserve far better than what this bill has to offer.

Thank you.

Joanna Bisgrove, MD, Family Practice

WISCONSIN CATHOLIC MEDICAL GUILDS

Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine

June 2, 2015

TO: Members, Senate Committee on Health and Human Services / Assembly Committee of Health

FROM: Robin Goldsmith, MD, President, Wisconsin Catholic Medical Guilds

RE: Senate Bill 179 / Assembly Bill 237: Pain-Capable Unborn Child Protection Act

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The Wisconsin Catholic Medical Guilds give our qualified support for 2015 Assembly Bill 237 / Senate Bill 179 because it imposes greater restrictions on abortion and thus limits the harm done by current laws and lessens the negative consequences of laws allowing abortion. We wish to reiterate our position that abortion, willed as an end or as a means, always constitutes a grave moral evil since it is the deliberate killing of an innocent human being. Hence, our support is "qualified" because we oppose the language allowing for "abortion" or to "terminate the pregnancy" in the case of "medical emergency."

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Testimony of Maureen L. Condic, Ph.D.
University of Utah, School of Medicine, Department of Neurobiology and Anatomy

JOINT PUBLIC HEARING: *Pain-Capable Unborn Child Protection Act*
(SB 179/AB 237)
State of Wisconsin Senate Committee on Health and Human Services and Assembly Committee on Health

Tuesday, June 2, 2015

Chairmen Vukmir and Sanfelippo, distinguished members of the Health and Human Services Committee and Assembly Committee on Health, I am Dr. Maureen Condic, Associate Professor of Neurobiology and Adjunct Professor of Pediatrics at the University of Utah School of Medicine. I am Director of Human Embryology for the Medical School at my institution. Thank you for this opportunity to testify regarding certain aspects of *Pain-Capable Unborn Child Protection Act* (SB 179/AB 237). This testimony is adapted from the testimony I gave before the Subcommittee on the Constitution and Civil Justice and the Committee on the Judiciary for U.S. House of Representatives in May of 2013.

What is Pain?

The experience of pain is complex, with physical, psychological and emotional elements. In the simplest sense, pain is an aversive response to a "noxious" (physically harmful or destructive) stimulus. The medical dictionary administered by the National Institutes of Health (NIH)[1] supports this view, defining pain as, "a basic bodily sensation that is induced by a noxious stimulus, is received by naked nerve endings, is characterized by physical discomfort (as pricking, throbbing, or aching), and typically leads to evasive action." As humans, we share this basic experience of pain with many other animals, from very simple creatures like reptiles and birds, up to mammals and primates.

Yet pain has more complex dimensions. The NIH dictionary also offers the following, more nuanced definition of pain: "a state of physical, emotional, or mental lack of well-being or physical, emotional, or mental uneasiness that ranges from mild discomfort or dull distress to acute often unbearable agony, may be generalized or localized, and is the consequence of being injured or hurt." This definition also defines pain as a response to a noxious stimulus or injury, but acknowledges that the response can have emotional or mental dimensions as well. And, like all mental experiences, it is difficult for any one of us to fully appreciate another person's psychological experience of pain. Every individual's reaction to pain is unique. Experiences one person might find extremely painful may seem insignificant to someone else. Moreover, even for a single individual, the perception of what is and what is not painful can change over time. Experiences a young woman might find painful (e.g. being snubbed at a social event) may seem trivial to a more experienced woman in middle age. And experiences a middle-aged woman

[1] See definition "b" at: http://www.merriam-webster.com/medlineplus/pain.

might find painfully difficult (e.g. death of a colleague) may be far less painful to a young woman who has a less acute sense of her own mortality.

How do we know if others are experiencing pain?

While the psychological and mental aspects of pain are important to us, they are also fundamentally *personal*, and therefore not something that can be fully understood by anyone else. We can listen to someone's explanation of a painful experience. We can empathize. We can measure certain physical, neurological and endocrine responses to painful stimuli. But we cannot directly share another individual's experience of pain.

Importantly, our inability to fully understand someone else's experience of pain does not prevent us from making rational and prudent judgments about painful situations and how they obligate us to behave. We do not justify inflicting pain on another person by saying, "I can't possibly know how anyone else experiences me punching them in the face, therefore I am not obligated to restrain from this behavior." When considering the pain-experience of other humans, we are guided by three simple principles: 1) what we know about pain, 2) what we observe about another individual's reaction to a painful stimulus and 3) what we can reasonably conclude from our own experience of pain.

1) What we know. When scientific data provides evidence that an experience causes harm to another individual (i.e. it involves a "noxious" stimulus), this experience is reasonably viewed as "painful." Even if the individual's perception of this harmful stimulus is compromised in some manner (perhaps by a genetic condition that limits their ability to receive painful neural information or by drugs that have temporarily limited this ability), we are nonetheless obligated to avoid causing pain to another human individual, both out of compassion and out of justice.

2) What we observe. When observation, either casual or scientific, provides reasonable evidence that an individual perceives an experience as "painful," (the individual withdraws, cries out, grimaces, or shows elevated respiration, heart rate or stress hormones), we are obligated to avoid causing pain to that individual.

3) What we experience ourselves. When our own reaction to the experience another individual is having would be one of pain, we can reasonably conclude it is painful to them as well. Perhaps not in precisely the same manner or to the same degree, but things that hurt us tend to be hurtful to others as well.

These three simple principles will be applied below to a summary of the current scientific and medical evidence regarding fetal pain.

Scientific data regarding fetal brain development and pain perception

The ability to perceive noxious stimuli and react to them develops over a very long period of time in humans, continuing well after birth and changing significantly across any individual's lifespan.

The earliest "rudiment" of the human nervous system forms by 28 days (four weeks) after sperm-egg fusion. At this stage, the primitive brain is already "patterned"; i.e. cells in different regions are specified to produce structures appropriate to their location in the nervous system as a whole.[2] Over the next several weeks, the brain will grow enormously and generate many complex connections, but the overall organization of the nervous system is established by 28 days. This is significant because it shows that even at this early stage, the brain is not anything like a mere collection of cells or a "blank slate" to be written upon by later developmental processes. Like all embryonic organs, the structure of the early brain "anticipates" the function of the mature system.

In the region of the brain responsible for thinking, memory and other "higher" functions (the neocortex or cerebral hemispheres), the earliest neurons are generated during the fourth week after sperm-egg fusion.[3] This tells us that at this early date, the brain is organizing the structures that will be required for distinctively human experiences, although these structures will not be fully mature for at least two decades.[4]

There is strong scientific evidence that communication between neurons of the brain is established in the seventh week. Synapses, or the molecular structures required for brain cells to communicate with each other, are detected in the cortex at this time.[5] In animals, synapses are functional immediately and this is also likely to be true of humans. Thus, the earliest function of the neocortex appears to commence in the seventh week.

The neural circuitry responsible for the most primitive response to pain, the spinal reflex, is in place by 8 weeks of gestation. This is the earliest point at which the fetus experiences pain in any capacity.[6] And a fetus responds just as humans at later stages of

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[2] Langman's Medical Embryology, 11th Edition T.W. Sadler. (2009). Lippincott Williams and Wilkins. (ISBN-10: 0781790697) Chapters 5 and 6.

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[5] Synaptogenesis in layer I of the human cerebral cortex in the first half of gestation. Zecevic N. Cereb Cortex. 1998;8:245-52.

[6] Synaptogenesis in the cervical cord of the human embryo: sequence of synapse formation in a spinal reflex pathway. Okado N, Kakimi S, Kojima T. J Comp Neurol. 1979;184:491-518.; Onset of synapse formation in the human spinal cord. Okado N. J Comp Neurol. 1981;201:211-9.; The fine structure of the spinal cord in human embryos

development respond; by with withdrawing from the painful stimulus. This simple response is tremendously important for humans at all ages because it rapidly protects the body from harmful events (heat, cold, chemical injury, crushing, cutting, etc.) without requiring the time it takes to reflect on the experience.

The earliest connections between neurons in the subcortico-frontal pathways (regions of the brain involved in motor control and a wide range of psychological phenomena, including pain perception) are detected by 37 days post sperm-egg fusion and are well established by 8-10 weeks.[7] This indicates that the brain is "wiring" itself in the first trimester, well before reaching the fetal stage of life. Early establishment of connections between neurons further indicates that brain formation is an active process of progressively building the structures and relationships required for mature brain function.

Connections between the spinal cord and the thalamus, the region of the brain that is largely responsible for pain perception in both the fetus and the adult, begin to form around 12 weeks and are completed by 18 weeks.[8] A recent study shows that 23% of infants born at approximately this stage (18-20 weeks post sperm-egg fusion) who receive active hospital treatment are able to survive.[9]

The long-range connections within the cortex that some believe to be required for consciousness do not arise until much later, around 22-24 weeks.[10] And these connections continue to develop for an exceptionally long time. Indeed, recent studies indicate that the anatomy of the human brain, and therefore the pattern of brain activity

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and early fetuses. Wozniak W, O'Rahilly R, Olszewska B. J Hirnforsch. 1980;21:101-24.; Early synaptogenesis in the spinal cord of human embryos. Milokhin AA. Acta Biol Hung. 1983;34:231-45.; Development of pain mechanisms. Fitzgerald M. Br Med Bull. 1991;47:667-75.

[7] Development of axonal pathways in the human fetal fronto-limbic brain: histochemical characterization and diffusion tensor imaging. Vasung L, Huang H, Jovanov-Miloševi N, Pletikos M, Mori S, Kostovi I. J Anat. 2010;217:400-17.; Insights from in vitro fetal magnetic resonance imaging of cerebral development. Kostovic I, Vasung L. Semin Perinatol. 2009;33:220-33.

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underlying all higher functions (reason, memory, emotion, language, etc.) is not fully mature until approximately 25 years after birth.[11]

What brain structures are necessary for a fetus to feel pain?

To experience pain, a noxious stimulus must be detected. *And it is entirely uncontested that the neural structures necessary to detect noxious stimuli are in place by 8-10 weeks of human development.*[12]

The debate over fetal pain experience is not whether the fetus *detects* pain in the first trimester of gestation (there is universal agreement on this point), but rather how pain is *experienced*; i.e., whether a fetus has the same pain experience a newborn or an adult would have. While every individual's experience of pain is personal, a number of scientific observations address what brain structures are necessary for a mental or psychological experience of pain—and what structures are *not* required.

First, the neocortex is unique to mammals,[13] yet it is clear that animals entirely lacking this region of the brain (fish, amphibians, reptiles and birds) are both conscious and capable of experiencing pain. While the experience of animals is unlikely to be identical to that of humans, few would justify inflicting pain on animals, simply because they lack the sophisticated cortical brain circuitry found in mature humans.

Second, it is clear that children born without higher brain structures ('decorticate' patients) are capable of conscious behaviors, including smiling, recognizing and distinguishing between familiar/unfamiliar people and situations, having preferences for particular kinds of music and having averse reactions to pain.[14] This indicates that long-range connections developing in the cortex only after 22 weeks (and absent in these patients) are not obligatory for a psychological perception of pain. Similarly, experimental animals that have had the cortex removed also show a vigorous response to painful stimuli,[15] again indicating that late-developing cortical pathways are not required

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[11] Ibid at 4.

[12] Ibid at 6.

[13] Genetic and developmental homology in amniote brains. Toward conciliating radical views of brain evolution. Aboitiz F. Brain Res Bull. 2011 Feb 1;84(2):125-36.; Evolution of the amniote pallium and the origins of mammalian neocortex. Butler AB, Reiner A, Karten HJ. Ann N Y Acad Sci. 2011 Apr;1225:14-27.

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for pain perception and response.

Third, all of the observations noted above are consistent with what is known about the representation of consciousness and emotion in the brain. A recent review from the prestigious journal "Nature" states, "Feelings constitute a crucial component of the mechanisms of life regulation, from simple to complex. Their neural substrates can be found at *all levels of the nervous system, from individual neurons to subcortical nuclei and cortical regions*." (emphasis added).[16] Importantly, development of brainstem and thalamic nuclei (among the "subcortical nuclei" mentioned above) occurs quite early in humans, with the earliest spino-thalamic connections forming by 12-18 weeks post sperm-egg fusion.[17] Similarly, a second recent review of "higher" brain functions (including pain experience) concludes that "consciousness" persists in the absence of "vast regions of the cortex."[18]

Fourth, as noted above, the cortical regions associated with response to pain (dorsal-lateral prefrontal cortex and dorsal-anterior cingulate cortex[19]) continue to develop for decades after birth, with these regions being among the last to achieve maturity.[20] However, our perception of pain remains relatively constant from childhood into adulthood, strongly indicating that mature cortical circuitry is not required for human experience of pain and suffering.

Finally, direct experimental evidence from adult humans contradicts the assertion of ACOG,[21] JAMA[22] and Royal College of Obstetricians and Gynaecologists [23] that mature pain perception requires cortical circuitry. Ablation[24] or stimulation[25] of the cortex does

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decerebrate rats but not attenuated by morphine. Matthies BK, Franklin KB. Pain. 1992; 51:199-206.

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[20] Ibid. at 4.

[21] *Amicus Curiae Brief,* American College of Obstetricians and Gynecologists And American Congress of Obstetricians and Gynecologists. Paul A. Isaacson et al., v. Tom Horne No. 12-16670. United States Court of Appeals for the Ninth Circuit.

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[23] Royal College of Obstetricians and Gynaecologists, Fetal Awareness: Review of Research and Recommendations for Practice (Mar. 2010)

[24] Ibid at 12 and 13.

not affect pain perception, whereas ablation of "lower centers," including the thalamus, does.[26] This indicates that "mature" pain perception is largely localized to the thalamus, with the spino-thalamic circuits required for pain perception are to be in place at the time being established at 12-18 weeks post sperm-egg fusion.

What we observe about fetal pain

The preceding sections of this statement have dealt with only the first principle outlined above for how we can determine whether another individual experiences pain; i.e., what we know about the neuroanatomical structures underlying pain perception. In addition, what we directly *observe* about fetal pain is very clear and unambiguous. Fetuses at 20 weeks post sperm-egg fusion have an increase in stress hormones in response to painful experiences that can be eliminated by appropriate anesthesia.[27] Multiple studies clearly indicate, "the human fetus from 18–20 weeks elaborates pituitary-adrenal, sympatho-adrenal, and circulatory stress responses to physical insults."[28] All of these responses reflect a mature, body-wide response to pain.

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[25] Motor cortex stimulation in patients with post-stroke pain: conscious somatosensory response and pain control. Fukaya C, Katayama Y, Yamamoto T, Kobayashi K, Kasai M, Oshima H. Neurol Res. 2003;25:153-6.; Stimulation of the human cortex and the experience of pain: Wilder Penfield's observations revisited. Mazzola L, Isnard J, Peyron R, Mauguière F. Brain. 2012;135:631-40.

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[28] Ibid at 22. See also; Human fetal and maternal noradrenaline responses to invasive procedures. Giannakoulopoulos X, Teixeira J, Fisk N, Glover V. Pediatr Res. 1999;45:494-9.; Fetal plasma cortisol and beta-endorphin response to intrauterine needling. Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. Lancet. 1994;344:77-81.; Acute cerebral redistribution in response to invasive procedures in the human fetus. Teixeira JM, Glover V, Fisk NM. Am J Obstet Gynecol. 1999;181:1018-25.

Fetuses delivered prematurely, as early as 23 weeks, show clear pain-related behaviors[29] (we know less about infants delivered prior to 23 weeks only because so few are available for study). Strikingly, the earlier infants are delivered, the stronger their response to pain.[30] These and many other direct observations of fetal behavior and physiology have resulted in a clear consensus among professional anesthesiologists (highly specialized physicians who are experts in pain management) that the use of medications to relieve pain is warranted in cases of fetal surgery.[31] Many of the advocates of fetal anesthesia make no claims regarding the *qualitative* nature of fetal pain, but based on both the scientific literature and on their own observations, they clearly conclude that pain *exists* for these fetuses and that they are obligated to address fetal pain medically, despite the many serious challenges and medical risks this procedure entails.[32]

Our own experience; Why fetal pain matters

As individuals and as a society we must choose the attitude we will embrace regarding fetal pain. Those who insist, "It is impossible to know what a fetus experiences," are denying the obvious fact that it is equally impossible to know what any other human individual experiences at any stage of life. This is not a legitimate argument for ignoring what we know from science and from our own observations. Similarly, those who insist, "Neuroscientists agree the cortex is required for pain perception," are denying the ample modern scientific evidence from credible, professional neuroscientists and physicians that contradicts this conclusion. The absence of a universal consensus regarding what anatomical structures are required for the complex (and personal) psychological experience of "conscious" pain perception does not excuse us from making a decision based on the best evidence available.

In the end, when considering pain in any other human individual we must choose whether we will give that individual the benefit of the doubt, out of compassion, empathy and justice, or whether we will ignore the pain they experience simply because the precise psychological quality of their pain cannot be known with certainty. And this choice is as much about the kind of society we want to be as it is about the experience of the fetus.

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[29] Pain behaviours in Extremely Low Gestational Age infants. Gibbins S, Stevens B, Beyene J, Chan PC, Bagg M, Asztalos E. Early Hum Dev. 2008;84:451-8.

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Imposing pain on any pain-capable living creature is *cruelty*. And ignoring the pain experienced by another human individual for any reason is *inhumane*. Most modern societies have enacted laws against animal cruelty, irrespective of the precise quality of pain involved. We don't need to know if a human fetus is self-reflective or even self-aware to afford it the same consideration we currently afford other pain-capable species. We simply have to decide whether we will choose to ignore the pain of the fetus or not.

From the perspective of neuroscience, it is unclear precisely what "psychological" aspects of a mature pain experience are in place at precisely what point in human prenatal or postnatal development. It is impossible for me to know with certainty whether another adult, a teenager or a fetus experiences pain in exactly the same manner I do. Yet it is *entirely* uncontested that a fetus reacts to painful stimuli, and therefore experiences pain in some capacity, from as early as 8 weeks of development.

If a living creature can experience pain, compassion demands we avoid cruelty. And most Americans would see inflicting unnecessary pain on any pain-capable creature, even those with a primitive nervous system, as *barbaric*. We would not approve of someone tearing the legs off of a cat or a dog out of sympathy for the pain this would cause, yet we condone this same cruelty in the context of abortion. Given that fetuses are members of the human species—*human beings like us*—they deserve substantially greater consideration than we give to other creatures. They deserve the benefit of the doubt regarding their experience of pain and protection from cruelty under the law.

In light of the scientific facts, the observations of medical professionals, our own experience of pain, and our indirect experience of others' pain, we must conclude that there is indeed a "compelling governmental interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain." And this unambiguously requires a 20 week fetus to be protected under *Pain-Capable Unborn Child Protection Act* (SB 179/AB 237).

ONEWISCONSINNOW

TO: Members, Assembly and Senate Committees on Health
FR: One Wisconsin Now Research Director Jenni Dye
DATE: June 2, 2015
RE: Assembly Bill 237/Senate Bill 179

Thank you for the opportunity to share testimony on Assembly Bill 237 (AB 237) and Senate Bill 179 (SB 179). My name is Jenni Dye and I am an attorney and serve as the Research Director at One Wisconsin Now. Previously I was the Executive Director of NARAL Pro-Choice Wisconsin.

The implications of what these bills will do to Wisconsin families and the healthcare of Wisconsin women are dramatic and negative.

This latest abortion ban targets women and families who are overwhelmingly people who are in the difficult position of making the agonizing decision of whether to end a wanted pregnancy because something has gone seriously wrong.

Instead of supporting these families -- ensuring women get the best care possible, helping them make the decision that is best for themselves and their family and allowing them to base it on the best judgement of a medical professional -- you are imposing your judgement.

While some of us may know someone or even have personal experience with a difficult or dangerous pregnancy, it is not our place to impose our judgement or our decision on another family.

These bills also have the effect of overriding the medical expertise of a trained doctor, and threatening them with jail time if they do not do as you wish, substituting their medicine for your politics.

With all due respect, your election did not confer a medical degree on you.

Take what nationally recognized women's reproductive health expert, Dr. Douglas Laube, said about this abortion ban in a recent radio interview. He noted that the bills could force a woman terminating a pregnancy to save her life to undergo an invasive cesarean section (c-section) surgery that dramatically increases the chance of injury to or death of the mother.

Dr. Laube said, and I quote, "what it actually means in certain cases is that cesarean section — which really is a concept applicable much later in pregnancy — a cesarean delivery would need to be done..."

- over -

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He went on to note that forcing a woman to undergo such a procedure, "Becomes a matter of patient safety as it pertains to her morbidity and her mortality," increasing the chances of serious injury to or death of the mother by five to eight times.

I urge you to support Wisconsin families and protect Wisconsin women by rejecting AB 237 and SB 179 and leaving these difficult and intensely personal decisions where they belong - in the hands of Wisconsin families and their physicians.

# # #

One Wisconsin Now is a statewide communications network specializing in effective earned media and online organizing to advance progressive leadership and values.

WISCONSIN CATHOLIC CONFERENCE

TESTIMONY ON SENATE BILL 179 AND ASSEMBLY BILL 237:
PAIN-CAPABLE UNBORN CHILD PROTECTION ACT

Presented to the Senate Committee on Health and Human Services
and the Assembly Committee on Health
By Barbara Sella, Associate Director
June 2, 2015

The Wisconsin Catholic Conference, the public policy voice of the state's Catholic bishops, strongly supports Senate Bill 179 and Assembly Bill 237, known as the Pain-Capable Unborn Child Protection Act, which would prohibit abortions at and after 20 weeks so as to spare these children the pain of being dismembered in the womb by means of a dilation and evacuation (D&E) abortion.

Our support is grounded in the first principle of Catholic social teaching, namely that every human being has intrinsic dignity and the right to life from conception until natural death.

As we do so, we stress that much more can and must be done to help families to care for these children. Because it is never enough just to outlaw injustice; society must also address the isolation, despair, and suffering that can give rise to injustice.

The Church encourages everyone to find ways to help families who face unplanned or grief-stricken pregnancies: to encounter and walk alongside them, as Pope Francis teaches us, with compassion and tenderness. We need to help them talk about their struggles and their grief. We need to let them know that they are not alone and that others have walked in their footsteps. We urge more families to consider adopting children, especially those with special needs, or to provide respite care to parents. We urge politicians to ensure that government assistance is readily available to families who do not have sufficient personal resources to care for their loved ones.

We call on the medical profession to give parents words of hope and to avoid sending the message that children with disabilities are burdens best eliminated. We urge them to inform patients about the option of perinatal hospice, which is a series of services provided to parents who choose to bring their babies to term. As a March 13, 2007, *New York Times* article observed, dozens of these programs have been developed across the U.S. in the last two decades (http://www.nytimes.com/2007/03/13/health/13hospice.html).

What the rapid proliferation of perinatal hospice demonstrates is how ready parents are to love and care for their fragile children to the very end of their natural lives. We are very happy to see that Senate Bill 179 and Assembly Bill 237 require that information on perinatal hospice be made available to women seeking abortions.

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The website www.perinatalhospice.org currently lists five such programs for Wisconsin, including the Perinatal Palliative Care Program at Meriter Hospital here in Madison (http://www.meriter.com/specialty-care/center-for-perinatal-care/perinatal-palliative-care-program), which describes its services before, during, and after birth as follows:

> A care plan is created with the family and specialized providers that focuses on what is important for the family in terms of the birth of their baby and his or her comfort and well-being after delivery. Throughout the pregnancy, the Care Coordinator continues to meet with the family to provide counseling and resources as well as to review and revise their care goals as needed. Resources may include spiritual care, mental health support, bereavement information, emotional support, and childbirth education options. A referral can be made to Now I Lay Me Down to Sleep, a non-profit organization of photographers who specialize in remembrance photography for parents suffering the loss of a baby. Upon admission to the hospital for the birth, the care plan is accessible to all staff to ensure personalized care. Supportive bereavement care is provided by dedicated nursing and medical staff. A memory box, footprints, mementoes, and photographs are provided. Post discharge bereavement support is provided with follow-up calls, cards, and perinatology consults or other referrals as needed.

None of us wants to be a burden, but each one of us is vulnerable in some way. Each one of us is an illness or an accident away from complete debilitation. But suffering need not be senseless or defeating. By God's grace and the support of family, friends, and community the most difficult circumstances can become occasions to give purpose to our lives. Simply put, all human lives matter.

Allow me to close with the words Pope Francis spoke last Friday to a group of children with disabilities and their parents. "You said that they recommended an abortion. You said, 'No, whatever comes, he has a right to live.' Never, does one solve a problem by eliminating a person. Never."

Thank you for the opportunity to testify today. Please support passage of Senate Bill 179 and Assembly Bill 237.

Rodrigo R. Merino, MD
N1691 S. Washington Rd
Chilton, Wisconsin 53014

In support of Assembly Bill 237

I am here to offer support for HB 237, which seeks to amend current Wisconsin legislation regarding the performance of elective abortions.

I am here representing myself, as a Citizen and as a Physician specializing in Neurology, which I have practiced since 1978.

This bill seeks to protect unborn human babies from harm who are 20 weeks gestational age or older, the harm under consideration being that of physical destruction for reasons other than an emergency involving its mother.

Research performed in the last 15 years has shown that the state of neurological knowledge with regard to the formation, organization and functionality of neural pathways necessary for the perception of pain keeps getting ever younger. The baby's pain sensors begin to form at about 7 weeks' gestation, they are present all over its body by 16 weeks' gestational age, and they are connected to the thalamus and to the subcortical plate by age 20 weeks.

Much has been argued as to the necessity of a functional cortex as being necessary to experience pain.

It appears, however, that this is not required. There are cases of unfortunate individuals who are missing large parts of the brain, including the cerebral hemispheres, or whose cortex is defective whether by disease or malformation who can clearly experience pain. Such people withdraw, grimace, moan, and so forth when painfully stimulated.

Although it may be surprising, the cortex is itself insensitive to pain, as neurosurgical procedures of the kind that must be done under local anesthesia have shown for many decades. However, lesions to the thalamus can result, and do, in very serious and frequently intractable central pain syndromes.

There has been vigorous argument as to whether the production of stress hormones by the unborn baby, in response to painful stimulation, might somehow indicate the presence of pain, just as happens in a term baby or adult. The fact remains that, if the unborn baby is anesthetized prior to the performance of something painful, such as preterm surgery, this stress response is diminished, as measured by decreasing titers of these hormones. I think this is suggestive, at the very least, that there is no conclusive evidence an unborn baby of less than 20 weeks is unable to feel pain. A baby of that age is frequently able, at that age, of surviving with adequate technological support.

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Wisconsin Medical Society

TO: Senate Committee on Health and Human Services
Senator Leah Vukmir, Chair

Assembly Committee on Health
Representative Joe Sanfelippo, Chair

FROM: Chris Rasch
Director of State and Federal Relations

DATE: June 2, 2015

RE: Opposition to 2015 Senate Bill 179 / Assembly Bill 237

On behalf of 12,800 members statewide, the Wisconsin Medical Society thanks the committees for this opportunity to share our opposition to 2015 Senate Bill 179 / Assembly Bill 237 (SB179/AB237) which establishes new ill-conceived and unsafe requirements into the physician-patient relationship for specific medical encounters. That these bills focus on an emotional topic—abortion—makes the overall issue more complicated, yet the underlying principle is the same. The Society is deeply concerned about the interference in the physician-patient relationship and criminalizing certain medical procedures.

Interferes with the Physician-Patient Relationship

The legislature should not insert itself into medical care decision-making. The Society is concerned that SB179/AB237 interferes with the physician-patient relationship by establishing arbitrary standards of care instead of medically informed decision making. About one percent of abortions are performed at 21 weeks last menstrual period (LMP) or later in a pregnancy. Most of these abortions are performed because of lethal fetal genetic anomalies or due to the health of the mother. These decisions are medically complex and difficult decisions for women and their families, and are best left to women to make in consultation with their physician.

The Society opposes efforts that interfere with the sacred patient-physician relationship, as SB179/AB237 would do by mandating specific requirements in a patient-physician encounter. The requirements and limitations interferes with the sanctity of the physician patient relationship which is the foundation of all medical care. The infringement proposed in these bills are a dangerous slippery slope that interferes with the patient-physician relationship, and places an unneeded and unprecedented burden on Wisconsin physicians and women.

Including Inappropriate Definitions of Medical Care and Fetal Pain in State Statute

What constitutes optimal and standard medical care is constantly evolving—statutory law is an inappropriate place for establishing and enshrining specific ever evolving standards of medical care.

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The dangerousness of replacing physicians' medical judgement with rigid state statutes that are or will be based on antiquated and unscientific medical science is a concern any time the legislature does so whether the issue is controversial or not. To use inaccurate medical information as the basis of legislation and requirements for physicians, as SB179/AB237 do, is ill-conceived and puts physicians at odds with their professional ethics to act in the manner of their best medical judgment for patients.

The bills put into state statue a definition of fetal pain that is not scientifically accepted by the medical community. Pain perception requires recognition of noxious stimuli. While the pain receptors may be present in 20-week old fetuses and a startle response shown, systematic reviews of the literature have found that the majority of rigorous scientific data on fetal pain show that pain is not felt by fetuses until 29-30 LMP weeks. It is at this time that the brain is developed that perceives pain as a painful stimulus. Opposing views and science are based on little evidence and speculation, and when weighted together with the best and most rigorous evidence should not be used as justification for the definition of when fetal pain may begin. Given the evidence suggests fetal pain does not exist prior to 24 LMP weeks, the legislature should not be putting into state statute that it begins at 20 weeks post-fertilization[1].

There are Not Adequate Exceptions

We should never put in place requirements that put physicians in the place of denying necessary medical services to pregnant women whose continued pregnancy seriously threatens their life or health, much less put these harsh requirements into state statute. SB179/AB237 do not properly protect the safety of the mother and lack adequate health of the mother exceptions. Specifically, the medical emergency exception as defined in the bill is much too restrictive. OB/GYNs are concerned that the bill's limit on exceptions would force a physician to assist women in carrying their pregnancy to term when there is a real potential for increased risk to the health and life of the mother. It could also force OB/GYNs to perform a C-section in certain situations on a woman for a non-viable fetus due to the requirement to terminate the pregnancy in a manner that provides the best opportunity for a fetus to survive. In general, C-sections are not performed before 24 weeks gestation because technical difficulties and the dismal or non-existent survival rates along with an increased risk of current and future harm to mothers. In short, the limitations included in the bills will negatively impact the quality and safety of care that is delivered to pregnant women at a time when physicians are focused on providing the highest quality of care.

Criminalizing and Penalizing Certain Medical Practices

The Society is opposed to criminalizing physicians for performing legal and medically necessary procedures. Under the bill a physician who performs or induces or attempts to perform or induce an abortion upon a woman when the unborn child is considered capable of experiencing pain unless the woman is undergoing a medical emergency could be criminally charged with a felony subject to a fine not to exceed $10,000, imprisonment not to exceed three years and six months, or both.

The Society is also opposed to additional civil remedies to be brought claiming damages if a physician performs, or attempts to perform an abortion after 20 weeks. The bills also require new provider reporting and patient disclosures and sets new penalties for those who violate the requirements which the Society opposes.

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1. Rysavy M et al. Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants. *NEMJ* 2015; 372;19: 1801-1811.

Interfering with Informed Decision Making

Pregnant women routinely undergo an ultrasound at 20 weeks LMP, in part to evaluate the fetus for abnormalities. It is at 20 weeks or more that most anomalies can best be seen and fully evaluated. Often times even when an anomaly is detected before 20 weeks additional tests and the scheduling of follow-up appointments and additional tests takes time. An unintended consequence of this legislation is that a ban on abortions after 20 weeks post-fertilization will undoubtedly put some women in the position to choose an abortion prior to 20 weeks and prior to getting a full consultation to make an informed decision on the neonatal outcomes because of the time constraints a 20 week ban presents.

The Society's general abortion policy views abortion as medical procedure:

ABO-004

Abortion as a Medical Procedure and Providing Abortion-Related Information: The Wisconsin Medical Society: 1) supports enactment of appropriate legislation that would acknowledge the right of a physician to perform and to practice this medical procedure as he/she might any other medical procedure or to refuse to perform an abortion according to the dictates of his/her training, experience and conscience; 2) supports the development of guidelines that ensure that abortions be performed only under proper medical circumstances with adequate provision for safeguarding the health of the patient; and 3) although abortion is a contentious issue, it is a legal medical procedure and physicians should be expected to advise their patients of all available options. (HOD, 0408)

This policy highlights two important points in this area of medical care: that abortion is a legal, accepted medical procedure, and that abortion is controversial. The Society believes that *all* medical care should follow a full and confidential discussion between a patient and her/his physician—there should be no exceptions to that relationship simply because a certain procedure is controversial.

Conclusion

An intrusion in the patient-physician relationship is unacceptable. Again, a medical procedure should not be singled out for potentially onerous requirements solely because it is controversial and these requirements should not be based on dubious science that is disputed by the majority of the medical community. Physicians should be deciding with their patients what procedures are needed and will be performed based on the best available medical evidence, guidelines of care, and shared decision making between the patient and physician

We respectfully ask you to oppose SB179/AB237.

Thank you for this opportunity to provide testimony. If you have further questions please feel free to contact Chris Rasch at chris.rasch@wismed.org or call 608.442.3800.

TO: Wisconsin Assembly Committee on Health DATE: June 2, 2015
RE: Statement in support of SB 179 and AB 237

Thank you for the opportunity to submit testimony in favor of SB 179 and AB 237. I am a board certified physician anesthesiologist and practiced for 25 years at the Medical College of Wisconsin, Froedtert and Zablocki Veterans Administration hospitals. I am now retired.

In a May 27, 2015 Medscape article, Mark S. DeFrancesco MD, MBA, states that there is no evidence for fetal pain in the second trimester and states that "Medical and legislative decisions should be made be based on science, not ideology. I agree with the latter. http://www.medscape.com/viewarticle/845157?src=wnl_edit_specol&uac=115449DJ

Two of his three references are from ideologically prochoice physician groups, the American College of Obstetrics and Gynecology and the Royal College of Obstetrics and Gynecology. He claims that the 2005 Journal of the American Medical Association is a "landmark review" and "incontrovertibly found no existence of fetal pain until much later in gestation," saying, "Importantly no research since its publication has contradicted its findings."

However, there are at least 6 references after 2005, referenced and summarized by Doctors on Fetal Pain most recently updated in February 2013. These and other peer reviewed original studies give evidence of pain sensation from at least the 20th week and probably earlier, even without connections to the cerebral cortex, and *in utero*. http://www.doctorsonfetalpain.com/answering-the-pain-deniers/#.VW0pyVxViko http://www.doctorsonfetalpain.com/wp-content/uploads/2013/02/Fetal-Pain-The-Evidence-Feb-2013.pdf

"Pain has been historically undertreated in pediatric patients." (Accessed 6/1/15 asahq.org file:///Users/czainer/Downloads/practice-guidelines-for-acute-pain-management-in-the-perioperative-setting.pdf)

In the early 1980's little to no anesthetics or analgesics were given during surgery on premature infants and neonates because of a mistaken belief that they did not experience pain, along with the concern that drugs would be deleterious. Survival was first, pain relief second, if at all. Drugs have changed somewhat but also our beliefs and practice.

In the late 1980's a major paradigm shift in pediatric anesthesia occurred with the work of Dr. Anand et al. It turns out that survival did depend on pain relief. His work on premature infants showed that treatment with pain medication blunting the stress responses to surgery resulted in lower death and complication rates. (Anand, et. al. "Pain and its effects in the human neonate and fetus." New England Journal of Medicine, 317:1321-1329, 1987; Anand, et. al. "Randomized trial of fentanyl anaesthesia in preterm neonates undergoing surgery: effect on the stress response." Lancet 321:243-248, 1987)

Dr. Jean Wright, MD, MBA, Professor and Chairman of Pediatrics, Mercer School of Medicine has summarized findings related to fetal pain in a congressional staff briefing in June, 2004 and again in testimony to the Wisconsin legislature in 2005:
* Markers of fetal pain perception start at the 7th week and mature over the next 12 weeks.
* By week 20, the anatomy of the nervous system and the physiology of responding to the pain impulse draw a clear cause and effect relationship.
* Fetal responses are more than reflexes and infer consciousness.
* Fetal sensations of pain may be more intense than those of term infants, and cannot be modulated or inhibited as in term infants.
* Maternal anesthesia alone is not sufficient.

Anesthesia is necessary in patients without obvious "pain sensation."

For example in patients with spinal cord injuries, an anesthetic is given even though they don't "feel" the painful stimuli in order to suppress the body's responses which may lead to life-threatening changes in blood pressure.

During a general anesthetic, even though the patient by all evidence is unconscious, when a reaction consistent with pain such an increase in heart rate or blood pressure or movement occurs, the anesthesiologist while considering drugs to directly alter heart rate and blood pressure, may commonly give pain relieving drugs, even if she doesn't think that the patient is "consciously aware" of the painful stimulus. She may increase the inhalational anesthetic agents, administer medications to hopefully provide amnesia for the noxious stimuli, and/or give neuromuscular blocking drugs to prevent movement not only to maintain a quiescent field for the surgeon but also patient safety.

Hence, the "conscious recognition or awareness" of "pain perception" is not the standard used to actually treat physiologic responses consistent with, although not necessarily associated with "conscious pain" in patients. Yet, some would insist on this higher standard for the fetus for whom dismemberment is being considered. To others, the possibility of pain does not matter. Their mothers deserve to know.

Let's not underestimate the reasonable and substantial scientific evidence of pain in the fetus. (Latin for offspring, young one).

Thank you.

Christine Zainer MD

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Testimony *for Information Only* on Senate Bill 179/Assembly Bill 237
Senate Committee on Health/Assembly Committee on Health
Julaine K. Appling, WFA President
June 1, 2015

Thank you, Chairwoman Vukmir and Chairman Sanfelippo, for the opportunity to testify on Senate Bill 179/Assembly Bill 237. I am testifying for information only today.

This is a bill we would love to support 100 per cent. After all, Wisconsin Family Action, as a part of our mission, is totally pro-life. Further, we believe this bill has the potential of being one of the very best pro-life bills we have considered in Wisconsin. This Pain-Capable Unborn Child Protection bill truly respects the humanity of unborn babies by acknowledging that these babies who are at or beyond twenty weeks gestation feel pain. For all these reasons, we believe this well-intentioned bill needs to be the very best it can be.

While we readily thank the authors for their work and acknowledge their noble intent—protecting unborn babies who feel pain from gruesome, life-taking abortions, we find ourselves unable to unreservedly support this bill. Our problem is with the "medical emergency" language in the proposal. We believe this language is unnecessary and could provide a loophole resulting in late-term babies being aborted that should and could have been saved.

The definition of "medical emergency" used in this bill is in the section of the state statutes entitled, "Voluntary and informed consent for abortions." The wording of the definition makes it abundantly clear that this definition enables a physician to use his/her "reasonable medical judgment" in determining if an "immediate abortion" is necessary. (Highlights added by memo author.)

253.10 (2) (d) *"Medical emergency" means a condition, in a physician's reasonable medical judgment, that so complicates the medical condition of a pregnant woman as to necessitate* ***the immediate abortion of her pregnancy*** *to avert her death or for which a 24-hour delay in performance or inducement of an abortion will create serious risk of substantial and irreversible impairment of one or more of the woman's major bodily functions.*

In this statute, given its placement, "abortion" must have the meaning ascribed to it in 253.10 (2) (a): *"Abortion" means the use of an instrument, medicine, drug or other substance or device with intent to terminate the pregnancy of a woman known to be pregnant or for whom there is reason to believe that she may be pregnant and with intent other than to increase the probability of a live birth, to preserve the life or health of the infant after live birth or to remove a dead fetus.*

The bill clearly indicates that this is the definition of "medical emergency" and "abortion" for purposes of this bill. We believe there is some confusion caused by using "termination of pregnancy" within the proposed language and not making it clear exactly how this term is being used. Does it have a different meaning from abortion as defined in the statutes? Nevertheless, the use of "medical emergency" is clear and allows a physician to make a determination regarding not to just "terminate the pregnancy" but to do a direct abortion. All the physician must then do is to justify his/her decision by reporting a "statement" evidencing, essentially, compliance with the "medical emergency" statute.

In addition, the reporting requirements portion of the proposed bill are created in the section of the State Statutes entitled "Induced abortion reporting" (69.186) further solidifying that this is about an abortion as defined in 253.10 (2) (a).

That means a woman who is 20 weeks or more pregnant who has been in a severe car accident and is in an Emergency Room could end up having an attending physician determine that an abortion of her baby is the only way to save her life, based on that physician's "reasonable medical judgment." He simply must answer some basic questions in the reporting process to justify his "judgment."

Today with advancements in science and medical technology such an "either/or" situation is virtually never necessary; health care professionals can deal extremely successfully with these emergencies as both/and. Even former abortionists assert that medical personnel have the ability now to save both mother and baby even in extreme situations. That said, if the baby inadvertently dies during the course of treating the mother so as to save her life or prevent irreversible harm to a major bodily function, while profoundly sad, that is far different from making a purposeful decision to abort—to intentionally kill an unborn child. Under current Wisconsin law, if a baby died in this scenario, the attending physician would not be charged with a crime.

Some assert that the US Supreme Court's decision in *Planned Parenthood v. Casey* demands this "medical emergency" exception. However, *Casey* is bad law, concocted rather like *Roe v. Wade* was, by judicial activists to advance a political agenda. We believe it is time to push the court to deal with the realities that this bill is about the babies and the pain they feel and that today we don't need loose "medical emergency" language that allows for a physician to do a direct abortion purportedly to save the mother.

Wisconsin Family Action does not see any reason to weaken this great piece of pro-life legislation by yielding this ground and giving anyone an opportunity to inflict incredible pain on an unborn child at 20-weeks development or beyond. Removing the "medical emergency" language doesn't jeopardize the mother. It keeps the focus where it should be—on the baby and the pain he/she feels, while also recognizing that medical science can save both the mother and the baby without resorting to a horrific, pain-inflicting, life-taking, intentional abortion.

If the bill is amended to remove the "medical emergency" language, we would wholeheartedly endorse and support this bill.

Thank you for your time.

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To: Senate and Assembly Health Committee Members
From: Dr. Mary Landry
Date: June 2, 2015
Re: Opposition to AB 237 and SB 179

Dear legislators,

I am opposed to the 20 week ban on abortion. I hope that you will join me in opposition to this legislation, which limits a woman's right to determine what is best for her or her child prior to a gestational age when a medical care team can support a life outside her body. In circumstances in which a woman, with the help of her medical provider, determines that her health or the health of her pre viable fetus is negatively impacted by the birth of the child, she and only she should have the right to decide to end the pregnancy. As an example, a child with no chance of survival outside of the mother due to lethal congenital anomalies, often not detected and confirmed prior to 20 weeks, would be denied the dignity of ending the pregnancy at 20-24 weeks gestation and would instead go through a birth followed by death, with needless and inevitable added suffering of both child and mother during the interval between. It is far more humane and just for both child and mother to allow the mother, not a government, to maintain control in this unfortunate health situation instead of forcing her to carry the child to term, postponing an inevitable tragedy with the added suffering. Whether the circumstance be a child with anencephaly, hydrops, hypoplastic left heart, to name a few, or maternal severe preeclampsia, lupus with renal failure, or advanced stage cancer requiring toxic chemotherapy, the right to choose how to best care for woman or fetus needs to remain with the woman, as these cases of life and death are rarely clear enough for a one size fits all legal mandate.

Please allow individuals, with their health providers support, family support, spiritual support, the dignity to choose what's best between the 2 horrible options leading to death and death, when life and life are not possible.

Vote NO on the 20 week abortion ban, which is YES for women and their family's to choose what's best when best is far from clear.

Respectfully,

Mary S. Landry. M.D.
5666 Alpine Road
Brooklyn, WI

WISCONSIN COALITION AGAINST SEXUAL ASSAULT

To: Members of the State Senate Committee on Health and Human Services and the State Assembly Committee on Health
From: Wisconsin Coalition Against Sexual Assault
Re: 20-Week Abortion Ban: SB 179 / AB 237
Date: June 2, 2015

Good morning, my name is Dominic Holt, public policy and communications coordinator at the Wisconsin Coalition Against Sexual Assault (WCASA). WCASA is a membership agency comprised of organizations and individuals working to end sexual violence in Wisconsin. Among these are the 50 sexual assault service provider agencies throughout the state that offer support, advocacy and information to survivors of sexual assault and their families.

WCASA asks that you join us in opposing SB 179 and AB 237, a 20-week abortion ban. In addition to its long-lasting trauma, sexual assault is about domination and control over another person's body and decision-making. Consequently, it is important to offer survivors of sexual assault opportunities to regain that control by empowering them to make their own decisions. This is especially true regarding their body and reproductive health.

Restricting access to abortion, as proposed, further limits the control survivors have to make decisions after an assault. Limiting access to abortion is also re-victimizing for survivors and impedes their long-term recovery. Such restrictions can cause a survivor who has become pregnant as a result of the assault to seek an unregulated abortion or to carry their perpetrator's child to term.

Consistent with our 2015-2016 Public Policy Agenda, WCASA supports policies that protect or advance women's reproductive health. WCASA also supports policies that allow survivors of sexual assault to make their own decisions about their health and reproductive care. In fact, one of WCASA's 10 core concepts of sexual violence prevention is empowerment and body autonomy. The proposed abortion ban stands in stark contrast to WCASA's positions.

If lawmakers are serious about preventing the need for abortion, then they should support policy initiatives that provide for comprehensive, evidence-based sexual health education and access to reproductive health services for all Wisconsinites. Not only is this education important for sexual health, it is also an important component to sexual violence prevention, by promoting healthy sexuality and teaching consent.[1] Prevention is incredibly important, as sexual violence affects Wisconsinites from every walk of life and every part of the state.

The numbers are staggering. An estimated 390,000 women — essentially one in five — have been raped in Wisconsin.[2] Nationally, it is estimated that 5% of sexual assaults result in pregnancy each year, which equates to over 32,000 pregnancies as a result of rape per year.[3] One

[1] An Overview on Healthy Sexuality and Sexual Violence Prevention. National Sexual Violence Resource Center. http://www.nsvrc.org/sites/default/files/SAAM_2012_An-overview-on-healthy-sexuality-and-sexual-violence.pdf
[2] Prevalence estimates from the National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Published 2011. Centers for Disease Control and Prevention.
[3] Sexual Violence: Consequences. Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html

might assume that survivors receive medical care immediately after an assault to prevent pregnancy. However, one study found that only 11.7% of survivors received immediate medical care after the assault, and 47.1% received no medical care related to the assault.[4] Furthermore, 32.4% of survivors did not learn that they were pregnant until sometime in the second trimester, which overlaps with the proposed 20-week abortion ban.[5]

A survivor who becomes pregnant from an assault must be presented the full range of medical and treatment options. Decisions should be made between the pregnant woman and her healthcare provider, without interference from politicians. The proposed abortion ban puts politicians squarely in the middle of those critical healthcare discussions, where politicians do not belong.

Moreover, mainstream medical organizations, such as the Wisconsin Chapter of the American College of Obstetricians and Gynecologists and the Wisconsin Chapter of the American Academy of Pediatrics, oppose the 20-week ban legislation.[6] According to many medical organizations, abortion bans are based on inaccurate medical information, put women's lives at risk, and attempt to prescribe how medical professionals should care for patients.

Thank you for your consideration. If you have any questions, you can reach me at dominich@wcasa.org or at the phone number above.

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[4] American Journal of Obstetrics and Gynecology. 1996 Aug; 175(2): 320-4; discussion 324-5. Cited as a primary resource article in Sexual Violence: Consequences. Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html

[5] Ibid.

[6] On May 26, 2015, the Wisconsin Chapter of the American Academy of Pediatrics endorsed Issue Paper 20 from the Wisconsin Section, American College of Obstetricians and Gynecologists. This issue paper addresses 2015 Senate Bill 179, which seeks to block termination of pregnancy after 20 weeks of gestation. https://www.wiaap.org/termination-of-pregnancy-after-20-weeks/

TO: Senate Committee on Health and Human Services and Assembly Committee on Health
FROM: Kenneth W. Merkitch Jr. M.D.
RE: Opposition to SB 179/AB 237
DATE: June 2, 2015

I am submitting this written testimony to express my opposition as a practicing obstetrician-gynecologist to SB 179/AB 237, which would make almost all pregnancy terminations beyond 20 weeks gestation illegal, with only very limited exceptions. I believe this legislation, although well-intentioned, will be harmful to patients and may actually result in an increased number of abortions.

I have been a practicing obstetrician-gynecologist in La Crosse, Wisconsin for over 26 years. During that time, I can only recall 2 patients who had "elective" abortions beyond 20 weeks gestation- and one of those was the result of amniocentesis proving that the pregnancy was the result of a sexual assault (notably under this proposal, that patient would be denied access to abortion services). Rather, those patients for whom I have cared that have made this very difficult decision, to terminate a pregnancy after 20 weeks gestation, did so because their baby had birth defects that were lethal, would result in a terrible quality of life, and/or only allow their baby to live for a very brief amount of time after being born.

This bill would affect couples like the one I cared for recently, whose baby's kidneys did not form. Without kidneys, there is no amniotic fluid and the lungs can't develop, which results in babies who cannot breathe and die soon after birth of asphyxiation. Couples like the one I cared for recently, whose baby's vital organs- heart, intestines, stomach, liver- were on the outside of their bodies. Couples whose baby's brain did not form- or protruded out gaping holes in their skulls. Couples with babies whose hearts were so malformed that they could not pump blood throughout their bodies. When confronted with this difficult and heartbreaking information, and only after extensive counseling and only when we are sure of the information/diagnosis, mothers/couples sometimes will choose pregnancy termination. They do so not because they do not love these children, but because they do not want to put themselves- and their babies- through another several months of limbo when the **final result is certain**. It has been my privilege and responsibility to counsel mothers/couples during these difficult times, and I have never seen them not be devastated and heartbroken if and when they make this choice. To force these mothers/couples to continue a pregnancy whose end result is certain seems cruel.

I put **final result is certain** in bold for a reason. Presently, most screening ultrasounds are performed at 18-20 weeks- at this point the baby's organs are formed and we are able to do a detailed survey of the anatomy- and, if abnormalities are seen, there is time to obtain specialized consultations and do further testing to determine the baby's prognosis. This allows mothers/couples to process this information. What I fear will be an unintentional result of the legislation is that the timing of the screening ultrasound will be pushed up- when it is more difficult to make a diagnosis with certainty- or if still done at about 18 weeks, this will decrease the time that mothers/couples have to make informed decisions. I worry that one result of this legislation is that there will be **more** pregnancy terminations- as mothers/couples, under fear of the 20-week deadline, make less-than-well-informed decisions on incomplete information.

I thank you for reading this testimony and considering these thoughts as you consider this difficult issue.

Wisconsin Alliance for
Women's Health
www.supportwomenshealth.org

TO: Senate Committee on Health and Human Services and Assembly Committee on Health
FROM: Angela Janis, M.D., Board President, Wisconsin Alliance for Women's Health
RE: Testimony for in Opposition to SB 179/AB 237
Date: June 2, 2015

Chairwoman Vukmir and Chairman Sanfelippo, thank you for the opportunity to share my testimony in opposition to SB 179 and AB 237, which would prohibit almost all women from accessing abortion services after 20 weeks gestation. As a practicing physician who is concerned about both the well-being of my patients and the integrity of medicine, I believe that this proposal is a dangerous and unwarranted intrusion into the doctor-patient relationship.

First, we must consider the women and families who will be directly affected by this proposal. The vast majority of women who seek abortion services after 20 weeks of pregnancy do so because they face dire circumstances that involve severe fetal abnormalities and/or serious risks to their health as a result of the pregnancy. Except for a woefully inadequate exception for cases involving a "medical emergency" that is far too narrowly defined, SB 179/AB 237 almost completely ignores this reality.

I strongly urge all of you to listen closely to and carefully consider the compelling testimony you will hear today from many practicing physicians who care deeply about the health and welfare of their patients to understand what the real impact of this legislation will be on our patients and their families. Even more importantly, several women who, as a result of medical complications beyond their control, made the heartbreaking decision to terminate a wanted pregnancy have bravely shared their stories with you in order to illustrate what these situations and decisions entail. Please take a moment to put yourselves in these women's shoes, or the shoes of their physicians, and ask if this legislation is really right for Wisconsin.

Second, it is striking to me the unanimity with which the medical community has expressed it strong opposition to this bill. The Wisconsin Medical Society, the Wisconsin Section of the American Congress of Obstetricians and Gynecologists (ACOG), the Wisconsin Chapter of the American Academy of Pediatrics, and the Wisconsin Academy of Family Physicians all oppose this legislation. Not one mainstream medical organization supports this legislation. This widespread opposition from physicians and organizations who work to ensure that patients in Wisconsin have access to medically necessary care should tell you that this bill is wrong for women's health and wrong for the integrity of medicine in our state.

Finally, as a practicing physician, I take my responsibility to ensure that my patients have every opportunity to make informed decisions that are best for their health and their families very seriously. I am greatly disturbed by the fact that this proposal represents a political intrusion into a physician's relationship with her patients. Many of the provisions and legislative findings in this bill are not grounded in medical science, but would still dictate the care that physicians would be allowed to provide to their patients. When these medically unsound mandates are combined with the threat of significant criminal and civil liability for any physician who violates these proposed standards, the end result is the criminalization of physicians who would otherwise simply be providing their patients with the medically accepted standard of care as determined by the mainstream medical community. When viewed from this perspective, it is unimaginable to me why the Legislature would want to intrude into the field of medicine is such a harmful manner to both patients and physicians.

Thank you for taking the time to consider my testimony. I strongly urge you to do the right thing for Wisconsin's women and medical community by opposing SB 179/AB 237. I would be happy to answer any questions you may have.

P.O. Box 1726, Madison, WI 53701-1726 608-251-0139 toll free: 866-399-9294 fax: 608-256-3004 info@wiawh.org

Thank you for taking my testimony today. I am a retired family physician who did obstetrics and practiced in Madison for 35 years. In February of this year, my family suffered a heart-wrenching loss. My daughter-in-law, 2 days before her scheduled C-section to deliver twin girls at the end of a much anticipated and wanted pregnancy, suffered a cardiac arrest and died, along with both babies. Pregnancy can be viewed as a gift from God or a wonderful act of Nature that allows us to continue as a species. But, it should never be forgotten, that pregnancy, like any other facet of human life, carries real, palpable and fearful risks. Modern obstetrical practice has reduced these risks dramatically over the past 100 years and therapeutic abortion is one of the important tools in this practice, which this bill seeks to limit.

Make no mistake: abortions performed at the time of pregnancy that this bill would prohibit are rarely done for elective reasons. An abortion is done at this stage of pregnancy most commonly because a woman is being confronted with an awful choice. In the middle of what was supposed to be a wanted and valued pregnancy, she has learned, most likely from a recent ultrasound, that she is carrying a fetus with a serious, even lethal deformity or that the pregnancy itself has a grave complication. Far from being "cool", this ultrasound has been most *cruel*. If she is forced, as this bill would do, to carry the pregnancy to term or, to however long it may last, she and the fetus may suffer life-ending consequences. To prevent a doctor from offering this medically appropriate procedure, indeed to criminalize it, is to legislate malpractice.

Abortions at 20 weeks are offered to women who never have wanted to end their pregnancies this way. This bill will force them to leave the state to get this procedure. And women in Maple Bluff and River Hills and Waukesha will do just that.

This bill will penalize poor women and women in rural communities, women who are constituents of many of you in this room. You must vote for all the women in your districts and for maintaining rational and safe medical practice in the State of Wisconsin.

Thank you for your time.
Calvin S. Bruce, MD June 2, 2015

Angela Debbink

Cedar Grove, WI

June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

My name is Angela Debbink, I'm 17 years old, and I'm here to be a voice for all the unborn babies who can't cry out when they feel pain during an abortion.

Since I was born after 1973, I could very easily have been one of those babies who lost their lives to abortion. I feel like I need to speak for all the babies that didn't make it outside of the womb like I did. And I truly believe it is the duty of this legislature to protect these babies, especially when they can feel pain, with the *Pain-Capable Unborn Child Protection Act*.

The truth is, unborn babies can feel pain by 20 weeks post-fertilization, at the latest. They thrash around when poked, their stress hormone levels go up when prodded, and they have a "closed circuit" nervous system developed by the 20 week mark. All physical structures they need to feel pain is developed by this point - that's why doctors give these babies anesthesia during fetal surgery.

You know, when I turn 18, I will be able to vote. And I hope I can vote for Senators and Representatives who care about protecting the unborn as much as I do.

These unborn babies have no voice in our government, but we do. We can protect them from the pain of abortion. I urge you to pass the *Pain-Capable Unborn Child Protection Act*, and be a voice for the voiceless.

Thank you for your time,

Angela Debbink

TESTIMONY Opposing AB 237 & SB 179
Wisconsin Senate Committee on Health and Human Services and
Assembly Committee on Health
June 2, 2015

I am Co-Administrator of Women's Medical Fund, an all-volunteer non-profit organization which has, for almost 40 years, assisted Wisconsin women in paying for abortion care, including women who request help after 20 weeks of pregnancy.

I write to express our organization's opposition to AB 237 & SB 179.

This legislation would take away a Wisconsin woman's ability to make a personal medical decision in consultation with her trusted health care provider. It has been widely rejected by the nation and state's leading authority on women's health, the American College of Obstetricians and Gynecologists (ACOG), as well as national and state constitutional experts.

In Wisconsin it is very unusual for women past twenty weeks to access abortion care. According to the 2013 Wisconsin Department of Health Report on Induced Abortions Statistics, based on forms collected for every abortion performed in Wisconsin, a total of 6,462 abortions were performed with only 89 women in 2013 having had an abortion past twenty weeks.

While the number is small, those 89 women are real, and their lives matter. Politicians should not decide the medical care of Wisconsin women. Women and their health care providers should decide.

Women seeking this abortion care are often facing extremely complicated pregnancies and should have every medical option — including ending the pregnancy — available to them to consider in consultation with medical professionals and their families.

AB 237 & SB 179 fail to contain real health or real life exceptions, allowing abortions after 20 weeks only under very narrow circumstances. The bill impedes the exercise of physician's best medical judgment and could force a Wisconsin woman to have a dangerous and unnecessary surgical procedure, instead of safer alternatives.

There are no exceptions in these bills for fetal anomalies or for cases of rape or incest. Politicians who vote for this bill would be responsible for forcing a woman to carry her rapist's pregnancy to term, then, outrageously, fight that rapist in court "if she wishes to oppose establishment of paternity or to terminate the father's parental rights."

It is troubling that the legislative findings in this bill are not supported by fact, medicine or science. The Journal of the American Medical Association published peer-reviewed research refuting claims of fetal pain at 20 weeks and the Royal College of Obstetrics and Gynecology similarly refutes such claims. [1]

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[1] University of California, ANSIRH: http://www.ansirh.org/research/late-abortion/countering-misinformation/fetal-pain.php

AB 237 & SB 179 are unconstitutional on their face. The U.S. Constitution prohibits a state from enacting a law that bans abortion prior to the point in pregnancy when a fetus is viable. In fact, the Supreme Court has held that states may not do so.[2] Every time unconstitutional abortion bans like AB 237 & SB 179 have been challenged in the courts, they have been blocked, including challenges to legislation passed in Arizona, Georgia, and Idaho. The United States Supreme Court refused to review the Arizona ban—allowing a ruling from an appellate court striking the measure as unconstitutional to stand.

Most recently, just last Friday, three federal judges unanimously struck down an Idaho law that banned abortions after 20 weeks of pregnancy, just as these Wisconsin bills seek to do. A panel of the U.S. 9th Circuit Court of Appeals upheld a previous decision by the U.S. District Court of Idaho, which also found this portion of the Idaho law unconstitutional. The Circuit Court's opinion reasoned that the law violated women's rights because it "categorically bans some abortions before viability" by prohibiting abortions before the 24-to-28-week viability benchmark.

If you vote for this bill, you will be subjecting the state of Wisconsin to an expensive, protracted legal battle trying to defend an indefensible, clearly unconstitutional bill.

Women's Medical Fund asks that you consider the legal and health-related defects of this legislation and do all that you can to protect the well-being of Wisconsin women.

Please vote NO on AB 237 & SB 179.

Thank you for your consideration.

Nora Cusack
Co-Administrator
Women's Medical Fund
PO Box 248
Madison WI 53701
wmfwisc@gmail.com
wmfwisconsin.org

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[2] The U.S. Constitution prohibits a state from enacting a law that bans abortion prior to the point in pregnancy when a fetus is viable. *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 859 (1992). Moreover, even after viability, any prohibition on abortion must make exception for circumstances when abortion "is necessary, in appropriate medical judgment, for the preservation of the life or health" of the woman. *Roe v. Wade*, 410 U.S. 113, 165 (1973); *Casey*, 505 U.S. at 879.

To: Members of the Senate & Assembly Health Committee
From: Laura Hanks, MD
Date: June 2, 2015
Re: Opposition to SB 179 & AB 237

Chairwoman Vukmir and Chairman Sanfelippo, thank you for the opportunity to share my testimony in opposition to Senate Bill 179 and Assembly Bill 237. I am a recent graduate from the University of Wisconsin School of Medicine and Public Health. I will begin my residency training in Obstetrics and Gynecology next month.

I decided to pursue a career in women's health during my time in the Peace Corps in the South Pacific. A woman I worked closely with became pregnant with her 5th child. She was exhausted and did not have money to support another mouth to feed. Because of her embarrassment and lack of access to safe and legal abortions, she gave herself an abortion, which nearly cost her her life. This is not unique to particular country or society. When we restrict access to safe and legal abortions, we stigmatize our patients and force them to resort to harmful measures.

As a medical students and physicians, our patients seek our medical expertise for a myriad of reasons. The women I've met who requested abortion services after 20 weeks were scared and often ashamed. I've talked with these women; held their hands, listen to their stories. Their reasons for needing an abortion during this time are varied, but are their own. I recently swore an oath to provide the best medical care for my patients and its legislation like this that hinder my ability to do so. The medical organizations in this state and other physicians you have heard from today fundamentally disagree with these bills because it ignores the standard of care physicians provide for most patients in the rest of the country. We are the people who see these women every day and know their stories and try to provide the best medical care for them, not the politicians in this state who make flippant comments regarding medical equipment.

As a newly minted physician I beg you to listen to the medical community and let us provide the best medical care for our patients. This is an incredibly hard decision, but a decision that should be made between a patient and physician, not by legislation. I strongly urge you to do the right thing for Wisconsin's women and medical community by opposing SB 179/AB 237. Thank you for your time and consideration.

Angela Debbink

Cedar Grove, WI

June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

My name is Angela Debbink, I'm 17 years old, and I'm here to be a voice for all the unborn babies who can't cry out when they feel pain during an abortion.

Since I was born after 1973, I could very easily have been one of those babies who lost their lives to abortion. I feel like I need to speak for all the babies that didn't make it outside of the womb like I did. And I truly believe it is the duty of this legislature to protect these babies, especially when they can feel pain, with the *Pain-Capable Unborn Child Protection Act*.

The truth is, unborn babies can feel pain by 20 weeks post-fertilization, at the latest. They thrash around when poked, their stress hormone levels go up when prodded, and they have a "closed circuit" nervous system developed by the 20 week mark. All physical structures they need to feel pain is developed by this point - that's why doctors give these babies anesthesia during fetal surgery.

You know, when I turn 18, I will be able to vote. And I hope I can vote for Senators and Representatives who care about protecting the unborn as much as I do.

These unborn babies have no voice in our government, but we do. We can protect them from the pain of abortion. I urge you to pass the *Pain-Capable Unborn Child Protection Act*, and be a voice for the voiceless.

Thank you for your time,

Angela Debbink

Anthony Levatino, MD, JD

Distinguished members of the Senate Health and Human Services Committee and the Assembly Health Committee,

I am a board-certified obstetrician gynecologist. I received my medical degree from Albany Medical College in Albany, New York in 1976, and completed my OB-GYN residency training at Albany Medical Center in 1980. In my 32-year career, I have been privileged to practice obstetrics and gynecology in both private and university settings. From June 1993 until September 2000, I was associate professor of OB-GYN at the Albany Medical College, serving at different times as both medical student director and residency program director. I have also dedicated many years to private practice and currently operate a solo gynecology practice in Las Cruces, New Mexico. I appreciate your kind invitation to address issues related Wisconsin's Pain-Capable Unborn Child Protection Act (SB 179/AB 237).

During my residency training and during my first five years of private practice, I performed both first and second-trimester abortions. During my residency years, second- trimester abortions were typically performed using saline infusion or, occasionally, prostaglandin instillation techniques. These procedures were difficult, expensive and necessitated that patients go through labor to expel their pre-born children. By 1980, at the time I entered private practice first in Florida and then in upstate New York, those of us in the abortion industry were looking for a more efficient method of second-trimester abortion. We found that the "Suction dilation and evacuation" procedure (or "Suction D&E") offered clear advantages over older installation methods. The procedure was much quicker and never ran the risk of a live birth.

Understand that my partner and I were not running an abortion clinic. We practiced general obstetrics and gynecology, but abortion was definitely part of that practice. Relatively few gynecologists in upstate New York would perform such a procedure at the time, and we saw an opportunity to expand our abortion practice. I performed first-trimester suction dilation and curettage abortions in my office up to 10 weeks from last menstrual period and later procedures in an outpatient hospital setting. From 1981 through February 1985, I performed approximately 1200 abortions. Over 100 of them were second-trimester Suction D&E procedures up to 24 weeks gestation, by which I mean 24 weeks from the first day of the woman's last menstrual period (LMP), which is equivalent to 22 weeks post-fertilization age.

As an aside, both the LMP dating system and the post-fertilization dating system are equally valid and both are found in the practice of medicine and in mainstream medical literature. Most if not all embryology textbooks, for example, typically date fetal development in terms of days or weeks post-fertilization. In clinical obstetrics we use the LMP system. Both are perfectly valid. It is only necessary that one specify which system is being utilized, and SB 179/AB 237 does that. Any competent physician can read the definitions in SB 179/AB 237 and understand exactly where the cut off line is.

Imagine, if you can, that you are a pro-choice obstetrician/gynecologist like I once was. Your patient today is 24 weeks pregnant (LMP). At twenty-four weeks from last menstrual period, her uterus is two finger-breadths above the umbilicus. If you could see her baby, which is quite easy on an ultrasound, she would be as long as your hand plus a half, from the top of her head to the bottom of her rump, not counting the legs. Your patient has been feeling her baby kick for the last month or more, but now she is asleep on an operating room table and you are there to help her with her problem pregnancy.

The first task is to remove the laminaria that had earlier been placed in the cervix, the opening to the uterus, to dilate it sufficiently to allow the procedure you are about to perform. With that accomplished, direct your attention to the surgical instruments arranged on a small table to your right. The first instrument you reach for is a 14-French suction catheter. It is clear plastic and about nine inches long. It has a bore through the center approximately of an inch in diameter. Picture yourself introducing this catheter through the cervix and instructing the circulating nurse to turn on the suction machine, which is connected through clear plastic tubing to the catheter. What you will see is a pale yellow fluid the looks a lot like urine coming through the catheter into a glass bottle on the suction machine. This is the amniotic fluid that surrounded the baby to protect her.

With suction complete, look for your Sopher clamp. This instrument is about thirteen inches long and made of stainless steel. At the business end are located jaws about 2 inches long and about 1/2 an inch wide with rows of sharp ridges or teeth. This instrument is for grasping and crushing tissue. When it gets hold of something, it does not let go. A second trimester D&E abortion is a blind procedure. The baby can be in any orientation or position inside the uterus. Picture yourself reaching in with the Sopher clamp and grasping anything you can. At twenty-four weeks gestation, the uterus is thin and soft so be careful not to perforate or puncture the walls. Once you have grasped something inside, squeeze on the clamp to set the jaws and pull hard – really hard. You feel something let go and out pops a fully formed leg about six inches long. Reach in again and grasp whatever you can. Set the jaw and pull really hard once again and out pops an arm about the same length. Reach in again and again with that clamp and tear out the spine, intestines, heart and lungs.

The toughest part of a D&E abortion is extracting the baby's head. The head of a baby that age is about the size of a large plum and is now free floating inside the uterine cavity. You can be pretty sure you have hold of it if the Sopher clamp is spread about as far as your fingers will allow. You know you have it right when you crush down on the clamp and see white gelatinous material coming through the cervix. That was the baby's brains. You can then extract the skull pieces. Many times a little face may come out and stare back at you. Congratulations! You have just successfully performed a second-trimester Suction D&E abortion.

If you refuse to believe that this procedure inflicts severe pain on that unborn child, please think again.

Before I close, I want to make a comment on the claims that I often hear that we must keep abortion legal in order to save women's lives, or prevent grave physical health damage, in cases of acute conditions that can and do arise in pregnancy. Albany Medical Center, where I worked for over seven years, is a tertiary referral center that accepts patients with life-threatening conditions related to or caused by pregnancy. I personally treated hundreds of women with such conditions in my tenure there. There are several conditions that can arise or worsen, typically during the late second or third trimester of pregnancy, that require immediate care. In many of those cases, ending or "terminating" the pregnancy, if you prefer, can be life saving, but "terminating a pregnancy" does not necessarily mean "abortion." I maintain that abortion is seldom if ever a useful intervention in these cases.

Here is why: Before a Suction D&E procedure can be performed, the cervix must first be sufficiently dilated. In my practice, this was accomplished with serial placement of laminaria. Laminaria is a type of sterilized seaweed that absorbs water over several hours and swells to several times its original diameter. Multiple placements of several laminaria at a time are absolutely required prior to attempting a suction D&E. In the mid-second trimester, this requires approximately 36 hours to accomplish. If one

were to use the alternate method defined in federal law as Partial-Birth Abortion (but now generally banned), this process requires three days, as explained by Dr. Martin Haskell in his 1992 paper that first described this type of abortion.

In cases where a pregnancy places a woman in danger of death or grave physical injury, a doctor more often than not doesn't have 36 hours, much less 72 hours, to resolve the problem. Let me illustrate with a real-life case that I managed while at the Albany Medical Center. A patient arrived one night at 28 weeks gestation with severe pre-eclampsia or toxemia. Her blood pressure on admission was 220/160. A normal blood pressure is approximately 120/80. This patient's pregnancy was a threat to her life and the life of her unborn child. She could very well be minutes or hours away from a major stroke. This case was managed successfully by rapidly stabilizing the patient's blood pressure and "terminating" her pregnancy by Cesarean section. She and her baby did well. This is a typical case in the world of high-risk obstetrics. In most such cases, any attempt to perform an abortion "to save the mother's life" would entail undue and dangerous delay in providing appropriate, truly life-saving care. During my time at Albany Medical Center I managed hundreds of such cases by "terminating" pregnancies to save mother's lives. In all those cases, the number of unborn children that I had to deliberately kill was zero.

Many thanks for your time,

Anthony Levatino, MD, JD

Anne Hafner

Combined Locks, WI

June 2nd, 2015

Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

I always wanted to be a mom. At Marquette University I was studying to be an Intensive care unit nurse when I met my husband Dan, who was studying to be an Emergency room PA. We married after obtaining our degrees and began to work on starting a family. After three painful miscarriages, we were pregnant again, with our son Bryce. After our previous losses, it was hard to be optimistic with this pregnancy.

The first few months passed slowly. As the five-month ultrasound approached, panic set in and the "what if" game began. But to our sheer joy, from the ultrasound we learned that the baby looked fine. It was then my heart began celebrating for what was to come. We began preparing and I began to feel the baby move inside me. The baby's room was soon filled with yellow and blue, a new crib and dresser were assembled. We were very, very excited.

Our 35 week appointment came. I felt great. The baby was moving inside of me. We were just over a month until we got to meet our baby face-to-face. During our appointment, the doctor told us he thought the baby was breech. Despite my fear of having a c-section, I knew this was only a minor challenge. To confirm his suspicions, he decided to do an ultrasound. Once it was complete, the doctor turned to Dan and I and said, "Do you know what hydrocephalus is?" We began to cry as we shook our heads yes. Our unborn baby had water on the brain – a terrible diagnosis. We were sent to a specialist the next morning.

The drive home was overwhelming. We asked ourselves, "Did we not go through enough? How could this have happened?" Tuesday morning couldn't come soon enough as Dan and I anxiously awaited the specialist to give us hope. Unfortunately, we received just the opposite. We were told that our baby was missing part of his brain, and would not survive. The doctor told us that we had the option of "terminating the pregnancy" because my life would be in jeopardy if the baby was delivered vaginally. But I refused.

I couldn't cause my child pain from abortion, and I was going to give him the most love a baby could have in his short life on this earth.

Soon the time came, and my water broke. I called my doctor and he said we needed to go to Madison for delivery. My parents offered to drive us. Rain was pouring down that night as we made the two hour ride to Madison. Along with the rain were tears from my eyes. For now, our baby was safe and alive – moving and hiccuping quietly in my womb.

When we arrived, specialists confirmed that our baby would indeed die shortly after birth. In addition to the news, the doctor informed us that due to the excess fluid they may have to make a c-section incision so large that we would not be able to have any more children. Under the circumstances,

the specialist informed us again the best option would be to decompress the baby's head, killing him and allowing me to deliver naturally – giving us a chance to try again to have a family.

Appalled, we hastily informed her that we would never kill our baby no matter what the outcome. We were numb with grief and very upset to hear such a thought.

At 6:28 am the doctor announced, "It's a boy!"

No cries. No squeaks. No movement. With deafening silence, my baby was baptized by the hospital chaplain. He continued not to move, not to breathe, the only thing that showed that he was alive was his heart beat. The doctor said to Dan, "you better get him to his mom, his heart rate is dropping." Dan placed my baby's face by mine.

I was a mom...holding my child. My baby was blue and lifeless, but he was mine. I loved him so much, even though I knew his life would be brief.

Moments later, Dan noticed his color changing and then we heard our baby boy declare his presence as he let out his first scream.

Thirteen long minutes after he was born, our son took his first breath. He was here, a child to hold and love, and he was alive.

The doctors warned us that after 13 minutes with no oxygen, and severe hydrocephalus, Bryce would suffer seizures and many neurological complications throughout his life. None of this ever occurred.

The next day the doctors performed an MRI on Bryce's brain – and his entire brain was there. The doctor who counseled me to abort my baby came to visit my room, with the original ultrasound where Bryce's brain was missing. She stated, "in this picture your baby's brain was missing. But, now we know your son's brain is intact."

Today, Bryce is eleven years old and doing terrific. He is in fifth grade and does very well in school. He also loves to play basketball and baseball. He just started playing on his school's basketball team this year. The boy that was supposed to die after birth, the boy who would never function...he is alive and well, and nothing but a joy to our lives.

I cannot imagine what would have happened if we allowed our son to lose his life to abortion, especially when he could feel pain in the womb. I cannot imagine the pain I would have felt.

Every single second of my son's life matters - no matter its length or what condition he could be living with. I am so happy the Wisconsin Legislature is considering the *Pain-Capable Unborn Child Protection Act* to help protect unborn babies like my son and support parents who receive similar prenatal diagnosis.

I wish every parent, even those who lose their little ones, could have the support of the medical community in those situations with perinatal hospice, and that all of them could have the privilege of holding their little ones no matter how brief. You never know what may happen.

Thank you for your time,

Anne Hafner

Distinguished Members of the Health and Human Services Committee and Assembly Health Committee,

My name is Bryce Hafner. I am 11 years old and am in 5th grade. I love to play basketball, baseball, and be a big brother to my little sisters.

I would like to first thank you for all of the hard work you do down here in Madison.

Second, I would like to ask each one of you to please pass the bill that would not allow doctors to hurt the babies.

Please give kids like ME the chance to LIVE.

Thank you for your time!
Bryce Hafner

CHARLOTTE LOZIER INSTITUTE

Written Testimony of David A. Prentice, Ph.D.
Vice President and Research Director, Charlotte Lozier Institute
Adjunct Professor of Molecular Genetics, John Paul II Institute, Catholic University of America
Founding Member, Do No Harm: The Coalition of Americans for Research Ethics

Joint Public Hearing
Wisconsin Senate Committee on Health and Human Services
Wisconsin Assembly Committee on Health
June 2015

To the Distinguished Chairs and Honored Members of the Committees.

Thank you for the opportunity to offer written testimony IN SUPPORT of AB 237/SB 179, the Pain-Capable Unborn Child Protection Act.

I am a cell and developmental biologist, currently working for the Charlotte Lozier Institute in Washington, D.C. as Vice President and Research Director; I also serve as an adjunct professor at a Washington, D.C. university, and as an Advisory Board Member for the Midwest Stem Cell Therapy Center, a unique comprehensive stem cell center in Kansas. Previously I spent 10 years as Senior Fellow for Life Sciences at another policy think tank in Washington, D.C., and prior to that almost 20 years as Professor of Life Sciences at Indiana State University, and Adjunct Professor of Medical and Molecular Genetics, Indiana University School of Medicine. Before that I was a faculty member in the Department of Obstetrics, Gynecology and Reproductive Sciences, University of Texas Medical School at Houston. I have done federally-funded laboratory research, lectured, and advised on these subjects extensively in the U.S. and internationally. I've taught embryology, developmental biology, molecular biology and biochemistry for over 30 years to medical and nursing students, as well as undergraduate and graduate students. I am testifying in my capacity as a scientist and on behalf of the Charlotte Lozier Institute.

Pain, also termed nociception, is an aversive response to a physically harmful or destructive stimulus. There is significant evidence from peer-reviewed scientific studies that unborn children as young as 20 weeks after fertilization, and probably younger, can experience pain. In 1987, Dr. Kanwaljeet Anand published a ground-breaking review of pain studies, in the *New England Journal of Medicine*.[1] Dr. Anand found that the pain receptor nerves are already present throughout the developing human body by 20 weeks gestation (18 weeks post fertilization). He also found that neonates and fetuses could feel pain as early as 20 weeks because the cortex, which begins development at 8 weeks, has a full complement of neurons at 20 weeks. His review included *in utero* studies measuring the brain electrical activity (EEG) of unborn babies.

The basic organization of the human nervous system is established by 4 weeks (28 days) post-fertilization (6 weeks gestation.)[2] At this stage of development the patterning of the early nervous system is in place, prepared for tremendous growth and increases in complexity that build upon this

[1] Anand KJS and Hickey PR, Pain and Its Effects in the Human Neonate and Fetus, *N Engl J Med* 317, 132, 1987
[2] Carlson BM, Patten's Foundations of Embryology, Sixth Edition, McGraw-Hill, Inc., New York; 1996.

basic pattern. The earliest neurons in the cortical brain (the part responsible for thinking, memory and other higher functions) are established during the fourth week.[3] The evidence points to the formation of synapses (the communication connections between neurons) in the seventh week, and that the neural connections for the most primitive response to pain, the spinal reflex, are in place by 8 weeks post-fertilization (10 weeks gestation).[4] Furthermore, sensory receptors for pain (nociception) develop first in the perioral area (around the mouth at 5 weeks post-fertilization (7 weeks gestation), and are present throughout the skin and mucosal surfaces by 18 weeks post-fertilization (20 weeks gestation.)[5] Thus, there is evidence that the fetus can begin to experience pain as early as this point in development.

The evidence also shows that significant cortical neuronal connections are in place by 8-10 weeks post-fertilization,[6] and further that connections between the spinal cord and the thalamus (which functions in pain perception in fetuses as well as adults) are relatively complete by 18 weeks post-conception (20 weeks gestation).[7]

You may hear that that the science of fetal pain is disputed, quoting a *JAMA* review from 2005 that claims pain sensation does not develop until 29-30 weeks gestation, and requires development of a functioning cortex in the brain.[8] That study, while widely quoted, was published by physicians with significant ties to the abortion lobby. That 2005 paper ignored numerous studies showing that the thalamus,[9] not the cortex, is needed for pain sensation. In fact, children born without a cortex are conscious.[10] The 2005 *JAMA* review also didn't address other evidence such as studies demonstrating that premature babies feel pain as early as 20 weeks; its biased conclusions have been discredited.

Significant documentation shows that the fetus reacts to noxious stimuli, with avoidance reactions and stress responses. As early as 6 weeks post-fertilization (8 weeks gestation) the fetus exhibits reflex movement during invasive procedures, resulting from spinal reflex pathways.[11] There is also extensive literature indicating the hormonal stress response by unborn babies, as early as 16 weeks post-

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[3] Bystron I *et al.*, The first neurons of the human cerebral cortex, *Nature Neuroscience* 9, 880, 2006.

[4] Okado N *et al.*, Synaptogenesis in the cervical cord of the human embryo: Sequence of synapse formation in a spinal reflex pathway, *J. Comparative Neurol.* 184, 491, 1979; Okado N, Onset of synapse formation in the human spinal cord, *J. Comparative Neurol.* 201, 211, 1981

[5] Brusseau R, Developmental Perspectives: Is the Fetus Conscious?, *International Anesthesiology Clinics* 46, 11, 2008; Lowery CL *et al.*, Neurodevelopmental Changes of Fetal Pain, *Seminars in Perinatology* 31, 275, 2007

[6] Vasung L *et al.*, Development of axonal pathways in the human fetal fronto-limbic brain: histochemical characterization and diffusion tensor imaging, *J. Anatomy* 217, 400, 2010

[7] Van de Velde M and De Buck F, Fetal and Maternal Analgesia/Anesthesia for Fetal Procedures, *Fetal Diagnosis and Therapy* 31, 201, 2012; Van Scheltema PNA *et al.*, Fetal Pain, *Fetal and Maternal Medicine Review* 19, 311, 2008; Kostovic I and Goldman-Rakic PS, Transient cholinesterase staining in the mediodorsal nucleus of the thalamus and its connections in the developing human and monkey brain, *J. Comparative Neurol.* 219, 431, 1983

[8] Lee SJ et al., Fetal Pain: A Systematic Multidisciplinary Review of the Evidence, *JAMA* 294, 947, 2005

[9] *E.g.*, Boccard SG *et al.*, Long-term outcomes of deep brain stimulation for neuropathic pain, *Neurosurgery* 72, 221, 2013; Brooks JCW *et al.*, Somatotopic organisation of the human insula to painful heat studied with high resolution functional imaging, *Neuroimage* 27, 201, 2005; Nandi D *et al.*, Thalamic field potentials during deep brain stimulation of periventricular gray in chronic pain, *Pain* 97, 47, 2002

[10] Merker B, Consciousness without a cerebral cortex: A challenge for neuroscience and medicine, *Behavioral and Brain Sciences* 30, 63, 2007

[11] Ohashi Y *et al.*, Success rate and challenges of fetal anesthesia for ultrasound guided fetal intervention by maternal opioid and benzodiazepine administration, *J Maternal-Fetal Neonatal Medicine* 26, 158, 2013

fertilization (18 weeks gestation)[12] including "increases in cortisol, beta-endorphin, and decreases in the pulsatility index of the fetal middle cerebral artery."[13]

Modern imaging techniques and analysis also document the pain experience of unborn and newborn babies. In 2006, two independent studies used brain scans measuring blood flow in the sensory part of the brain to show response to pain.[14] Brain scans were performed to measure their response to painful stimuli in the cortex, the higher portion of the brain which processes pain sensation in adults. They found that there was a "clear cortical response". The authors concluded that "noxious information is transmitted to the preterm infant cortex from 25 weeks, highlighting the potential for both higher-level pain processing and pain-induced plasticity in the human brain from a very early age." Looking at the results of the studies, Dr. Ruth Grunau, a pediatric psychologist at the University of British Columbia, said:

> "We would seem to be holding an extraordinary standard if we didn't infer pain from all those measures."[15]

A 2008 study validates these earlier studies in terms of how pain is usually measured in contrast to feeling pain.[16] The study's authors found that infants showed cortical responses indicating pain, but often did not show response to pain as measured by typical pain scoring methods used in the clinical setting. This indicates that observers may often not recognize or may underestimate infant pain. The authors went on to note that:

> "While painful stimulation generally evokes parallel cortical and behavioral responses in infants, pain may be processed at the cortical level without producing detectable behavioral changes."

In an interesting application of 4-D ultrasound, a 2013 study used newer scan technology to measure facial movements in healthy unborn children, at 22 to 34 weeks post-fertilization (24-36 weeks gestation.) The authors of the study found that unborn children showed distinct and recognizable facial expressions expressing pain or distress, providing a directly measurable tool.[17] Another study done in 2014 found that complicated facial expressions such as yawning, smiling and scowling occurred in unborn children from 18-22 weeks post-fertilization (20-24 weeks gestation), and increased with age of development.[18]

Another study in 2013 validated the earlier studies regarding potential for pain processing in the human fetal brain. Scientists at Wayne State University used functional magnetic resonance imaging (fMRI) to study the brains of healthy human fetuses within the womb, from 22-37 weeks post-fertilization (24-39 weeks gestation). They found that functional connections existed as early as 22 weeks post-fertilization (24 weeks gestation), and that the healthy human fetal brain has functional connections between the

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[12] Myers LB *et al.*, Fetal endoscopic surgery: indications and anaesthetic management, *Best Pract Res Clin Anaesthesiol* 18, 231, 2004; Brusseau R and Mizrahi-Arnaud A, Fetal Anesthesia and Pain Management for Intrauterine Therapy, *Clinics in Perinatology* 40, 429, 2013

[13] Lin EE and Tran KM, Anesthesia for fetal surgery, *Seminars in Pediatric Surgery* 22, 50, 2013

[14] Slater R *et al.*, Cortical Pain Response in Human Infants, *J Neuroscience* 25, 3662, 2006; Bartocci M *et al.*, Pain Activates Cortical Areas in the Preterm Newborn Brain, *Pain* 122, 109, 2006

[15] Qiu J, Does it hurt?, Nature 444, 143, 2006

[16] Slater R *et al.*, How Well Do Clinical Pain Assessment Tools Reflect Pain in Infants?, *PLOS Medicine* 5, e129, 2008

[17] Reissland N *et al.*, Can Healthy Fetuses Show Facial Expressions of 'Pain' or 'Distress'?, *PLOS One* 8, e65530, 2013

[18] Sato M *et al.*, 4D ultrasound study of fetal facial expressions at 20–24 weeks of gestation, *Int J Gynecol Obstet* 126, 275, 2014

brain hemispheres as well as regional connections within brain hemispheres, all sufficient to experience pain.[19]

These areas of the brain were included in measures of pain response in newborns and adults, in a new study just published in 2015. An Oxford University team used fMRI to measure pain response in newborns (1-6 days old) versus adults (23-36 years old).[20] The authors noted that: "Brain regions that encode sensory and affective components of pain are active in infants, suggesting that the infant pain experience closely resembles that seen in adults." In fact, 18 out of 20 brain regions in the newborns showed responses similar to the adults. Moreover, the newborns showed greater sensitivity to even a mild pain stimulus, responding at a level that required four times the pain stimulus in adults to achieve the same response.

This increased sensitivity to pain has previously been recognized in the literature. For example, Badr *et al.* noted that "the earlier infants are delivered, the stronger their response to pain."[21] The reason for this increased sensitivity is that the neuronal mechanisms that inhibit or moderate pain sensations do not begin to develop until 32 to 34 weeks post-fertilization (34-36 weeks gestation), and are not complete until a significant time after birth. The lack of these inhibitory neural pathways prior to term birth means that unborn as well as newborn and preterm infants show a "hyperresponsiveness" to pain, compared to older infants or adults.[22]

These young preterm patients keep getting younger, and surviving more. The concept and timing of viability keeps changing, especially with advances in medicine and recognition of challenges of fetal physiology, including fetal pain. As just one example, very preterm infants are now surviving. A study in *JAMA* in 2009 found that "1-year survival of infants born alive at 22 to 26 weeks of gestation in Sweden was 70% and ranged from 9.8% at 22 weeks to 85% at 26 weeks."[23]

The recognition of fetal pain has been key to the development of fetal surgery. Previously it was thought that unborn children, and even newborns, did not experience pain. Substantial evidence, such as that already presented, now shows that assumption is false, and has led to improvements in fetal surgery and fetal anesthesia.[24] Tran states the obvious:

> "Invasive fetal procedures clearly elicit a stress response..."[25]

Perinatal medicine has advanced rapidly in recent years, saving ever younger preterm babies and rapidly expanding treatments *in utero*. A leader in this area is the Children's Hospital of Philadelphia (CHOP), which maintains a separate fetal surgery unit that is the most advanced of its kind in the world. The Center for Fetal Diagnosis and Treatment has performed over 1,200 surgeries on babies as young as 16 weeks post-fertilization (18 weeks gestation). Fetal surgery units can now be found in St. Louis, Nashville, Cincinnati, Kansas City, Boston, and several other cities.

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[19] Thomason ME *et al.*, Cross-Hemispheric Functional Connectivity in the Human Fetal Brain, *Sci. Transl. Med.* 5, 173ra24, 2013

[20] Goksan S *et al.*, fMRI reveals neural activity overlap between adult and infant pain, *eLife* 4:e06356, 2015

[21] Badr LK *et al.*, Determinants of Premature Infant Pain Responses to Heel Sticks, *Pediatric Nursing* 36, 129, 2010

[22] Greco C and Khojasteh S, Pediatric, Infant and Fetal Pain, *Case Studies in Pain Management*, Alan David Kaye and Rinoo V. Shah, Eds., (Cambridge: Cambridge University Press, 2014), 379

[23] Blennow M et al., One-Year Survival of Extremely Preterm Infants After Active Perinatal Care in Sweden, *JAMA* 301, 2225, 2009

[24] Ngamprasertwong P *et al.*, Update in fetal anesthesia for the ex utero intrapartum treatment (EXIT) procedure, Int Anesthesiol Clin. 50, 26, 2012

[25] Tran KM, Anesthesia for fetal surgery, *Seminars in Fetal & Neonatal Medicine* 15, 40, 2010

The fetal surgeons and their teams at these centers recognize the existence of fetal pain in their young patients, and address this aspect of care. It is routine procedure to use anesthesia and analgesia for unborn and premature infants undergoing surgery, including additional doses of anesthetics administered directly to the unborn baby to supplement general anesthesia for the mother, and to provide postoperative relief.[26]

Mayorga-Buiza *et al.* state:

> "The administration of anesthesia directly to the fetus is critical in open fetal surgery procedures. Fetal pain response with bradycardia should make us consider that the fetus is not adequately anesthetized."[27]

The leading textbook on clinical anesthesia puts it this way:

> "A significant body of evidence, however, has grown to suggest the importance of mitigating the fetal stress response to enhance fetal outcome and possibly limit preterm labor. It is clear that the fetus is capable of mounting a physiochemical stress response to noxious stimuli as early as 18 weeks gestation. Given the state of current knowledge, it is impossible to know exactly when the fetus first becomes capable of experiencing pain, although most agree that the gestational age range in which this occurs is between 20 and 30 weeks. It so happens that this range coincides with the gestational ages during which most fetal interventions occur. Indeed, the fetal experience of pain may be even greater than that of the term neonate or young child, due to the immaturity of systems of descending inhibition."[28]

The study guide for the medical boards, noting that it is providing up-to-date, accurate information, echoes the textbook:

> "The fetus is able to mount a physicochemical stress response to pain starting around 18 weeks of gestation. It becomes capable of experiencing pain between 20 and 30 weeks of gestation."[29]

That recognition of the existence of fetal pain and the need for compassion has advanced medical care for mothers and babies alike. As just one example, here is what is told to the mother before fetal surgery by a group who has done large numbers of such surgeries:[30]

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[26] See, e.g., Ramirez MV, Anesthesia for fetal surgery, *Colombian Journal of Anesthesiology* 40, 268, 2012; Schwarz U and Galinkin JL, Anesthesia for fetal surgery, *Semin Pediatr Surg* 12, 196, 2003

[27] Mayorga-Buiza MJ *et al.*, Management of fetal pain during invasive fetal procedures. Lessons learned from a sentinel event, *European Journal of Anaesthesiology* 31, 88, 2014

[28] Brusseau R and Bulich LA, Anesthesia for fetal intervention, in Essential Clinical Anesthesia, Charles Vacanti, Pankaj Sikka, Richard Urman, Mark Dershwitz, B. Scott Segal, Eds., Cambridge University Press, NY; July 2011; 772-776

[29] Kloesel B and Farber MK, Anesthesia for fetal intervention, in Essential Clinical Anesthesia Review: Keywords, Questions and Answers for the Boards, Linda S. Aglio, Robert W. Lekowski, Richard D. Urman, Eds., Cambridge University Press, NY; March 2015; 399-400

[30] Adzick NS et al., A Randomized Trial of Prenatal versus Postnatal Repair of Myelomeningocele, New England J Med 364, 993, 2011

> "You will be given general anesthesia, and that anesthesia will put your baby to sleep as well. In addition, during the prenatal surgery, your unborn baby will be given an injection of pain medication and medication to insure that the baby doesn't move." (from the Informed Consent section of the supplementary Protocol to the paper)

> "The fetus was given an intramuscular injection of fentanyl (20 mcg/kg) and vecuronium (0.2mg/kg)." (from the Supplementary Appendix to the paper)

Fentanyl is an analgesic (a pain medication) stronger than morphine. Vecuronium is a muscle relaxant.

These are indeed young patients needing special care. As clinical anesthetists put it:

> "Anesthesia provision for fetal intervention differs from most other anesthetic situations insofar as the anesthesiologist (or anesthesiologists) must care for two, or possibly more, patients – each with potentially conflicting requirements."[27]

One of the premier fetal surgeons makes the obvious point:

> "Fetal therapy is the logical culmination of progress in fetal diagnosis. In other words, the fetus is now a patient."[31]

The published scientific evidence shows that the developing human being (the human fetus) can and does experience pain as early as 20 weeks in the womb. This young human being is indeed a patient, deserving of care and compassion.

I urge you to pass AB 237/SB 179, the Pain-Capable Unborn Child Protection Act.

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[31] Adzick NS, Prospects for fetal surgery, Early Human Development 89, 881, 2013

Stacy Eckes-Borys
DePere, WI
June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Service Committee and the Assembly Health Committee,

When my daughter Grace was turning 4, she found out at her family birthday party that she was going to become a big sister – not to one, but two little brothers or sisters. You can't even imagine the surprise, screams and faces of happiness in our living room. This was the beginning of a very special journey.

About 3 months later, I had my 20 week ultrasound. After, my ob/gyn delivered shocking news – the hearts of my two little baby boys were not forming correctly. She said they had an extensive heart defect and that I needed to see a specialist to learn more.

The very next day we went for another ultrasound, then met a high-risk pregnancy doctor and then a genetic counselor who told us...

1. Both babies have a severe heart defect, but we needed to get another opinion on which specific defect it is...it's either Tetralogy of Fallot or Truncus Arteriosus.
2. And, there's a reason both boys have the same defect ...it's very likely they have a genetic abnormality. Given the heart defects that are common with certain genetic conditions, we were given a short list of possible situations – some common with a high survival rate, others not so much.

It was in this very first meeting we were told that given this information, the doctors needed to tell us about our rights to terminate the pregnancy. Honestly, I was shocked. My husband and I didn't hesitate – our answer was no. We would not consider this.

Next, we saw a pediatric cardiologist from Children's Hospital of Wisconsin. The doctor confirmed the heart defect as Truncus Arteriosus – basically the aorta and pulmonary artery did not divide into two and instead were one – like a trunk. There was also a hole between the lower chambers.

This doctor did an amazing job helping us understand the defect. She also brought up the same points as the genetic counselor did – truncus was likely a result of several genetic conditions. And for a 2nd time, we were informed about our right to terminate the pregnancy. We again said no.

As you'd expect, we went through various tests and monitoring in Green Bay, Neenah, and Milwaukee with high-risk pregnancy doctors, pediatric cardiologists, and genetic counselors. All of these doctors shared our files with each other. However, over the course of the rest of our pregnancy, we were asked probably 5-7 times if we wanted to terminate the lives of the two babies growing inside me. The answer was no. Why didn't they get it? How could they not pass on our wishes in the file?

That was frustrating. However, what's even more sad and heartbreaking is: Why did they even have to ask? My children are alive, special humans like you and I, and absolutely deserve the right to live. And just the thought of taking their lives when they can feel pain from abortion is unfathomable.

Today, my twin boys are 3 years old. They've each fought and recovered like heroes from two open heart surgeries, one at 2 weeks old and the second at 2 years old. They also both have DiGeorge Syndrome (the deletion of chromosome 22q) as well as the rare deletion of chromosome 12p. My

children technically have a disability. But, they are the most energetic, compassionate, and smart boys who are just loving life!

Why should a child with a known disability be any less worthy of a chance at life, the opportunity to live, learn, and grow? As a parent and Wisconsin citizen, I urge you to protect our unborn children, especially at the point that they can feel pain, with *the Pain-Capable Unborn Child Protection Act*. My two little miracles are living examples of why we need to protect these children.

Thank you for your time,

Stacy Eckes-Borys

Testimony of Colleen A. Malloy
Assistant Professor, Division of Neonatology/ Department of Pediatrics
Northwestern University Feinberg School of Medicine

May 28, 2015

Dear distinguished members of the committee,

My name is Colleen A. Malloy. I serve as an assistant professor in the Division of Neonatology in the Department of Pediatrics at Northwestern University Feinberg School of Medicine. I am pleased to have this opportunity to testify on current issues that may arise during your consideration of the District of Columbia Pain-Capable Unborn Child Protection Act (H.R. 3803).

This legislation would prohibit abortion beginning at 20 weeks fetal age, which is equivalent to 22 weeks in the dating system commonly employed in obstetrics, which counts pregnancy as beginning at the time of the last menstrual period (the "LMP" system). The bill contains an exception for certain cases in which an abortion is deemed necessary because of danger to the mother's life.

With the advancement of in utero imaging, blood sampling, and fetal surgery, we now have a much better understanding of life into the womb. Our generation is the beneficiary of new information which allows us to understand more thoroughly the existence and importance of fetal and neonatal pain. As noted in my biography, I am trained and board-certified in the field of neonatology. Standard of care in my field recognizes neonatal pain as an important entity to be acknowledged, recognized, and treated. With advancements in neonatology and perinatal medicine, we have been able to push back the gestational age at which a neonate can be resuscitated and resuscitated successfully. It is easy for us to imagine the life of a infant past 22 weeks LMP, as he or she is kicking, moving, reacting, and developing right before our eyes in the Neonatal Intensive Care Unit (NICU).

In neonatology, we also describe neonates in terms of last menstrual period dating. In LMP dating a pregnancy starts with day zero as the first day of the last menstrual period. Development in the womb is commonly referred to by post conception age (PCA). Like most legislation, this bill is written using PCA data. This is an important point, as PCA = LMP MINUS 2 weeks. This legislation concerns pain at 20-24 weeks PCA. In neonatologist terms, that is 22-26 weeks. In today's medical arena, we resuscitate patients at this age and are able to witness their ex-utero growth and development. In June 2009, the *Journal of American Medical Association* reported a series of over 300,000 infants. Survival at 20, 21, 22, 23, and 24 weeks PCA was 10%, 53%, 67%, 82%, and 85% respectively. Thus, we are easily able to witness their experiences with pain. In fact, standard of care for neonatal intensive care units requires attention to and treatment of neonatal pain. There is no reason to believe that a born infant would feel pain any differently than that same infant were he or she still in utero. Thus, the difference between fetal and neonatal pain is simply the locale in which the pain occurs. The receiver's experience of the pain is the same. I could never imagine subjecting my tiny patients to horrific procedures such as those that involve limb detachment or cardiac injection.

There is ample biologic evidence, physiologic, hormonal, and behavioral evidence for fetal and neonatal pain. As early as 8 weeks PCA, face skin receptors appear. At 14 weeks, sensory fibers grow into the spinal cord and connect with the thalamus. At 13-16 weeks, monoamine fibers reach the cerebral cortex, so that by 17-20 weeks the thalamo-cortical relays penetrate the cortex. Many authors have substantiated that pain receptors are present and linked by no later than 20 weeks PCA. (Myers

2004; Derbyshire 2010; Anand 1987; Vanhalto 2000; Brusseau 2008; VanScheltema 2008). In fact, by 20 weeks PCA (22 weeks by LMP), the fetal brain has the full complement of neurons that are present in adulthood (Lagercrantz H et al. *Functional development of the brain in fetus and infant.* Lakartidningan 1991;88:1880-85). At 19-20 weeks PCA, electroencephalogram (EEG) recordings are possible (Flower MJ. *Neuromaturism of the human fetus.* J Med Philos 1985;10:237-251). We often perform EEG studies on premature infants in our NICU. Even when done on the extremely premature, continuous EEGs show awake and REM sleep states typical of term neonates.

In the Neonatal Intensive Care Unit, we can witness first hand the change in vital signs associated with pain. When procedures such as an intravenous line placement, intramuscular injection, or chest tube insertion are performed on a neonate at 22-26 weeks LMP, the response is similar to that seen in an older infant or child. With the advent of ultrasound including real-time ultrasound, we know that even at 8 weeks PCA, the fetus makes movements in response to stimuli. At 20 weeks PCA, the fetus responds to sound, as many mothers commonly increased fetal movement in response to music, sirens, or alarms. At 23 weeks in utero, a fetus will respond to pain (intrahepatic needling, for example) with the same pain behaviors as older babies: scrunching up the eyes, opening the mouth, clenching hands, withdrawal of limbs. In addition, stress hormones rise substantially with painful blood puncture, beginning at 18 weeks gestation (Giannakoulopoulos X, Sepulveda W, Kourtis P, Glover V, Fisk NM. "Fetal plasma cortisol and beta-endorphin response to intrauterine needling." *Lancet* 1994;344:77-81). This hormone response is the same one mounted by born infants. In a 1992 study published in the *New England Journal of Medicine*, infants undergoing cardiac surgery had large increases in adrenaline, noradrenaline, and cortisol levels. Opioid analgesia markedly reduced these responses as well as reduced peri-operative mortality. Use of analgesia during neonatal surgery is standard of care; any infant undergoing fetal surgery is expected to receive appropriate pain medication as adults receive.

In fact, the fetus and the premature neonate may even be more susceptible to the pain experience. There is ample evidence to show that while the pain system develops in the first half of pregnancy, the pain modulating pathways do not develop until the second half. It is later in pregnancy that the descending, inhibitory neural pathways mature, which then allow for dampening of the pain experience. As reported in the *British Journal of Obstetrics and Gynecology*, the "... fetus may actually be more sensitive than the older child, and [this] may explain why the newborn shows exaggerated behavioral responses to sensory provocation" (*Br J Obs Gyn* 1999;106:881-886). The idea that premature infants actually have greater pain sensitivity is supported by the fact that while pain transmitters in the spinal cord are abundant early on, pain inhibiting transmitters are sparse until later. (Anand KS, McGrath PJ, editors. *Pain Research and Clinical management.* Vol. 5. *Pain in neonates.* Amsterdam:Elsevier 1993:19-38). In addition, the premature infant requires greater concentrations of drugs to maintain effective anesthesia, as compared to older infant. The fetus and premature infant may even have a heightened sensation of pain compared to an infant more advanced in gestation.

In conclusion, I have no doubt that my premature neonatal patients feel pain and experience pain. Even early on, they demonstrate personalities and interact positively as well as negatively with their environments. With our advanced "views into the womb," we are now better able to appreciate the active life of the developing fetus as one engaged with his or her uterine locale. I firmly believe, as the evidence shows, that the fetal pain experience is no less than the neonatal pain experience or even than that which you or I would experience from dismemberment or other physical injury. One of the most basic of government principles is that the state should protect its members from harm. If we are to be a benevolent society, we are bound to protect the fetus from pain. We should not tolerate the gruesome and painful procedures being performed on the smallest of our nation.

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27 May 2015

I apologize for my inability to testify at the hearing in person, but my schedule does not permit it at this time. However, I still felt compelled to write and support *WI Assembly Bill 237/Senate Bill 179, the Pain-Capable Unborn Child Protection Act* under consideration this legislative session. My medical education, training and over 25 years of practice in high risk obstetrics gives me substantial insight into this issue. Most emphatically unborn children (or babies) do feel pain in their mother's womb. This is borne out not only by the science related to neurodevelopment and brain development, which finds that by 20 weeks of life there are present: pain receptors in the skin, spinal tracts to carry the message, nerve tracts, the thalamus, and cerebral cortex to "sense" pain, but also by, most notably, my own personal experience, which validates the presence of pain even earlier. As a physician who has performed hundreds of amniocenteses, I will tell you without any reservation, that the babies I have encountered at 16-20 weeks feel pain. If a baby happened to encounter my needle, they react immediately and demonstrate by their actions they do feel the needle and pain. We can only imagine the excruciating pain that a baby would feel in a destructive abortion procedure. Let us join together to end this barbaric practice in supporting *WI Assembly Bill 237/Senate Bill 179.* Thank you.

Respectfully Submitted,

Byron C. Calhoun, MD, FACOG, FACS, FASAM, MBA
Vice-Chair, Department of Obstetrics and Gynecology
West Virginia University-Charleston
Charleston, WV

Jeanne S.
Mukwonago, WI
June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,

We were thrilled to see the positive pregnancy test for my third pregnancy. Several months earlier we had lost a baby girl in a second trimester miscarriage. My husband and I were eager to grow our family and were looking forward to this new baby. During my first pregnancy, I had no problems and had worked until the day before my delivery. I was healthy and my doctor could not find any reason for the miscarriage in my second pregnancy. We were hopeful that this time would be fine.

I had prenatal care from the beginning of the pregnancy and had the usual examinations and tests. The first sign that there could be concerns about this pregnancy began with an abnormal AFP (alpha fetoprotein) test. My doctor advised that this could be a sign of a number of concerns, but at that time was non-conclusive. I continued to hope and plan for our baby. One afternoon at the beginning of my 25th week I noticed abdominal cramping. After resting in bed it did not stop, and I call my physician's office. I was advised to go to the hospital and be checked by the doctors there. My husband and young son took me to the emergency room. Once there, the staff appeared to be very concerned. Upon examination, I was told that I was in premature labor and our baby was at risk. My doctor told me that his chances for survival, if they could not stop the labor and he was born, would only be 50/50 that night.

At this point a new medical team took over my care and I was introduced to a perinatalogist. I was hospitalized and medication was begun to try to stop the contractions. This was the beginning of twelve weeks of bed rest, medication, and close observation. I had hydramnios, an excess amount of amniotic fluid, and they believed this was causing the premature contractions. Despite treatment, the contractions continued, the hydramnios worsened, and the perinatalogist voiced increasing concerns about the baby. I was advised that the problems with the pregnancy may be related to abnormalities with the baby, and the abnormal AFP level was now more concerning.

Ultrasound studies did not show any obvious problems and the doctors wanted to proceed with more invasive studies, beginning with an amniocentesis, but these carried increased risks in my situation. I was told that amniocentesis, and possibly a chorionic villi sample could more definitively diagnose any abnormalities with the baby, since the circumstances could be indicative of neurological abnormalities, kidney problems or numerous other possibilities for our baby. The hospital staff encouraged us to do the testing, saying if we had more information we could decide what to do. I refused all invasive testing due to my concerns about the risks involved.

One of the worst times was a visit from the perinatalogist, in my hospital room, when he spoke of his concerns over my refusal to have the tests and stated that the tests would allow us to know if the baby had any congenital defects or abnormalities - then we would be able to decide if we wanted to continue with the pregnancy. I firmly stated that I would care for my baby regardless of any condition he may be born with, and would not risk invasive tests. I told the doctor that those tests would not give me any information I would find useful; we would raise our son no matter what.

After several weeks, I was allowed to go home with contraction monitoring, subcutaneous terbutaline, and strict bed rest. I returned to the hospital several times for increased contractions, and danger of early delivery, but was able to carry my son to term. The hospital had social workers speak with me on two occasions about the NICU and resources for care of a special needs child, and I told them we would deal with that when the time came. At the end of my 36th week I was allowed to end bed rest and was told the doctors wanted to deliver the baby in week 38 due to concerns about his possible condition. Despite the persistent contractions, the baby didn't come, and I had an induced labor at the end of week 38.

My delivery suite was located next to the NICU. When the baby was coming a NICU team came with their equipment, prepared for his birth. My son was born, cried out loudly, and went to the team. They checked him out, pronounced him fine, and let me hold him. Then they took their equipment and left. My doctor and the nurses remained to assist us through the last tasks of delivery. A pediatric specialist did come, and my son went for a more intensive examination, but no problems were found. When I went home my son came with me. Now, over 19 years later, he is a 6'4" college sophomore in engineering, a physics society member, an Eagle Scout, and a scout camp field sports director.

I urge the Wisconsin Legislature to spare unborn children like my son from the pain of abortion - every child, regardless of ability, deserves the right to life. And it is unimaginable to allow them to lose their lives to abortion when they can feel pain. I cannot wait to see the Wisconsin Legislature pass the *Pain-Capable Unborn Child Protection* Act to protect unborn babies who are just like my son.

Thank you for your time,

Jeanne S.

Chelsea Shields, Legislative/PAC Director, Wisconsin Right to Life

Senate Health and Human Services Committee, Assembly Health Committee

SB 179/AB 237, *Pain-Capable Unborn Child Protection Act*

Tuesday, June 2, 2015

Thank you to Chairwoman Vukmir, Chairman Sanfelippo, and Members of the Senate Health and Human Service Committee and the Assembly Health Committee for your time today.

My name is Chelsea Shields, and I am the Legislative/PAC Director of Wisconsin Right to Life, testifying in favor of SB 179/AB 237, the *Pain-Capable Unborn Child Protection Act*. It is imperative, based on the substantial medical evidence indicating that unborn children are capable of feeling pain at 20 weeks post-fertilization age at the latest, that Wisconsin protect these children from the pain of abortion.

I would like to first address the argument that the *Pain-Capable Unborn Child Protection Act's* definition of "medical emergency" would supposedly allow for elective, direct abortion. This is a complete misunderstanding of the bill's language, and removing this language would be a mistake.

Medical Emergency Definition

1.) "Abortion" is a medical term and legal term, not always meaning the direct abortion we would automatically assume it is when the word is used in regular conversation. There are times, both in a medical and legal sense, when abortion simply means the end of a pregnancy, such as miscarriage or induced birth.

2.) This bill must be read in its entirety. It doesn't take much effort, after reading the definition of medical emergency, to continue reading down to s. 253.107(3)(b) where the bill states:

> "When the unborn child is considered capable of feeling pain and the pregnant woman is undergoing a medical emergency, the physician shall terminate the pregnancy in a manner that, in reasonable medical judgment, ***provides the best opportunity for the unborn child to survive***" [my emphasis]

This means a physician cannot do a D&E procedure to dismember the child, because that would not leave the child any opportunity to survive. Therefore, this does not allow for direct abortion.

2.) Because of the Supreme Court decision *Planned Parenthood v. Casey*, we *must* have this medical emergency language in order for this to be upheld in court. It is unfortunate that we live under the shadow of this Supreme Court decision, but fortunately, this medical emergency language is more protective than the language in Wisconsin's post-viability ban and than the medical emergency language used in many other states.

3.) The goal, which is explicitly stated in the legislative findings of the bill, makes clear that this bill is not challenging the standards set in the Supreme Court decisions *Roe v. Wade* and *Planned Parenthood v. Casey* - rather, the legislature is trying to assert a new and compelling state interest in protecting the lives of pain-capable unborn children.

4.) Wisconsin law is unique. We know this medical emergency definition, directly taken from our informed consent law, has been upheld by the 7th Circuit Court in *Karlin v. Foust*. The court held our medical emergency definition as an objective standard (which is more protective) and that it is consistent with the *Casey* ruling. The use of this definition, upheld by the 7th Circuit, ensures that the courts could have little to no claim on any of our definitions being confusing or inconsistent with *Casey*. And, it allows the courts to focus *solely* on the question of whether the state has a compelling governmental interest in protecting the lives of pain-capable unborn children.

5.) It is key that we never let the "perfect" be the enemy of the good. The goal is to protect pain-capable unborn children. We cannot protect a single child from the pain of abortion if the *Pain-Capable Unborn Child Protection Act* were to be struck down in court.

I would also like to address a couple of the studies cited by the American Congress of Obstetricians and Gynecologists (Wisconsin Section), the Wisconsin Academy of Family Physicians, the American Academy of Pediatrics, and the Wisconsin Medical Society in their press release yesterday.

A Closer Look at Those Who Deny the Pain of The Unborn at 20 Weeks

1.) *Journal of the American Medical Association's 2005 Article on Fetal Pain*

Did you know that in JAMA's 2005 article on fetal pain, absolutely no new laboratory research was presented, but rather, it was only a commentary on a *selection* of existing medical literature on fetal pain? And, the method of selection used, according to the "father" of fetal pain study, Dr. Sunny Anand in his testimony to Congress in 2005, "cannot be replicated and therefore calls into question the scientific validity of [JAMA's] approach"?

Even more interesting, two of the authors of the JAMA article are pro-abortion activists. Lead author Susan J. Lee, who was a medical student at the time of the article's publication, was previously employed by pro-abortion advocacy group, the National Abortion Rights Action League (NARAL), as a lawyer. And, Dr. Eleanor A. Drey was the director of the largest abortion facility in San Francisco, a self-described activist, and staffer for the Center of Reproductive Health Research and Policy when this article was published.

In fact, JAMA's editor-in-chief at the time, Catherine DeAngelis, was contacted by journalists about Lee's and Drey's pro-abortion advocacy connections, which she confessed she was unaware of, acknowledged that it could hurt the journal's credibility, and said such ties should have been disclosed.

2.) *The Royal College of Obstetricians and Gynecologists 2010 Article on Fetal Pain*

Similarly, one of the RCOG article's authors, Professor Allan Templeton, was one of the leaders of the field of chemical abortions in the 1990's. He most certainly was not a fetal pain expert, and clearly had a vested interest in the abortion industry as a whole due to his work with chemical abortions.

3.) It is sad to see that those commenting on fetal pain have political agendas and interests in the abortion industry. Experts in fetal pain, such as Dr. Sunny Anand, have no such political ties, and their studies have made a significant impact in the field of fetal anesthesiology, where it is now routine during fetal surgery to administer anesthesia directly to the unborn child to prevent pain.

In Conclusion

As a young woman born after 1973, I am keenly aware that I could have had the same fate as all of the pain-capable unborn babies that have been killed by abortion. These children likely expired in a very gruesome way, from a dilation and evacuation (D&E) abortion procedure that tore them apart, limb-by-limb.

I urge you, not only as elected officials with an interest in protecting unborn life, but also as compassionate human beings, to protect these children capable of feeling pain from abortion. These unborn babies cannot cry out when they feel pain - therefore, we must be their voice.

Thank you very much for your time,

Chelsea Shields

Testimony of Anita Showalter, DO, FACOOG (Dist)
Distinguished Fellow of the American College of Osteopathic Obstetricians & Gynecologists

Senate Health and Human Services Committee
Assembly Health Committee
Pain-Capable Unborn Child Protection Act

Thank you Chairmen and Committee Members for the opportunity to address you in support of SB 179 and AB 237. I am an Obstetrician/Gynecologist licensed to practice in the State of Washington. I am the Assistant Dean of Clinical Education at Pacific Northwest University of Health Sciences where I also serve as Associate Professor and Chief of Women's Health. I speak representing myself.

When abortion first became legalized in the United States, there was no limit on how far along in pregnancy an abortion could occur. Most people who are in favor of abortion are repulsed by the thought of terminating an infant that could live independently outside the womb. States have appropriately set limits on when an abortion could occur, most often at the time of viability, or around 24 weeks gestational age, 22 weeks from fertilization.

Since that time, science has advanced tremendously. The 24 week fetus that barely had a chance of survival now routinely lives without serious long term problems. Recently, the New England Journal of Medicine published research on very preterm infants showing that 23.1 % of neonates at 22 weeks gestation or 20 weeks after fertilization survived with active treatment. [1] This is the same gestational age addressed by this bill.

The question then is, why have a bill that focuses on the fetuses ability to feel pain rather than viability? Viability is a moving target that gets pushed earlier and earlier as neonatal science improves. Also, there has been a lot of interest in our society to protect creatures of all kinds from pain. It only makes sense in a civil society to protect the smallest, frailest members of the human community from pain, the child within the womb.

Opponents of this bill would state that an intact brain cortex is necessary for the sensation of pain, and that this does not occur until 29-30 weeks gestational age. [2] Those caring for very premature infants would probably be surprised to hear that some medical professionals think that the pain responses they see in the children they care for are not really pain.

Fetal surgery has brought us insight into the fetal response to a pain. By 18-20 weeks the fetus shows the same stress hormones that adults do when faced with a painful procedure.[3] It is well documented that if these children do not receive appropriate anesthesia for procedures that the stress response compromises their ability to do well, and they vigorously thrash about without adequate anesthesia[4] Furthermore, there is a growing body of research that indicates painful experiences early in gestation may change the way the neurologic system develops, making the individual more sensitive to pain throughout his life..[5] This gives evidence that the fetus actively interacts with the world around it which shapes its very being.

This is what we know: By 8 weeks gestation the fetus will respond to touch [6] and brain waves can be measured. [7] The fetus has pain receptors throughout the body by 14 weeks. [8.] From 14 to

20 weeks gestation, the spinal cord has pain fibers, called afferents, connected to it, and by 20 weeks after fertilization, the spinal cord and pain fibers are connected to the thalamus and the subcortical plate.[9]

Research on the thalamus shows that this tissue processes pain impulses. Ablation of the thalamus alters the pain experience while ablation in the cortex did not. It is also interesting to note that patients with an ablated cortex did not change levels of consciousness. [10] Children without cortexes exhibit the same pleasure and painful responses as children with a normal brain. [11] A cortex is not necessary for the sensation of pain as we understand it, but the thalamus is. Thus it is clear that the fetus has the capability of feeling pain and responding to it's environment by 20 weeks after fertilization.

The state's interest should be in promoting a civil society and protecting the tiniest and weakest human beings within its domain. I urge you to support SB 179 and AB 237.

Respectfully submitted,

Anita Showalter, DO

Please see attached CV for other credentials

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For more information about fetal pain, please visit www.doctorsonfetalpain.com

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LICENSURE

Medical License – State of Washington #OP00002278

Board Certification - AOBOG May 2000

EDUCATION

1975-1976 Goshen College Goshen, IN

1987-1989 Indiana University at South Bend South Bend, IN

- B.S., Biological Sciences Awarded 1991
- Graduated with High Distinction

1989-1993 Ohio University College of Osteopathic Medicine Athens, OH

- D.O., Doctor of Osteopathic Medicine

1993-1994 Doctors Hospital of Stark County Massillon, OH

- Specialty Track Internship in Obstetrics and Gynecology

1994-1997 Cuyahoga Falls General Hospital Cuyahoga Falls, OH

- Residency in Obstetrics and Gynecology

AWARDS

Freshman Chemistry Award, Indiana University at South Bend, 1988

Ciba-Geigy Community Service Award, OU-COM, 1991

Outstanding Osteopathic Mentor, Ohio University College of Osteopathic Medicine, 1999-2000

Community Faculty Clinical Teaching Award, Des Moines University Osteopathic Medical Center College of Osteopathic Medicine and Surgery, June 2003

Distinguished Fellow - American College of Osteopathic Obstetricians and Gynecologists, March 2007

AOA Osteopathic Mentor Hall of Fame, 2007

MEDICAL STAFF PRIVILEGES

Yakima Valley Memorial Hospital, Yakima, Washington

Yakima Regional Medical Center, Yakima, Washington

TEACHING APPOINTMENTS AND EMPLOYMENT

Acting Dean, Pacific Northwest University of Health Sciences, July 23 to September 16, 2013

Assistant Dean of Clinical Education, Pacific Northwest University of Health Sciences, July 1, 2011 to present

Associate Professor and Chief of Women's Health, Pacific Northwest University of Health Sciences, April 2008 to present

OB Hospitalist, OB Hospital Group (OBHG), July 2013 to present

Innovation Women's Health and Gynecology, private practice, January 2012 to May 2013

Yakima Valley Farm Workers Clinic, Clinical Practice, October 2007 to December 2011

Adjunct Clinical Professor, Touro University College of Osteopathic Medicine, August 2009 to present

Assistant Professor, Oklahoma State University Center for Health Sciences, February 2007 to December, 2007

Self Employed in Private Practice, Kidron, Ohio 1997-2007

Clinical Assistant Professor OU-COM CORE, 2003-2006

Clinical Assistant Professor Kirksville COM, 2003

PROFESSIONAL MEMBERSHIPS AND POSITIONS

American Academy of Osteopathy

American College of Osteopathic Obstetricians and Gynecologists

- Board of Trustees
- Chair Annual Conference 2006
- Continuing Medical Education Committee
- Committee for Women's Rights in Childbirth Choices
- Chair: Committee for Osteopathic Curriculum Development
- Philanthropy Committee

"OMM in a Specialty Practice"

- OU-COM Specialty Emphasis Week 1999

"OMM in Obstetrics and Gynecology"

- OU-COM UAAO presentation and hands-on workshop, 1999

"Getting the Delivery You Want"

- International Cesarean Awareness Network Conference, Workshop, Cleveland, Ohio, April 2000

"Osteopathic Manipulation in Obstetrics and Gynecology"

- Visiting Professor Program, ACOOG 2004-2006
- Lecture and lab for second year students at OSU-COM, 2000-2007
- Lecture and lab for CORE OB/GYN residents, May 2002
- Lecture and lab for ACOOG Midyear Conference, October 2002
- Lecture for ACOOG Annual Conference, March 2003, March 2005
- OMM Workshop table trainer ACOOG Annual Conference March 2006
- Lecture and lab Kansas City University of Medicine and Biosciences, March 2004, March 2005, March 2006, March 2007
- Lecture and lab, Touro College of Osteopathic Medicine, Vallejo, CA, Spring 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013
- OMM Workshop, ACOOG Fall Conference, September 2006
- OMM Workshop, ACOOG Spring Conference, March 2007
- "Osteopathic Practice and Principles for the Female Patient" Lecture and Workshop, ACOOG Fall Conference, September, 2007
- Osteopathic Practices and Principles for the Female Patient, Workshop Michigan OPTI OB/GYN Residents, November, 2007
- AOBOG Board Review lecture, April 2007, April 2009
- Lecture, Washington Osteopathic Medical Association Spring Conference, March 2009
- Osteopathic management of Pelvic Pain Russo CME, Yakima, WA April 2012
- Women's Pain, It's Not All in Your Head OMED Public Health Seminar, San Diego CA, October 2012
- Female Sexual Dysfunction: A Diagnostic and Management Challenge WOMA, Seattle WA, December 2012
- Pelvic Pain: An Osteopathic Perspective IOPA, Boise, Idaho April 27, 2013
- Giving Feedback, Adjunct Clinical Faculty Development, Fairbanks, AK, September 12, 2013
- OMT Skills Workshop, OB/GYN Techniques: MSU Consortium for OB/GYN Residents, Lansing MI, September 19, 2013

"Osteopathic Philosophy in OB/GYN"

Lecture and Lab AOA Unity Conference, October 2005

"The Holistic Woman"

- Lecture for Women's Health Update: A Look to the Future, Doctors Hospital, Columbus, Ohio, May 2006

- Membership and Promotions Committee
- Osteopathic writing group

American Osteopathic Association

Christian Medical and Dental Association

Sigma Sigma Phi

Washington Osteopathic Medical Association

SERVICE ACTIVITIES

NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS BOARD OF TRUSTEES DECEMBER 2012 TO PRESENT

COMAT COMMITTEE FOR OB/GYN 2010 TO PRESENT

NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS ITEM WRITER 2004 TO PRESENT

CHAIR, COMMITTEE TO DEVELOP A CURRICULUM IN OMM FOR OB/GYN RESIDENTS FOR ACOOG

DEVELOPED A TRAINING PROGRAM FOR ADJUNCT CLINICAL FACULTY IN BECOMING A GREAT PRECEPTOR FOR YAKIMA VALLEY FARM WORKERS CLINICS

ADMISSIONS COMMITTEE PNWU

CURRICULUM COMMITTEE PNWU

ACOOG TECHNICAL BULLETIN COMMIITTEE

CHAIR, ACOOG WRITING GROUP FOR APGO LEARNING OBJECTIVES

LECTURES, PUBLICATIONS AND PRESENTATIONS

Poster Presentation: Osteopathic Manipulation in Obstetrics: A Historical Perspective

- Presented at the ACOOG Annual Convention, La Jolla, CA 1997

Poster Presentation: Postpartum Pelvic Dysfunction: A Case Report

- Presented at the ACOOG Annual Convention, La Jolla, CA 1997

"Exercise in Pregnancy"

- Dunlap Memorial Hospital Health Fair – 1998

"When the Hormones Swing, I Duck!"

- Dunlap Memorial Hospital Community Awareness Lecture –1999
- Aultman Hospital Community Service Lecture - 1999

"Cervical Cancer Screening"

- Family Practice Update, Yakima Valley Memorial Hospital, October 15, 2008

"Keeping Your OMT Skills in Shape – A New Osteopathic Curriculum for OB/GYN" and accompanying workshop,

- AOA Unity Conference, Las Vegas, Nevada, October 29, 2008

"Becoming a Great Preceptor"

- Washington Osteopathic Medical Association Annual Conference, July 2012

"Menstrual Irregularities"

- Physician Assistant Training Program, University of Washington, Three hours of classroom training, Spring 2011, Spring 2012

PUBLISHED WORKS

Complementary and Alternative Medicine use in the Amish

- V.E. von Gruenigen, A.L.Showalter, K.M. Gill, H.E. Frasure. M.P. Hopkins, E.L. Jennison, Comprehensive Therapies in Medicine (2001) p.232-233.

A Pocket Guide: The Osteopathic Management of the Female Patient

- JP Maganito, A Showalter, M Tettambel. Published 2010, available through the AAO Website Bookstore

Fetal Pain Bill (SB 179, AB 237)

I am submitting this testimony in support of SB 179 and AB 237, the Fetal Pain Bill. I am speaking for myself.

My name is Cynthia Jones-Nosacek, MD. I am a family physician in private practice in Milwaukee, WI, having been in practice for over 30 years in the Milwaukee area. My practice includes everything from delivering babies, caring for the baby, mom, dad, grandparents, even great-grandparents. I do hospice work and continue to see my patients in the hospital.

When I was in residency, I had to learn how to do circumcisions. I hated it. In those days, it was done without any anesthesia because, as my obstetrical attendings told me, "babies don't feel pain." They tried to convince me that the babies were crying merely because they didn't want to be strapped down, ignoring the fact that they would scream harder when we crushed their foreskin. When I found out there were ways to eliminate their suffering, I learned it, especially after reading a study by Anna Taddio which found that circumcised boys cried more with their vaccinations months later than uncircumcised boys. And so I was the first, and for many years the only, doctor who used nerve blocks so **MY** babies didn't feel pain. In fact, the nursing assistants would tell me that they really liked assisting my circumcisions because sometimes the baby would even sleep through the procedure.

The reason I bring this up is because now there is the suggestion that fetuses can't feel pain. Yet we know the connections from the pain nerves to the thalamus to the cortex are present by 18 weeks after fertilization (20 weeks gestation), the latest being 22 weeks post fertilization (24 weeks gestation). This is also the time when over 50% of premature babies will survive. Unfortunately, those connections occur before the ability to consciously modulate the pain so the brain is flooded with the sensation. Fetuses receiving blood transfusions at this time will act as if in pain and after receiving a pain killer, did not.

With viability occurring around 22 weeks post fertilization (24 weeks gestation), there is a need to remind physicians that, in a medical emergency in the mother, there are 2 patients to be concerned about. And these bills require the doctor to deliver the baby in a manner that "provides the best opportunity for the unborn child to survive."

Over the years, I have cared for women whose babies had anomalies which we knew would probably result in the death of their child before, during, or shortly after birth. There can be nothing more heartrending than watching the anguish of parents who have been told that their child may not survive even six months, no matter if that child be an adult, teenager, toddler, infant or before birth. Yet it only those unborn where we somehow think that to ease the parents' emotional suffering includes taking the life of the child who is not suffering at all. This is what makes perinatal hospice is so important. Parents facing this tragedy need this support. When offered these services, up to 87% of parents chose to parent their baby for as long as it lives. And since medicine is never error free, it also gives everyone a second chance in those occasions where it happens.

The grief of a woman who has had an abortion for fetal anomalies can be severe, even complicated, with higher rates of depression and post-traumatic stress. I had a patient who, due to premature rupture of membranes, decided to have an abortion rather than continue the pregnancy, before she had

a chance to do so, nature intervened and she went into labor and delivered her baby who died shortly thereafter. Before, she insisted there was no difference. After, she admitted there was and she much preferred how everything turned out. She did not have to live with added guilt of ending her child's life mixed in with the grief of losing her child.

Unfortunately, while these bills state that perinatal hospice be offered, it is not a covered benefit. Luckily where I practice, the hospital's foundation pays for the support, but in rural hospitals, this may not always be available and I would hope a way would be found to address this.

Finally, abortions at this time are more dangerous for the mother than term delivery (9 maternal deaths at 21 weeks vs 7.5 at term/100,000 per the Guttmacher Institute and CDC).

SB 179 and AB237 address a reality: that a human being before birth experiences pain, maybe not in the way you and I "feel", but in a way that is uniquely their own. It also shows concern for the parents, especially the mother, by giving support through this trying time.

Thank you.

Dr. Donna Harrison

June 2nd, 2015

RE: Testimony in Support of Prohibition of Abortion at 20 Weeks Gestation

Dear Committee Chairman and Committee Members,

Thank you for the opportunity to present my opinions regarding the *Pain-Capable Unborn Child Protection Act* as it relates to women's healthcare in the State of Wisconsin. I am a board certified obstetrician gynecologist with 15 years of experience delivering babies of all gestational ages, as well as teaching experience as an Associate Clinical Professor, teaching medical students and residents within the University of Michigan during my early years of practice. I am currently the Executive Director of the American Association of Pro-Life Obstetricians and Gynecologists, and I testify on behalf of 2700 members nationwide, including 10 members in Wisconsin.

In recently passing the *Pain-Capable Unborn Child Protection Act*, the U.S. House of Representatives stated:

"Congress finds and declares the following:
(1) Pain receptors (nociceptors) are present throughout the unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks after fertilization.
(2) By 8 weeks after fertilization, the unborn child reacts to touch. After 20 weeks, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling.
(3) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.
(4) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly,emotional, behavioral, and learning disabilities later in life.
(5) For the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli are applied without such anesthesia. In the United States, surgery of this type is being performed by 20 weeks after fertilization and earlier in specialized units affiliated with children's hospitals.
(6) The position, asserted by some physicians, that the unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and

analysis, especially since 2007, provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.
(7) Substantial evidence indicates that children born missing the bulk of the cerebral cortex, those with hydranencephaly, nevertheless experience pain.
(8) In adult humans and in animals, stimulation or ablation of the cerebral cortex does not alter pain perception, while stimulation or ablation of the thalamus does.
(9) Substantial evidence indicates that structures used for pain processing in early development differ from those of adults, using different neural elements available at specific times during development, such as the subcortical plate, to fulfill the role of pain processing.
(10) The position, asserted by some commentators, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from engaging in vigorous movement in reaction to invasive surgery.
(11) Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain at least by 20 weeks after fertilization, if not earlier.
(12) It is the purpose of the Congress to assert a compelling governmental interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain."

In my experience, I know that ob gyns are trained to separate the mother and her unborn child, and sometimes we have to separate the mother and her unborn child to save the life of the mother or the life of her child. But the purpose of an abortion is not to save anyone's life. The purpose of an abortion is to kill the unborn child before it is born, to guarantee that the mother will have a dead baby.

In cases after 20 weeks, when we know baby's can survive outside of the mother's womb and most certainly feels pain from abortion, legitimate doctors will do their very best to make sure that the baby has the best chances to survive. But abortionists do their best to make sure that the baby does not survive.

Note on gestational age dating:

Determination of gestational age of the fetus is foundational to the standard of care of pregnant women prior to surgical intervention, in order to minimize the risks of surgery and to plan the appropriate procedure. Thus the bill appropriately requires that the gestational age of the fetus be determined with reasonable probability, using the standard of care for gestational dating. Gestational age is to be assigned using standard methods, which include physician judgment of all relevant dating parameters, including but not limited to date of last known menstrual period, ultrasound dating, and date of the positive pregnancy test. This assignment of gestational age will include the outer confidence intervals relative to that method of dating. This is in fact the

standard of care for obstetrical patients, regardless of whether the desired outcome is live birth or delivery of a dead fetus as in elective abortion. The standard of care for all obstetrical care is based on the most accurate determination of gestational age possible in the specific circumstances of the individual patient.

For example, the current standard of care in obstetrics is to not permit elective induction of labor prior to 39 0/7 weeks gestational age. If a patient is 38 6/7 weeks gestational age, she may not be electively induced. (ACOG Practice Bulletin No. 107, August 2009, page 3). ACOG cites the use of last menstrual period dating, date of a positive pregnancy test and obstetric ultrasound prior to 20 weeks gestation as just some of the indicators supporting assignment of gestational age and estimated due date, among other criteria. Gestational age determination decisions are well defined in obstetrical literature and are the basis for all gestational age specific procedures including timing of chorionic villus sampling, genetic amniocentesis, cervical cerclage, second trimester ultrasound screening, gestational diabetes testing, rhogam administration, external cephalic version, administration of antenatal steroids, use and avoidance of use of various medications during pregnancy, and elective induction of labor, just to name a few. **The argument that gestational age cannot be determined with accuracy is fallacious and a misrepresentation of the current national and local standards of care,** and contrary to published practice guidelines set forth by the American College of Obstetricians and Gynecologists and by the March of Dimes.

Testimony June 2, 2015
Joint Health Committee Hearing

Thank you for this opportunity to speak. I am Dr. Kathy Hartke, Chair of the WI Section of the American Congress of Obstetricians and Gynecologists. I would like to present our written Policy Statement and Talking Points on the AB 237 and SB 179 the "20 week abortion ban" and a written copy of my comments today.

I have been practicing as a general OB/GYN in Waukesha County for 28 years. I DO NOT perform elective abortions. I DO perform medically indicated abortions for my patients who have life threatening conditions or severe fetal conditions. While in residency, our institution received maternal transfers from throughout the state for management of these devastating problems.

When a woman comes to me for prenatal care, we discuss options for genetic screening. Many of my patients decline first trimester testing rationalizing that they would not do anything to interrupt a pregnancy. We would hope that all pregnancies would be healthy, but that is not always the case. All mothers are anxious for the 20 week "fetal anatomy screen". (20 weeks based on last menstrual period). While the perinatologist is looking with ultrasound to confirm that the fetus is normal, parents are hoping to find out the sex of the baby. What happens when the doctor says "your baby has a serious condition and will not live"? Until you are personally faced with this devastating news, you cannot predict the choice that you will make. These babies are wanted, planned and may be a result of treatment for infertility. Some of the most pro-life families suddenly realize that this is not someone else, this is us and we want to terminate this pregnancy.

Some women choose to carry the pregnancy until they go into labor or become so ill that labor must be induced. I have supported women whose fetuses have lethal anomalies and choose to continue their pregnancies. I have induced a mom at 35 weeks with severe pre-eclampsia and HELLP syndrome with liver and kidney involvement and the risk of hemorrhage. Her fetus had a lethal trisomy but she chose to hold her and have her baptized. I stayed with her for two hours until the heart stopped beating, meanwhile the clerk called 7 different on call chaplains at 2 am until she found one that would come in to baptize the baby and pray with all of us.

More often, women choose to end their pregnancy after thoughtful consultation. They cannot bear to continue knowing their baby will die, but not knowing if it will be this week, in labor, or shortly after birth. They cannot bear to be asked about their baby by unknowing strangers or friends every time they go out in public. They want closure. In most cases, labor is induced and the fetus is delivered, just like they would be at term. Whatever the gestation is, the fetus is treated with dignity and respect and allowed to die peacefully rather than extreme medical intervention that will only cause more pain and suffering.

Should a woman be forced to carry a fetus who has no brain? (Anencephaly). What about a fetus with no kidneys (renal agenesis) that the best neonatal program in the country for this condition said there is nothing that could be done to save this fetus? How about a severe congenital diaphragmatic hernia with a huge hole in the diaphragm and the chest is filled with bowel so the infant suffocates when born? Or severe congenital myotonic dystrophy where all the muscles are so weak that the baby will never breathe on its own. Some of these women are older, having their first child and want the opportunity to have a family, but their biological clock is running out.

What about the mother's life? I had a friend who was diagnosed with pulmonary hypertension (high pressure in the pulmonary artery). Her risk of dying in pregnancy was greater than 50% if she continued the pregnancy. An article on "Pregnancy I women with pulmonary hypertension" from the National Institute of Health states "When a pregnancy occurs, termination should be offered even if the women is in a good clinical condition." She chose to continue her pregnancy and died a few years later leaving two small children. If you had a 50% chance of dying driving to work in the next month, would you continue to drive to work? What should the obstetrician do when the cardiologist says "you must deliver this woman with severe aortic stenosis as soon as possible because she is going to die unless she has surgery"? What is an emergency? Shouldn't she have a voice?

In rare cases, the mother is so critically ill that she likely will not survive labor. In these cases, the only way to save her is a dilatation and evacuation (D&E). We know from rigorous scientific review that a fetus does not feel pain until 29-30 weeks. The 20 week fetal pain argument is just false.

What about a mother with twins where one bag of waters ruptures at 19 weeks gestation? Because the second fetus had a heartbeat and she was in a catholic institution, delivery was not allowed. After a few weeks she developed chorioamnionitis, a severe infection in the uterus with very high fever. Fortunately, the second fetus died and she was induced. Recall Savita Halappanavar the Indian dentist who pleaded for pregnancy termination after rupture of membranes? She was denied an abortion at an Irish hospital and died in 2012. Even the Catholic Church now has Directive 47 which allows delivery to save the life of the mother with certain medical conditions.

What about a 10 year old child who is the victim of incest and whose body is not ready to carry a pregnancy? Or a sex trafficking victim who becomes pregnant and her "john" tries to induce an abortion at 22 weeks causing her to hemorrhage but there is still a heartbeat?

Who are you to make these end of life decisions instead of the parents, physicians, geneticists, clergy and ethicists?

No legislative proposal should deny women safe and legal medical care by interfering with the patient-provider relationship.

No legislative proposal should threaten providers with fines and imprisonment, or criminalize physicians in any way that ay intimidate them from providing care even in health emergencies.

No legislative proposal should place doctors in the untenable position of denying needed services to women whose pregnancies threaten their health or are plagued with severe ad lethal fetal anomalies that could not have been previously diagnosed.

No legislative proposal should be predicated on unscientific premises about fetal pain, fetal viability or fetal anomalies that are not supported by medical evidence.

Scientific evidence should be central to the legislature's deliberations on any women's health care policy, especially when the measures would severely restrict access to necessary women's health care and related lawful medical services.

I have seven children. I hope my daughters and daughter-in-laws never have to face these situations in Wisconsin. I would do everything possible to save their lives!

Kathy D Hartke, MD

Fetal Pain—Scientific Observations

Joint Public Hearing
Wisconsin Senate Committee on Health and Human Services
Wisconsin Assembly Committee on Health
June 2015
AB 237/SB 179, the Pain-Capable Unborn Child Protection Act

Dear Distinguished Members of the Senate Health and Human Services Committee and the Assembly Health Committee,

My name is Sheila Page, DO. I am an Osteopathic physician, board certified in Neuromusculoskeletal Medicine. I have practiced for 23 years treating many patients with pain and related diseases, some at advanced stages. Although I treat patients of all ages, I have a special interest in children with disabilities and serious irreversible medical conditions, especially those who have little hope for recovery or improvement in their quality of life. I have found that the skills I have developed over the years have enabled me to help improve their quality of life and ease their suffering.

The question that all physicians have heard many times before performing a medical procedure or treatment is "will it hurt?" Doctors go to great lengths to minimize and prevent pain for their patients. Requiring proof that a patient has pain before he will treat him is in opposition to the ethical training of physicians. The physician anticipates pain and protects people from pain whenever possible.

The discussion of fetal pain is centered on the definition of pain, which can alter the direction of the study of this topic. There are two general definitions of pain that appear in literature: the subjective perception, and the objective observation. [i] [ii] [iii]

The JAMA article (6) that has often been used as the authoritative paper proving that the unborn child does not feel pain uses a psychological definition: "Pain is a subjective sensory and emotional experience that requires the presence of consciousness to permit recognition of a stimulus as unpleasant." (Bioethics) This statement is a hypothesis that is dependent on subjective and negative data for its conclusion.

The basic science definition of pain is formed by objective observation: "Pain is a protective mechanism for the body. It occurs whenever any tissues are being damaged, and it causes the individual to react to remove the pain stimulus." (Guyton)

Neuroanatomy and Physiology

The three scientific classifications of pain:

1. Pricking pain is felt when a needle is stuck into the skin or when the skin is cut with a knife, or when widespread area of the skin is irritated.
2. Burning pain is felt when the skin is burned, can be excruciating, and is most likely to cause suffering.

3. Aching pain is a deep pain with varying degrees of annoyance. Aching pain of low intensity in widespread areas of the body can summate into very disagreeable sensation.

Each of these types of pain stimuli are carried along different neurofibers in the organism:

1) Pricking pain: carried along Delta type A fibers, fast
2) Burning pain: carried along type C fibers, slow
3) Aching pain: carried along type C fibers, slow

The pricking pain pathway produces a rapid response to pain at the spinal cord level and travels to the reticular activating system (reticular formation of brainstem and intralaminar nuclei of thalamus) where the majority of the pain fibers terminate. A few Type A fibers travel to the thalamus and connect there to synapse with the somatic sensory cortex for the purpose of localizing the pain. The burning pain pathway terminates diffusely in the reticular formation and in the thalamus, with very few connecting fibers to the cortex. It is characterized by gross localization and the ability to summate when large areas of the body are being damaged. The purpose of these pathways is to alert the individual that damage is being inflicted. Guyton, 1986, 2010 (illustration).

A variety of approaches have been used to study pain perception. The methods for eliciting perception of pain include:

1. Pricking the skin with a pin
2. Applying pressure against a bone
3. Pinching the skin
4. Heating the skin.

One of the most reliable ways to measure a pain threshold is by gradually increasing heat applied to the skin. 'By far the greatest number of people perceive pain when the skin temperature reaches almost exactly 45C... Almost everyone perceives pain before the temperature reaches 47C." Across cultures this has been proven: there is very little difference in the threshold of pain perception, but there are wide variations in response to pain. [Guyton 1986, p 592-593]

The threshold at which pain is perceived (pain threshold), and the response to pain are different. As the human brain learns from various experiences and training, the response to pain may change and varies greatly with the individual.

Pain is directly correlated to tissue damage.

The point at which tissue begins to be damaged by heat is 45C, thus, the pain is correlated to tissue damage. "The intensity of pain has also been closely correlated to the rate of tissue damage by other effects besides heat," (contusion, chemical substances, infection, ischemia). Guyton 1986, p. 594.

Another important characteristic of pain fibers is the non-adapting nature of pain receptors: in contrast to other sensory fibers, pain receptors adapt either not at all or almost not at all. " In fact... the threshold for excitation becomes lower and lower as the pain stimulus continues, thus allowing these receptors to become progressively more activated with time." This increase in sensitivity is called hyperalgesia. [Guyton, 1986, p. 593.] **Consciousness and Pain**

"Although the cortex may elaborate the contents of consciousness, it's not the seat of consciousness." Merker 2007. Merker(8), Brusseau(10), and Bellieni (9)agree that consciousness is not dependent on the presence of a cerebral cortex. These conclusions are reached by their individual clinical observations of conscious behavior in individuals without a cortex. Infants with hydraencephaly, in which little or no cortical fibers are present, demonstrate conscious recognition, pain perception, musical preferences, and alert, wakeful behavior. These represent a counter- example to the hypothesis that consciousness requires a cerebral cortex. The implication is rather that consciousness is a function of the lower brain centers. Further, ablation of the somatosensory cortex does not alter pain perception in adults, underscoring the anatomical implication that pain perception occurs in the lower brain centers. Brusseau, p16.

The Sub-Cortical Neurological Pathways Involved in Pain Perception:

Type A and Type C pain fibers travel in the lateral division of the anterolateral pathway, remaining differentiated as fast or slow fibers. About three-quarters to nine-tenths of all pain fibers terminate diffusely in the reticular formation and in the thalamus (these two areas constitute the reticular activating system). The reticular formation is part of the medulla, pons, and mesencephalon.

Burning and aching pain fibers excite the RAS, thus activating the entire nervous system, causing arousal from sleep, creating a sense of urgency, and promoting defense and aversion reactions. The purpose of these pathways is to alert the individual that damage is being inflicted. Burning-aching pain is characterized by gross localization and the ability to summate when large areas of the body are being damaged. The summation property of the pain fibers in the RAS causes the most intense suffering in human experience. [Guyton, 1986, p. 596.]

Type A fibers enter the spinal cord, synapse with an interneuron, cross over and travel up in the anterolateral pathway. Very few type A fibers pass directly to the thalamus and terminate in the ventrobasilar complex and posterior nuclear group via the spinothalamic tract. From here the connecting neurons to the cortex serve to localize the pain.

The pain perception functions remain in the lower centers and are not dependent on the cortex, although some modification of the pain threshold may occur. Pain impulses that enter and terminate in the lower brain centers, especially the reticular formation and the thalamus, can cause conscious perception of pain. [Guyton, 1986, p. 596.]

Consciousness and Pain

"Although the cortex may elaborate the contents of consciousness, it's not the seat of consciousness." Merker 2007. Merker(8), Brusseau(10), and Bellieni (9)agree that consciousness is not dependent on the presence of a cerebral cortex. These conclusions are reached by their individual clinical observations of conscious behavior in individuals without a cortex. Infants with hydraencephaly, in which little or no cortical fibers are present, demonstrate conscious recognition, pain perception, musical preferences, and alert, wakeful behavior. These represent a counter- example to the hypothesis that consciousness requires a cerebral cortex. The implication is rather that consciousness is a function of the lower brain

centers. Further, ablation of the somatosensory cortex does not alter pain perception in adults, underscoring the anatomical implication that pain perception occurs in the lower brain centers. Brusseau, p16.

Embryological Concepts

The human being develops from a uniquely human single cell which comes into existence at the moment at which a human sperm penetrates a human egg. [reference M. Condic] The accumulation of biological data we have today clearly demonstrates that no developmental phase exists that constitutes a transition from the "non-human" to the "human". There is no scientific evidence for a stage in human development prior to birth in which one could claim that a being exists which is "not yet human". Human development is distinctly human and uniquely individual from conception.(1)

One of the scientific fallacies often repeated even today is the discredited concept of "phylogenetic recapitulation" or "ontogeny recapitulates phylogeny". This idea that the human conceptus passes through evolutionary non-human phases in its development was first purported by Haekel, and supported by drawings and data which Haekel later admitted were fraudulent.[1] However, by the time that the fraud was admitted, the concept had become firmly entrenched in biology, and is even repeated today. This falsely derived concept propagates the idea that the unborn human being is less than human, a concept not supported by scientific evidence.

One of the most accomplished scientists in the study of embryology was Eric Blechschmidt, (1904-1992), a German anatomist and physiologist who worked for more than forty years studying the development of the human form in principally the first eight weeks of life after conception. He produced more than 120 scientific papers and numerous books on the form and function of the developing human. Blechschmidt focused on the evidence presented by the embryo itself, producing more than 200,000 serial sections of embryos of different ages and sixty-four enlarged total reconstructions at the University of Göttingen.

Blechschmidt's observations were unique in his whole body approach to the embryo. He considered the function of all parts of the developing embryo to parallel the structure. "The development of the central nervous system implies the simultaneous development of functioning afferent and efferent central pathways (tracts) and centers. Nothing has been found to support the idea that the function of the nervous system is added *after* the development of its shape and cell structure. It is the author's opinion that the function and structure develop simultaneously. The beginning of the nervous system implies the simultaneous beginning of function." (7) P.105

Observations of fetal movements at very early developmental stages supports the findings of Blechschmidt, that function and structure are developed simultaneously. "Neural cells begin to generate and propagate action potentials as soon as they interconnect. Furthermore, it has been shown that neurons are able to communicate through non-synaptic mechanisms even before the onset of synapsogenesis. "Aida. p.1

Timeline of Development

The data on the chart below is a compilation of data from various sources, reflecting general agreement of the stages at which different structures have been observed to mature in the developing human.

Neurological Development of the Fetus:

WEEKS	Anatomical Structure Developed
7-20	nociceptors
8	cortex begins to develop
10-30	peripheral afferents
7.5	spinal reflex
20	spinothalamic connections
20-22	Thalamocortical tracts (cortical plate)
26-34	synapses of thalamocortical fibers

Development of the thalamus and corresponding structures is key to pain perception.

At 7.5 weeks, the spinal cord elicits a nociceptive response. The thalamus is already formed, and during the seventh week the thalamus rapidly expands. (Moore. P.395) in conjunction with the developing nociceptive system of the spinal cord. Projections from the spinal cord...can reach the thalamus...from seven weeks gestation. Fitzgerald M. (17), Andrews KA, (18). The necessary components for pain perception are in place at this stage. It is important to consider that the function develops along with the structure. As Blechschmidt described, the brain and spinal cord are developing as a whole unit, functionally developing at the same time. Blechschmidt. The principal unit of pain perception is in place and rapidly expanding at 7.5 weeks.

Conclusion

The fetus is physiologically equipped to perceive pain, and demonstrates physiological responses consistent with pain perception. These responses are seen at 7.5 weeks and continue to develop until birth. It is reasonable to conclude that by 8 weeks the developing human is capable of pain perception. Our ability to relate to this possibility is limited by our own narrow vision, lack of understanding, and sometimes our unwillingness to perceive that which we cannot readily see. As physicians, we are obligated to anticipate potential suffering and take action to prevent or alleviate it.

Thank you for your time.

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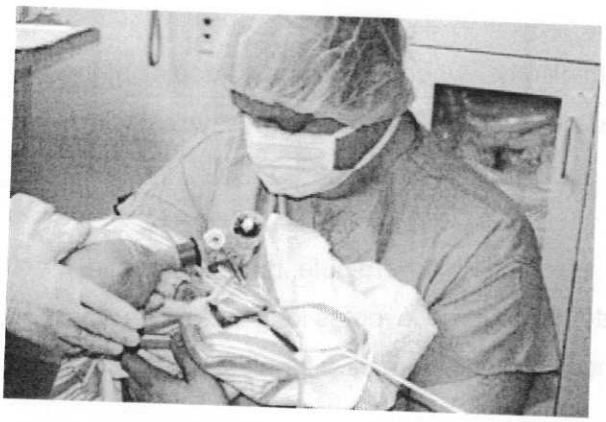
Kari Adamson

Fond du Lac, WI

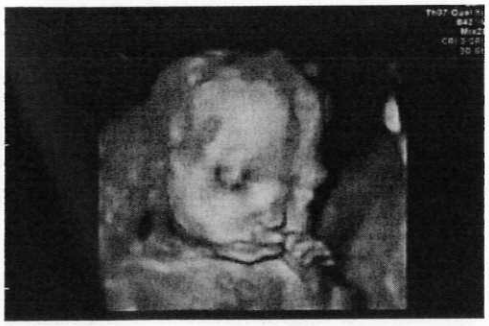
June 2nd, 2015

Dear Distinguished Members of the Senate Health and Human Services Committee and Assembly Health Committee,



When I found out that I was pregnant with our 4th child, I was very surprised! It was unexpected, but welcome. The pregnancy progressed nicely with normal morning sickness, but nothing was alarming or unusual. We went to a private 3D/4D ultrasound place to find out my child's gender at 16 weeks because we wanted to get the baby's room done before my husband and I went back to school as teachers. We had a little girl! But later on September 21, 2011, we went in for our "big" 20 week ultrasound, which would help us find out the health of our unborn baby girl.

We knew by what the technician wasn't saying during the ultrasound that something was wrong. We found out that our little girl had bilateral club feet, clenched hands, a single umbilical artery, choroid plexus cysts, a heart defect and a small jaw. We had no idea what this exactly meant, but we knew they were "markers." The next morning my husband received a call from my doctor that he wanted us in immediately for an amnio, and he notified us that my life could be at risk.

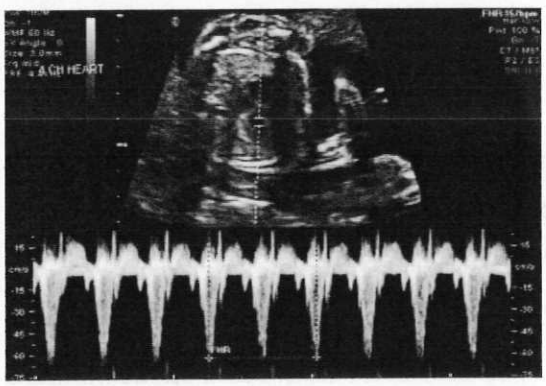


We had always refused all genetic testing up until this point and it made me very uncomfortable to do it. After a lot of persuasion, we cautiously went ahead with the amnio. The FISH test came back the following Monday…our daughter had Trisomy 18.

Trisomy 18, or Edwards Syndrome, is a chromosomal disorder where a child has 3 copies of the 18th chromosome, instead of the usual 2 in every cell of the body. This condition is typically considered "not compatible with life."

We were then given the option to terminate, or carry as long as we were able, but our daughter would most likely not make it to birth. Our daughter deserved to be loved as long as her life would be – so abortion was not an option for us. Especially since it would cause pain for all of us.

We decided to seek out a second opinion and went to a larger hospital for a more detailed scan. They told me that they had never sent a child home with Trisomy 18 that had lived for more than a day. We called 2 other hospitals and we were told that I should be happy that my doctor was even "allowing us" to continue the pregnancy since I had gestational diabetes.



I continued to see my OB, but he treated me, not my baby. I asked about having a c-section to reduce the stress on my baby, and was told that it was too risky for me. We met with perinatal

hospice, which was incredibly helpful as we created our birth plan. We met with our pastor to plan our daughter's funeral, and I contacted the funeral home about our plans.

But when we made it to 34 weeks, we decided that we wanted to change from comfort care to full intervention for our daughter. If she had made it this far, we had the chance of spending some, any time with her after birth. Little did we know the challenges we would face by choosing to do so. We were again told that she was "not compatible with life" and no lifesaving acts would be done. We were then told that our insurance wouldn't even cover the NICU. I knew time was running out. We had heard of a Trisomy 18 child who was born at a different hospital and lived for a month. For us, a month was at least time. Precious time. I called the NICU there and spoke directly with one of the neonatologists. She was willing to do whatever we wished, including intubation if needed. We then tried one of the OB's that was recommended. She had a cancellation for the following Tuesday (4 days away). Our daughter had a chance!

We celebrated Christmas and prepared as much as we could to meet our new OB. We were amazed with how supportive she was of our decisions. She asked us if we had a fetal echocardiogram and non-stress tests done yet. No. Had we met with a perinatologists? No. Since I was now 34-½ weeks, time could be running out. She asked us to come back the next day when the cardiologist was there to do an echo and a non-stress test. The next day during the tests, Leila was starting to fail and we were told that if we wanted any chance of seeing her alive that I had to go immediately to Labor & Delivery.

Leila Hope was born at 34 weeks, 6 days weighing 4 lbs 12 oz, which is very large for a Trisomy 18 baby. She was intubated and taken to the NICU. At 4 weeks of age, we requested a transfer to the Children's Hospital for an ENT consult and G-tube. When we got there, we were met by a very unsupportive neonatologist who could not understand why we would even consider doing surgery on a child like ours. He told us to take her home and let her die. When we refused and I forbid him from turning down her high flow support that was keeping her airway open, we found ourselves having to defend our decisions to the ethics board of the hospital. Fortunately, our case for our daughter's life won out.

While there will still doubters after our daughter was born, I am very proud to say that Leila Hope will be turning 4 years old on the 28th of December. She is proving the medical community wrong by living and thriving with full Trisomy 18. And she's not the only Trisomy child to do so!

Sometimes, a prenatal diagnosis is incorrect. And sometimes, it is correct. In Leila's case, her diagnosis was correct, but far from a death sentence.

It would have broken my heart if I had lost my daughter to a painful abortion. I would never have had a chance to treasure the time I have with her, and she would never have had a chance at life.

There are so many unborn babies, capable of feeling pain from abortion, who deserve a chance at life. I am so glad the Wisconsin Legislature is considering the Pain-Capable Unborn Child Protection Act that would protect unborn babies just like Leila, and support parents like me who may need help from perinatal hospice. I sincerely hope that the pain bill is passed quickly, so that no family or child has to experience the pain of abortion.

Many Thanks for Your Time,

Kari Adamson

eliminating racism
empowering women
ywca
madison

Race & Gender Equity | Job Training & Transportation | Housing & Shelter

June 2, 2015

To the Assembly Committee on Health and Senate Committee on Health and Human Services:

The YWCA Madison stands in opposition to Assembly Bill 237 and Senate Bill 179, prohibiting abortions after 20-weeks of pregnancy. We ask you to vote against it.

YWCA Madison supports policies that respect the rights of women of diverse cultures and perspectives to plan their lives and families and to control health and family planning decisions. It will oppose policies that seek to limit those freedoms or to impose a particular perspective on others. This includes access to comprehensive reproductive health care and abortions.

The proposed ban is exceptionally cruel because the overwhelming number of women who choose to have an abortion this far into pregnancy do so for health reasons. That is why these procedures are so rare; fewer than 1% of abortions in Wisconsin and nationally occur after the 19th week of pregnancy.

Regardless of the reason, the choice belongs with the woman and her healthcare providers. The proposed law unacceptably does not have exceptions for cases of rape and incest, and it includes jail time for doctors who perform these abortions.

Sincerely,

Rachel Krinsky, CEO
YWCA Madison
101 East Mifflin Street, Suite 100
Madison, WI 53703
rkrinsky@ywcamadison.org
608-257-1436 option 2
fax: 608.257.1439

JANEL BRANDTJEN

STATE REPRESENTATIVE • 22ND ASSEMBLY DISTRICT

TO: Members of the Assembly Health and Senate Health & Human Services Committees

FROM: Representative Janel Brandtjen

DATE: June 2, 2015

RE: Pain Capable Child Protection- AB 237 / SB 179

Committee Chairs Sanfelippo and Vukmir, and Legislative Health Committee Members,

Thank you for the opportunity to appear before you today on this important legislation, and thank you very much to the authors and everyone who has been involved in moving it forward, because we share the same good intention of protecting pre-born children from the pain of abortion by dismemberment.

I am offering a friendly amendment to bring clarification to the false and confusing proposition that abortion is ever medically necessary to save the life of the mother, particularly as the term "abortion" is understood within Wisconsin state statutes.

Abortion is never medically necessary to save the life of the mother, and hundreds of doctors have attested to that fact. There is a fundamental difference between abortion carried out with the intention of taking the life of the baby, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother. Treatment of ectopic pregnancies, cancer and pre-eclampsia are NOT abortions, nor are they considered as such medically, legally or by common sense. Any exceptions within the pain capable legislation would undermine the consistency and intent of the bills, as well as create confusion and seemingly justify and increase the acceptability of abortion. In fact, the performance of an abortion is generally more harmful to the life of the mother medically than if the child is brought to term and delivered.

The reason I am offering an amendment is the definition of "Medical Emergency" used within the bill, which references abortion and leaves an unnecessary and potentially abused loophole. By using the term "abortion" within this the Medical Emergency definition it is hard to interpret if the child was to be delivered alive, or to be dismembered.

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Home: N52W16632 Oak Ridge Trail • Menomonee Falls, WI 53051
Home: (262) 455-8311 • Rep.Brandtjen@legis.wi.gov

As currently written, AB 237 and SB 179 utilize the term "medical emergency" in creating an explicit exemption for the performance of an abortion. Notice the way the word intent is used in our state statutory definition of abortion:

253.10(2)(a) **(a)** "Abortion" means the use of an instrument, medicine, drug or other substance or device with intent to terminate the pregnancy of a woman known to be pregnant or for whom there is reason to believe that she may be pregnant and with intent other than to increase the probability of a live birth, to preserve the life or health of the infant after live birth or to remove a dead fetus.

In other words, *in both law and common sense, a medical procedure intended to save the life of the mother which would have the secondary and unintentional effect of the child dying in utero or being prematurely delivered is not considered an abortion, nor are miscarriages considered abortions.*

Medical treatments necessary for the mother which result in the death of a child, are not the same as the destruction of a child. Medical treatment should be for mother and child, not mother or child. Physicians can clearly provide equal care to mother and child in a way that abortion, certainly as our state law understands it, is never medically necessary.

Let me read to you the medical emergency definition.

d) *"Medical emergency" means a condition, in a physician's reasonable medical judgment, that so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a 24-hour delay in performance or inducement of an abortion will create serious risk of substantial and irreversible impairment of one or more of the woman's major bodily functions.*

I am concerned that the exception within AB 237/SB179 allows the pre-born child's pain to be disregarded if the mother's health is called into question- but all pre-born children impacted by this legislation experience pain. We need to also protect pre-born children from pain, particularly the excruciating, agonizing pain of a dismemberment abortion, when the mother needs emergency care.

21st Century medicine allows for expectant moms to have liver and heart transplants treating both mom and baby successfully. In other words, science allows us to treat both the mother and the child. It is our duty to do so.

I'm asking all of you to take a thoughtful look at the amendment and consider amending AB 237. We have a chance to put forward a bill that protects the pre born from experiencing pain which reflects all of our values.

Thank you for your consideration.

State Representative Janel Brandtjen.
22nd Assembly District.

Janel Brandtjen

State of Wisconsin
2015 – 2016 LEGISLATURE

LRBa0548/1
TJD:kjf

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 237

At the locations indicated, amend the bill as follows:

1. Page 1, line 6: delete "abortion reporting,".

2. Page 3, line 1: delete lines 1 to 17.

3. Page 6, line 4: delete that line.

4. Page 6, line 7: delete the material beginning with "Except" and ending with "no" on line 8 and substitute "No".

5. Page 6, line 12: delete "(a)".

6. Page 6, line 14: delete the material beginning with "unless" and ending with "emergency" on line 15.

7. Page 6, line 18: delete lines 18 to 21.

8. Page 6, line 22: delete "(a)".

(END)

Pro-Life Wisconsin

Defending them all...

P.O. Box 221, Brookfield, WI 53008-0221
Phone (262) 796-1111 Fax (262) 796-1115
info@prolifewisconsin.org www.prolifewisconsin.org

Testimony / Senate Bill 179 & Assembly Bill 237: Pain-Capable Unborn Child Protection Act
Senate Committee on Health & Human Services / Assembly Committee on Health
By Matt Sande, Director of Legislation, Pro-Life Wisconsin

June 2, 2015

Good morning Chairwoman Vukmir, Chairman Sanfelippo, and Committee members. My name is Matt Sande and I serve as director of legislation for Pro-Life Wisconsin. Thank you for this opportunity to express our concerns with Senate Bill (SB) 179 and Assembly Bill (AB) 237, also known as the *Pain-Capable Unborn Child Protection Act*, companion legislation that would prohibit direct abortion at or beyond 20 weeks based on the preborn child's capacity to feel pain at that gestational age.

Pro-Life Wisconsin supports legislation shielding preborn children from the excruciating pain of late-term dilation and evacuation dismemberment abortions. But we cannot support SB 179/AB 237 in its current form because it includes an exception for a "medical emergency," as defined in section 253.10 of the Wisconsin Statutes. Because the term medical emergency is defined to allow direct abortion, the medical emergency language in the bill constitutes an unacceptable life-of-the-mother exception.

Section 253.10 of the Wisconsin Statutes concerns *Voluntary and informed consent for abortions*, also known as the *The Woman's Right to Know Law*. This section of the statutes requires an abortion bound woman to wait 24 hours prior to the abortion procedure, except in cases of medical emergency. In defining the terms "abortion" and "medical emergency," SB 179/AB 237 references section 253.10 which, clearly, entails direct abortion.

In 253.10(2)(a), "abortion" means "the use of an instrument, medicine, drug or other substance or device *with intent to terminate* the pregnancy of a woman known to be pregnant or for whom there is reason to believe that she may be pregnant and *with intent other than to increase the probability of a live birth*, to preserve the life or health of the infant after live birth or to remove a dead fetus."

In 253.10(2)(d), "medical emergency" means "a condition, in a physician's reasonable medical judgment, that so complicates the medical condition of a pregnant woman as to *necessitate the immediate abortion* of her pregnancy to avert her death or for which a 24-hour delay in performance or inducement of an abortion will create serious risk of substantial and irreversible impairment of one or more of the woman's major bodily functions."

If we look at the definitions of these two terms in 235.10 and try to make them consistent, which a judge would do, then we come to the conclusion that certain medical emergencies necessitate the immediate, direct abortion of the child. The abortion of the child is by definition intended to terminate the pregnant state of the woman in such a way as to deny the probability of a live birth. In other words, medical emergencies justify, according to Wisconsin Statutes 253.10, the intentional killing of a preborn child.

In contradiction of the definition of medical emergency allowing direct abortion, SB 179/AB 237 (page 6, lines 18-21) states that when a pregnant woman, whose preborn child is at or beyond 20 weeks, is undergoing a medical emergency, "the physician shall terminate the pregnancy in the manner that, in

reasonable medical judgment, provides the best opportunity for the unborn child to survive." The legislation is internally inconsistent as it states that after 20 weeks, and when the woman is in a "medical emergency" (as defined in 253.10), the physician shall kill the child in the way that provides the best chance of survival for the child. If what the bill authors meant to say was that in cases of medical emergencies after 20 weeks the termination of a pregnancy should be done in a way that would not kill the child, then they cannot maintain the use of medical emergency as defined in 253.10. The definition of medical emergency the bill authors' reference is clearly different than how they seek to apply it.

Either the authors meant to amend the current definition of "medical emergency" or they meant to create a new one. But they cannot say that in a medical emergency, as defined in 253.10, a doctor shall kill the child in the way most likely for the child to survive. Accordingly, because SB 179/AB 237 makes explicit reference to the term "medical emergency" as defined in section 253.10, the bill does incorporate by reference a life of the mother exception, thus permitting direct abortion in the instance of a medical emergency.

Senate Bill 179/Assembly Bill 237 (page 3, lines 7-17) require the physician to report the nature of the medical emergency, and the method of abortion/pregnancy termination used, in Wisconsin Statutes 69.186 *Induced abortion reporting.* Why would the legislation require a report in the *Induced abortion reporting* statute if, in fact, the method of pregnancy termination was not, or could not be, a direct abortion? The simple answer is because the legislation permits direct abortion in the case of a medical emergency. Again, as we saw on page 6 lines 18-21, page 3 lines 7-17 is also internally inconsistent with the definitions of "medical emergency" and "abortion." Those definitions state that doctors shall intentionally kill a child during medical emergencies in a way other than to produce a live birth, while the legislation contradicts those definitions by stating in those cases of medical emergency, the doctor shall provide the best opportunity for the child to live.

In sum, the "medical emergency" language in SB 179/AB 237, at worst, constitutes an explicit life-of-the-mother exception by employing the term "medical emergency" in two sections of current law that entail direct abortion: 253.10 *Voluntary and informed consent for abortions* and 69.186 *Induced abortion reporting.* At best, the legislation is so ambiguous, contradictory and inconsistent that it will allow a physician to make a credible argument that his or her performance of a direct abortion in a medical emergency is legally permissible.

In order to be moral and effective, pro-life legislation must be simple and clear. In the instance of fetal pain legislation, it cannot explicitly authorize the intentional destruction of certain categories of human beings based, for example, on the circumstances of their conception or the health status of their mothers. Although SB 179/AB 237 does not contain exceptions for rape/incest, the medical emergency exception in the bill is a patent denial of equal protection under the law. We must never codify in law the importance of one innocent human life over and above another. Moreover, the exception undermines the legal premise of the bill by removing the focus on the baby's pain and shifting it to the mother's health. Certainly the courts will see right through this and recognize the legislation as an attempt to ban late-term abortion, rather than shielding the baby from pain. After all, the preborn child whose mother's life is threatened feels pain too. The argument is lost before it is made.

To be sure, there are no situations where abortion, defined as the direct and intentional killing of an unborn child, is medically necessary to save the life of the mother. Over 900 pro-life doctors and medical researchers have signed the *Dublin Declaration*, a document stating that abortion is never medically necessary to save a mother's life. Even abortionists agree that abortion is not necessary to save a woman's life. Former abortionist Dr. Bernard Nathanson, who himself performed over 30,000 abortions, said "if women with heart and liver transplants can be carried successfully through pregnancy, we can no longer conceive of any medical condition which would legitimize abortion. In short, we have slowly evolved to an

unshakable posture of no exceptions…[W]orkable, morally acceptable legislation proscribing abortion can have no exceptions written into it – not even medical ones." (Bernadell Technical Bulletin, April 1991)

It is important to distinguish between the intentional and willful destruction of a preborn child, and a legitimate medical treatment a pregnant mother may choose to save her life. Operations such as the removal of a cancerous uterus or an ectopic pregnancy, that poses the threat of imminent death, are not abortions even though the child dies as a secondary effect. Such operations are justified by the "principle of double effect," because the death of the child is an unintended effect of a medical operation independently justified to save the mother's life. They do not involve the intentional and willful destruction of an unborn child. Legally, such operations are not considered abortions. The removal of such conditions has never been prosecuted in this country, even when the mother's life was not immediately threatened. There is, therefore, no need to provide a specific exception for such operations in legislation prohibiting abortion.

Pro-Life Wisconsin would support an amendment to SB 179/AB 237 that simply removes all reference to "medical emergency" throughout the legislation and retains the prohibition on direct abortion after twenty weeks gestation. We remain hopeful that we can lend our support to this important legislation.

Thank you for your consideration, and I am happy to answer any questions committee members may have for me.