



National Advocates
for Pregnant Women

N A P W

TESTIMONY TO THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION

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Madame Chairwoman and Members of the Task Force: Thank you for this opportunity to present to you today. My name is Lynn Paltrow. I am an attorney and Executive Director of National Advocates for Pregnant Women, an organization devoted to protecting the interests of pregnant and parenting women and their families. In addition to litigation and policy analysis, I am author and co-author of numerous commentaries and articles including ones published in medical journals such as the *American Journal of Obstetrics and Gynecology* and the *Journal of the American Medical Association*.² I am also a frequent lecturer to medical and public health organizations and to health care providers.³ In addition, I have served on both state and federal panels concerning pregnant and parenting women.⁴ Many of the cases that I have worked on involve women who have wanted to continue their pregnancies to term and many of these women oppose abortion.

I have been asked by this Task Force to provide “An analysis from both the legalistic perspective and from the psychological perspective of the degree to which the decision to undergo an abortion is actually voluntary and the degree to which such abortion constitutes an appropriate legal waiver or termination of the relationship between the woman and the unborn child.”⁵

I want to begin by being clear about the women who are the subjects of this Task Force’s inquiries. More than half of all women having abortions already are mothers,⁶ raising one or more children.⁷ A majority of those having abortions that are not yet raising children, will someday become mothers and spend much of their lives raising and caring for their children and other loved ones. As a result, the questions addressed by this Task Force concern mothers and pregnant women. These are the women that I will be talking about today.

As an attorney, I will be focusing on legal questions especially on the meaning of the term “voluntary.” I will also address whether pregnancy should be viewed as some kind of contractual relationship between two wholly independent parties — pregnant woman and fetus. In order to explore these questions I will provide case examples that demonstrate what happens when pregnant women and fetuses are treated as separate and competing legal entities as well as cases where women’s reproductive and health decisions have unquestionably *not* been voluntary.

The meaning of “involuntary”

I begin with the case of Angela Carder: Angela Carder at 27 years old and 25 weeks pregnant became critically ill. She, her husband, and her parents as well as her attending physicians all agreed on treatment designed to keep her alive for as long as possible. The hospital, however, called an emergency hearing to determine the rights of the fetus. A lawyer appointed for the fetus used the anti-abortion argument that fetuses are separate legal persons with independent rights. This lawyer argued that the fetus had a right to life and that what Angela Carder, her husband, and her family wanted did not matter. Despite testimony that a cesarean section could kill Ms. Carder, the court ordered the surgery, finding that the fetus's rights were controlling. The surgery was performed over her explicit objections and resulted in the death of both Angela and her fetus. The fetus, or as in Angela's parents words — their “unborn grandchild” — died within two hours and Ms. Carder died two days later with the c-section listed as a contributing factor.⁸

According to the Webster's Third New International Dictionary at 2564 (1981) Voluntary means: “1(a): proceeding from the will: produced in or by an act of choice, (b): performed made, or given of one's own free will, (c): ready, willing, (d): done by design or intention: not accidental: intentional, intended.” Clearly the surgery Ms. Carder was forced to have in the name of fetal rights — that ended both her pregnancy and her life — was not voluntary.

Unlike Ms. Carder, Ayesha Madyun survived. She too, however, was forced to have a c-section based on the claim that her fetus had independent rights greater than hers. Ms. Madyun had been in labor for more than 30 hours and as a result, her doctors believed that her baby was at risk of dying from an infection. Her request to be allowed to wait longer before having a cesarean section so she could try natural delivery was portrayed to the court as an irrational religious objection to surgery. The court granted the order. After Ms. Madyun had been subjected to surgery without her consent and forcibly cut open, the doctors found that there was in fact no infection.⁹

The forced surgery that Ms. Madyun endured in the name of fetal rights was not voluntary. In Illinois, another hospital also using anti-abortion arguments claiming the existence of separate legal rights for fetuses, obtained a court order permitting it to force a pregnant woman to undergo a blood transfusion. Doctors “yelled at and forcibly restrained, overpowered and sedated” the woman, in order to carry out the order.¹⁰ This blood transfusion was not voluntary.

Although appellate courts and leading medical organizations have now overwhelmingly rejected these forced interventions, these cases provide key examples of what “*involuntary*” means in the context of pregnancy and what has and will happen if pregnant women and fetuses are viewed as having independent legal rights.¹¹

A more recent case provides another disturbing example. In January 2004, Pennsylvania resident Amber Marlowe went to the hospital to deliver her seventh baby. She and her husband describe themselves as true believers in the Bible and they deeply oppose abortion. For medical reasons far from compelling, the hospital believed that Mrs. Marlowe needed to have a c-section. Neither Mrs. nor Mr. Marlowe had any religious objection to surgery. Both felt however that after six other deliveries Ms. Marlowe knew her own body well enough to know that this delivery was

possible without surgery. In addition, the Marlowes did not want to subject either Amber or her unborn child to unnecessary surgery that would increase risks to both, and that would unnecessarily prolong the mother's period of recovery (something that this primary caretaker of six and soon to be seven children wanted to avoid). Rather than respect her informed decision, the hospital sought and obtained a court order giving the hospital custody of the fetus "before, during, and after delivery," as well as the right to force Ms. Marlowe to have the C-section. The hospital used anti abortion legal arguments asserting the independent legal rights of the fetus.¹² Mr. and Mrs. Marlowe left the hospital before the order could be executed. Mrs. Marlowe gave birth to a healthy baby through vaginal delivery.¹³

Mrs. Marlowe avoided involuntary surgery. Nevertheless, this case presents another clear example of action that would prevent voluntary medical decision-making. The hospital sought and obtained an order "permitting [the hospital] to perform a C-section delivery of Baby Doe *without* the consent of the Doe parents."¹⁴

There are other very clear examples of what "*in*voluntary" means. Over the course of American history, for example, thousands of white American women,¹⁵ Native American,¹⁶ Latina, and African American women were sterilized against their wills, without consent, or under threat. For example, in 1975 ten Chicana women sued Los Angeles County hospital and state officials for incidents of forced and coerced sterilization. One of the women had refused to give her consent to a sterilization. She was punched in the stomach by a doctor and then sterilized.¹⁷ This woman's reproductive health experience was unquestionably *in*voluntary.

In the *Relf* case, two African-American teenagers in Alabama were sterilized without their consent or knowledge. A federal district court found that there was "uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds and that an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization."¹⁸ These reproductive health outcomes were unquestionably *in*voluntary.

Another example of the true meaning of *in*voluntary is reflected in the lives of African-American women who, during slavery, had no rights whatsoever regarding their reproductive lives. Sexual intercourse, marriage, childbearing, and birth were all under the control of their masters.¹⁹

These examples of forced, and involuntary treatment of women provide an important contrast to the experience women have of abortion in America today.

The meaning of voluntary

Each year approximately one million women in America have abortions.²⁰ There is no legal, medical, or scientific evidence that these women who have had abortions have done so involuntarily. Indeed, in today's legal and political climate we would have to conclude that the abortion decision is "super voluntary" "ultra voluntary" or "voluntary plus."

South Dakota along with virtually every other state in the union has enacted stringent laws in the name of informed consent. These laws not only impose counseling and informational requirements far beyond those required prior to other medical procedures but some of these laws also require health care providers to convey explicit state opposition to the procedure. Since 1992 states have enacted 487 laws restricting access to abortion.²¹ Many of these laws call for scripted and mandatory counseling, waiting periods, and parental notice or consent. Some additionally require abortion providers to offer women ultra-sound images before the procedure and to inform them of economic supports hypothetically available to them if they continue to term.²²

The fact that approximately one million women each year have abortions in spite of these requirements, in spite of increasing social and political pressure against abortion, and sometimes in spite of picketers, protesters, and stalkers calling them murderers,²³ should reassure this Task Force that the abortion decision is more voluntary, conscientious, and determined than many health and family related decisions in America today.

I have not been able to find any cases that found that reproductive health providers have forced or coerced abortions. In instances where there have been concerns that family or teachers have attempted to coerce an abortion, the decision in *Roe v. Wade* has provided pregnant woman with protections. For example, in *Arnold v. Bd. of Educ. of Escambia County Ala.*, 880 F.2d 305, 311 (11th Cir. 1989) parents claimed that a school guidance counselor, vice-principal, and school board coerced a student into having an abortion. The court allowed a civil rights suit against the school officials to go forward. Citing none other than *Roe v. Wade*, the court explained that our constitutional law ensures that “the individual must be free to decide to carry a child to term.” Similarly, in *Planned Parenthood v. Casey*, the US Supreme court noted that its decision in *Roe v. Wade*, 410 U.S. 113 (1973), “had been sensibly relied upon to counter” attempts to interfere with a woman's decision to become pregnant or to carry to term. *Casey*, 505 U.S. 833, 859 (1992).

Lacking case law examples, or peer reviewed, evidence-based research establishing that women’s abortion decisions are not voluntary or informed, the analysis called for today relies on implication; the suggestion that the pregnant women and mothers of America are being tricked or manipulated. Far from reflecting involuntary, coerced or misinformed decisions, however, the real experiences of women who are the subject of today’s hearings make clear that their decisions are based on profound ethical, religious, and family considerations.

Some years ago women and family members were asked to write letters describing why they or someone they knew chose to have an abortion. Not one of the people who wrote said they or a loved one had had an abortion because they were forced to do so. Instead each of the writers talked about fundamental family and religious values and their deep sense of responsibility. One woman wrote: “When I found out I was pregnant, I had my two boys to care for, and Norma, a baby girl. I already had all that I could handle, because my third child, our daughter was a spina bifida baby, and I had made a promise to myself, when she was born with this condition, that I would take care of her . . .” Another explained her decision saying, “I was a Christian then, as I am now, and constant prayer asking for guidance through peace is how I was able to feel that God guided me toward that decision, also.”²⁴

For so many pregnant women and mothers, the decision to have an abortion is not only voluntary, it is ethically mandated by obligations to self and to others.

The legal, medical, and social history of abortion confirms that the decision to end a pregnancy is “super voluntary” or “voluntary plus.” Before the Supreme Court’s decision in *Roe v. Wade*, state governments were free to substitute their political judgments for the personal, moral judgments of women and the medical judgments of doctors. Despite the laws that prohibited or restricted abortion, women made decisions about their reproductive lives and obtained the abortions they needed and wanted.²⁵ After abortion became illegal in the United States in the late 1800’s,²⁶ women continued to have them, defying statutory prohibitions on abortion,²⁷ as well as public norms and for some, clear religious proscriptions. Estimates of illegal abortion in the United States in the 1960’s ranged between 200,000 and 1,200,000 a year.²⁸

The fact that women had abortions in the past, despite criminalization, and continue to have abortions in America today in spite of increasing barriers to that health care service makes clear that the decision to have an abortion – is a voluntary decision.²⁹

Finally, if this Task-Force is truly committed to the value of the lives of all pregnant women and mothers it would necessarily include within the scope of its investigation so-called crisis pregnancy centers. In contrast to the extraordinarily regulated providers of abortion services, who are required as a matter of medical ethics and law to provide accurate medical information and to obtain informed consent, crisis pregnancy centers are not similarly regulated and have repeatedly been found to provide false and misleading information to the women who seek help at those centers.³⁰

The decision to have an abortion is still “voluntary” even when made in constrained circumstances.

This committee should not confuse the question of whether or not a decision is voluntary and informed with the different question of whether or not men and women must make important life, health, and family decisions within real-life financial, community, and personal constraints.³¹

For example, if a woman chooses to have an abortion because her boyfriend beats her up when he finds out that he impregnated her, the decision to have an abortion can still be both voluntary and informed, even if made under circumstances that influence her decision and constrain unlimited choice.³²

According to the South Dakota Coalition Against Domestic Violence, in the United States, “1.3 women are raped every minute.” Put differently this means that in America there are “78 rapes each hour, 1,872 rapes each day, 56,160 rapes each month and 683,280 rapes each year.” Also according to SDCADV “50% of women in America will be battered in their lifetime; one out of three are battered repeatedly every year.”³³ The leading cause of pregnancy related deaths in America today is murder.³⁴

The violence so many women in South Dakota and across America experience on a daily basis is another good example of the meaning of “involuntary.” A Task Force to examine why men — who disproportionately though not exclusively — commit violence against women would reflect true valuing of mothers, pregnant women and their families and life itself.

The sad truth is that whether pro-or anti choice, the vast majority of women must make reproductive health decisions in a country that has sent a clear message: *We do not value the work that you do as mothers and caretakers.* America is one of only three industrialized nations in the world that does not require any paid maternity leave.³⁵ While holding this Task Force hearing about abortion, South Dakota has not to my knowledge explored the possibility of guaranteeing new mothers or fathers any paid parental leave. Similarly pregnant women of all political and cultural stripes are vulnerable to workplace discrimination. Between 10 and 20 million women, including those who work part-time or for small companies, are not protected from discrimination based on pregnancy.³⁶ Again, while this legislature has considered numerous bills over the years to restrict access to abortion,³⁷ no legislation to my knowledge has been introduced, much less passed, to prevent these forms of discrimination against pregnant women and mothers who must work in order to feed and house their children.

Pregnant women must also make reproductive decisions in a context in which they must worry about whether they will be able to provide for and protect the children they do have. Nearly one in five children are living in poverty.³⁸ In addition, America’s infant mortality rates continue to exceed many third world countries. According to the CIA’s World Factbook, the United States ranks 43rd in the world in infant mortality. If the United States could reach the level of Singapore, ranked first, we would save 18,900 children’s lives each year.³⁹

Rather than yet more restrictions on abortion, South Dakota’s legislature should consider how to help women to care for their families and ensure that pregnant women live in a country where they need not worry that their children will survive infancy or go without health care, food, shelter, a good education, and a safe and healthy environment.

The decision to have an abortion is still voluntary even if some women experience sadness or other feelings at some point after the procedure.

This committee must also distinguish between decisions that are voluntary and informed and the feelings people necessarily have about the decisions they have made in their lives. The fact that some women unquestionably experience severe post partum depression following child birth is something to be taken seriously, but it does not provide any basis for concluding that pregnancy and childbirth are involuntary, occurred without adequate information, or that it is now necessary — for their own protection — to require every woman seeking prenatal care to obtain a separate psychological evaluation. Similarly more than 900,000 women each year suffer miscarriages and stillbirths.⁴⁰ Many do so without meaningful support from any health care provider.⁴¹ Some experience serious psychological distress from this experience. These facts, however, again tell us nothing about whether or not the decision to become pregnant and to try and carry to term — in spite of the risks of miscarriage and stillbirth — was involuntary or uninformed.⁴²

Testimony by psychologist Vincent Rue before this Task Force claims that women who have abortions are at serious risk of experiencing what he has called “post abortion trauma,” a unique trauma associated with having had an abortion. Dr. Rue argued that this Task Force should adopt significant and costly new laws based on his personal theories. These theories, however, have been rejected by his peers — both in the field of psychology and among leaders opposed to abortion. Former United States Surgeon General, Dr. Koop, for example though personally opposed to abortion, has testified, “the psychological effects of abortion are miniscule from a public health perspective.”⁴³ Moreover the assertion that there are unique and significant psychological harms as a result of abortion has been rejected by numerous peer reviewed scientific studies addressing this question⁴⁴ and by leading medical groups including the American Psychiatric Association and the American Psychological Association.⁴⁵

Having said this, it is nevertheless crucial to the lives of all pregnant women and mothers that our families and communities acknowledge that women who have abortions, like those who suffer miscarriages, and those who continue to term, and those who give up their children for adoption,⁴⁶ may experience a wide range of emotional responses. However, to use those feelings to suggest that the very deliberate, conscientious, and sometimes difficult decision to have an abortion is somehow involuntary or misinformed is to express profound disregard and disrespect for the 25 million women who have made that decision.

Rather than deny women’s experiences or risk misusing them to justify a political agenda, this Task Force could support Exhale — a national non-judgmental abortion talk-line that offers women as well as friends and family members a place to talk about their feelings.⁴⁷ (1-866-4-EXHALE). Similarly, this Task Force could, if truly concerned with the lives and well-being of all pregnant women and mothers, endorse full parity for mental health services for everyone who needs them.

It is not possible to treat pregnant women and fetuses as competing legal entities in the context of abortion without undermining the health, wellbeing and safety of all pregnant women and new mothers.

This committee also asked me to consider “the degree to which such abortion constitutes an appropriate legal waiver or termination of the relationship between the woman and the unborn child.”

If pregnancy is a “legal” “relationship,” with opposing rights and the possibility of state oversight, the implications for the civil rights, health and well-being of pregnant women and their children is in serious question. Does a pregnant woman who cannot overcome her addiction to cigarettes violate this “legal” “relationship,” making her an appropriate subject for court ordered treatment, arrest for child endangerment, or child welfare interventions? Does a woman lose her right to informed medical decision when she becomes pregnant? Could the state mandate that all women deliver by c-section because of perceived benefits to the unborn child? Could the state outlaw vaginal births after c-sections?

Similarly, if pregnancy is viewed as a legal relationship between completely separate parties having separate, competing rights, shouldn’t every woman who has experienced a miscarriage or

stillbirth be questioned about the extent to which she may have contributed to that pregnancy loss and whether those actions or omissions constituted an appropriate legal waiver?

These questions do not represent far-fetched hypothetical possibilities.

For the last 30 years anti-abortion rhetoric has portrayed abortion as murder and the women who have those abortions as “baby killers” and “murderers.” Increasingly, *all* pregnant women are being viewed as proper subjects of the criminal law and court supervision. Pregnant women in more than 30 states including South Dakota⁴⁸ have been arrested based on the claim that a health problem, action or circumstance a woman experienced during pregnancy can be treated as child abuse if she continues to term, or murder if she suffers a miscarriage or stillbirth. Women in California,⁴⁹ Florida,⁵⁰ Utah,⁵¹ South Carolina,⁵² Tennessee,⁵³ Oklahoma,⁵⁴ and North Carolina⁵⁵ have been charged with manslaughter and even first-degree murder for having suffered *unintentional* stillbirths. Prosecutors in these cases have argued that something the women did or did not do during pregnancy caused these pregnancy losses. In some cases the pregnancy loss is blamed on an untreated drug problem, in another a severely depressed woman was arrested after an attempted suicide might have contributed to a pregnancy loss,⁵⁶ and in another it was the pregnant woman’s decision to delay having a c-section that transformed her into a murderer.⁵⁷ Such prosecutions continue despite the lack of authorizing legislation, court rulings rejecting such misuse of state law, and in spite of the overwhelming oppositions from medical, child welfare and public health organizations.⁵⁸

Today, many pregnant women and newly delivered birth mothers also face child welfare interventions based on the claim that something they did or did not do during pregnancy constitutes child abuse or neglect. Women for example who have tested positive for illegal drugs and even for drugs prescribed to them during labor, have had their children removed by child welfare authorities who viewed these women as somehow violating a contractual or legal relationship to their unborn children.⁵⁹ This is true in spite of the fact that not a single state, including South Dakota, has enough drug treatment available for all of the pregnant and parenting women who want and need it.⁶⁰

Finally, the earlier example of forced surgery over the objections of pregnant women, husbands and doctors has been the direct result of giving legitimacy to the idea of legal separation between pregnant women and the fetuses they carry.

This Task Force must recognize that to oppose the recognition of fetal personhood as a matter of law is *not* to deny the value and importance of potential life as matter of religious belief, emotional conviction, or personal experience. Rather, by rejecting such a new legal construct, the Task Force can improve both maternal and fetal health and ensure that no family ever has to endure the losses that Angela Carder’s family suffered at the hands of the state, in the name of fetal rights.

Creating Doubt, Leaving Too Many Pregnant Women and Mothers Out

By focusing exclusively on abortion, the committee implies that the provision of health care to women who continue to term is more than adequate and closes its eyes to the many serious

problems such women face in accessing fully voluntary and informed care. In fact, many women who are giving birth are not provided with essential information. For example, the World Health Organization considers acceptable levels for cesarean rates as not less than 5% and not more than 15% of all deliveries.⁶¹ Yet approximately 28% of all US births are by cesarean delivery, accounting for approximately one million cesareans.⁶² Some providers and hospitals have even higher rates. Nevertheless, South Dakota does not require health care providers to provide expectant parents with information about their c-section rates and related information, including rates of births using induction and births utilizing episiotomies.⁶³ Such information is necessary in order for families to make informed decisions about which providers they will use for their deliveries.

Many hospitals have also instituted policies banning vaginal birth after cesarean (VBAC), “misleading women to believe they must undergo cesarean surgery whether there is a medical need for it or not.”⁶⁴ Lack of attention to the ways in which pregnant women who continue to term are left uninformed or actually misled suggests a lack of concern for the majority of pregnant women in the state.⁶⁵

By focusing only on abortion, these hearings also create the illusion that all pregnant women who choose to deliver their babies are not only provided with full information but also treated with care and respect. Yet, instances of poor communications, failure to inform, and even abuse are apparently so common in the birthing context that one organization has created a guide for filing complaints. The form begins by asking:

What do we do when obstetricians or other hospital staff have treated us rudely, abusively or violently? Do they ever hear from us afterward? Abusive behavior toward women, especially in childbirth, is unacceptable and harmful (can cause Post Traumatic Stress Syndrome). Abusive or unacceptable behavior can include threats, scolding, coercion, yelling, belittling, lying, manipulating, mocking, dismissing, refusing to acknowledge, treating without informed consent, omission of information, over-riding your refusal of a treatment, misrepresentation (of medical situation, of interventions, of reasons they “need” you to do something or not do something), etc. For a raised consciousness on this topic, read: Violence against women in health-care institutions: an emerging problem. by A. F.P.L. d’Oliveira, S.G. Diniz and L. B. Schraiber *The Lancet*, Vol. 359. May 11, 2002.⁶⁶

Moreover, a growing number of pregnant women in America are now giving birth inside jails and prisons, some delivering while shackled to their beds, others left to give birth or miscarry in a prison bathroom.⁶⁷ A true commitment to all pregnant women and mothers would require investigation of all aspects of reproductive health care in all contexts, not just the care provided to women seeking to end their pregnancies.

Reproductive health care providers in general also often fail to provide women with essential information about the possibility of miscarriage and stillbirths. Even though miscarriages and stillbirths occur in as many as 15-20 percent of all pregnancies, ob/gyns and prenatal care providers rarely inform women of this risk or offer information that would help women prepare for and cope with this very common and very possible loss.⁶⁸ South Dakota does not mandate

such disclosure nor create mechanisms for training health care providers in how to convey this information or provide support through the process. The narrow focus of this Task Force again suggests a lack of concern for *all* pregnant women.

Earlier testimony also claimed that abortion providers fail to screen women for a history of sexual abuse and violence. Although it is unclear that any peer reviewed research finds any unique failure on the part of abortion providers in this regard, it is clear that raising this concern *only* on behalf of women seeking to end their pregnancies creates the disturbingly *false* impression that all other pregnant women and mothers are carefully screened and counseled. In fact numerous studies find that few physicians screen their patients for abuse.⁶⁹ A 1990 study published in the *Journal of the American Medical Association* found that only 10 percent of primary care physicians routinely screen for intimate partner abuse during patient visits.⁷⁰ Again, I need to ask if this Task Force in fact wishes to ignore the needs of the majority of pregnant women who continue their pregnancies to term each year and potentially make their situation worse by creating the impression that somehow their health care and informational needs are being fully met?

Earlier today, a witness also suggested that the voluntary nature of abortion services should be doubted because some women obtaining abortions do not meet the person who will perform the procedure until a few minutes beforehand. Even if true, there is no research to suggest that this phenomenon in any way jeopardizes women's health or in any way undermines the informed consent process. What this argument does do however, is create another false impression; that other medical patients are getting better care and more individual attention from their physicians than the group selected for scrutiny by this panel — pregnant women seeking to end their pregnancies.

The United States remains the only western industrialized country not to have a national system of health insurance.⁷¹ Forty-three million Americans, including eight and half million children, lack health care coverage.⁷² Forty-one percent of women of childbearing age, who have incomes below the federal poverty level, do not have private health insurance or Medicaid.⁷³ In South Dakota, 88,350 people are without health insurance, the equivalent of 12% of the state's population.⁷⁴ Forty-one % of South Dakota's Indian youth reported having no health insurance; 21 % report having received no routine health care in the past two years.⁷⁵

In fact as the March of Dimes recently noted: “An extensive literature documents that many uninsured Americans do not receive necessary or appropriate medical care.”⁷⁶ Moreover, low-income pregnant women receiving publicly funded care often “go to overcrowded hospitals staffed by interns and residents who are overworked and insufficiently trained.”⁷⁷ Again it is necessary to ask why, given the pressing problems so many American's face in obtaining adequate prenatal and delivery services as well as a full range of other health care, the focus of this Task Force is on one procedure — abortion— that has been proven time and again to be safe, effective, and voluntary?

Finally, Dr. Rue argued that all women seeking abortion services should be required to submit to some kind of psychological evaluation. It is ironic that in a country where millions of Americans who desperately need mental health services cannot get them, the State of South Dakota is

apparently considering requiring such services for a select group of women that do not by any evidence-based standard require such services. Indeed, South Dakota has chosen to provide only partial parity for insurance coverage of mental health services, leaving many South Dakotans who in fact need such services without coverage.⁷⁸

It is indeed ironic that this Task Force is focusing on an issue –abortion – that in fact has been extensively studied and shown time and again to be one of the most common and safest medical procedures in the United States today. The risk of abortion complications is minimal; less than 1% of all abortion patients experience a major complication.⁷⁹ The risk of death associated with childbirth is about 11 times as high as that associated with abortion.⁸⁰

Lacking scientific or medical evidence of its danger or harm, those opposed to abortion as a matter of religious or personal convictions must resort to the strategy of creating doubt. Posing questions such as “Are abortion decisions really voluntary?” and suggesting that not enough research has been done to demonstrate the safety and efficacy of abortion services is a strategy with fascinating parallels to the effort to undermine environmental protections. There, in the face of overwhelming evidence of human contribution to global warming, opponents of environmental protection and regulation create doubt about the extensive science establishing the relationship between human behavior and environmental hazards.

Suggesting that the 25 million women who have chosen to have abortions since 1973 somehow were acting under circumstances of coercion, force, or deception, serves the political purpose of creating doubt about the women who have made the abortion decision and about the safety, efficacy, and value of legal abortion itself. Perhaps even more disturbing is the extent to which such questions create doubt about pregnant women and mothers as moral agents and valued members of our society.

The questions that this Task Force is considering do not focus on pregnant women and mothers as life and caregivers — but rather only as people who “terminate” or abandon their “unborn children.” This focus distracts attention from the profound debt America owes to its pregnant women and mothers. American women — many of whom at some point in their lives have had or will have abortions — “do 80 percent of the child care and two-thirds of the housework.”⁸¹ They do this work without any form of formal compensation, without any guaranteed pensions, and without any form of insurance or healthcare should they need it. Economists suggest that if Americans had to pay for the volunteer and unpaid labor that America’s pregnant women and mothers do, we would go bankrupt.

We claim to be a culture of life — but that has little meaning when the primary way we value the women who give that life is to portray them as incompetent decision makers and limit their access to abortion services. If we truly love and respect our mothers we will address the range of health and economic issues that really do harm them and their children. Suggesting that they cannot make decisions or that they need to be supervised by courts or psychiatrists says yet again to America’s pregnant women and mothers: *We do not value you or the work you do.* South Dakota has the opportunity to send a different message: We take mothers and parenthood seriously, and our next hearings will be about how to ensure that you have the health insurance, economic security, and access to educational resources that you and your family need.

¹ The author wishes to acknowledge and thank Professor Jeanne Flavin, Sarah K. Schindler-Williams, Katy Quissel, and Wen-Hua Yang for their assistance in preparing this testimony.

² See, e.g., Howard Minkoff, MD & Lynn M. Paltrow, JD, *Melissa Rowland and the Rights of Pregnant Women*, 104 J. OBSTET. & GYNECOL., 1234 (2004); Wendy Chavkin, MD, MPH and Lynn M. Paltrow, JD, *Physician attitudes concerning legal coercion of pregnant alcohol and drug users*, Letter to the Editor, 188 AM. J. OBSTET. GYNECOL. 298 (2003); Lisa H. Harris, MD and Lynn Paltrow, JD, *The Status of Pregnant Women and Fetuses in US Criminal Law*, 289 MS- JAMA 1697 (2003); Mary Faith Marshall, Jerry Menikoff, and Lynn M. Paltrow, *Perinatal Substance Abuse and Human Subjects Research: Are Privacy Protections Adequate?*, 9 Mental Retardation and Developmental Disabilities Research Reviews 54-59 (2003).

³ Lynn Paltrow presenter to: North American Society of Psychosocial Obstetrics and Gynecology, Thirty First Annual Meeting, Lihue, HI, PAUL C. WEINBERG MEMORIAL LECTURE, *The Many Prices of Reproductive Capacity for Women*; American Psychiatric Association, ISSUE WORKSHOP, *Politics and Pregnancy: The Regina McKnight Case*, New York, New York, with Andrea G. Stolar, M.D. and David J. McDowell, Ph.D.; NYU School of Medicine, Masters Scholar Program and the Jonas Salk Society for Biomedical and Health Sciences, Women's Health Care Seminar, New York, New York, Speaker "Pregnancy and the Fourth and Fifth Amendment: Does Pregnancy Limit a Woman's Right to Privacy?"; University of Louisville, Institute for Bioethics, Health Policy and Law, Louisville Kentucky, "Pregnant Drug-Using Women: Issues of Concern to Bioethicists." Featured Speaker, New York University School of Medicine, Master Scholars Program Colloquium, Medical-Legal Intersections in Women's Health, New York, New York; Rand Corporation, Grant Hill Speakers Series on Science and Drug Policy, Santa Monica, California.

⁴ Advisory committee member, *Statewide Provider Advisory Committee*, for THE NEW YORK STATE DEPARTMENT OF HEALTH, NEW YORK CITY DEPARTMENT OF HEALTH AND OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, 2000-2002; Panel Member, *Domain II: Reducing the Stigma and Changing Attitudes, CSAT National Treatment Plan, Substance abuse and Mental Health Services Administration, 2000-2002*

⁵ Legislative Research Council, Dr. Marty Allison, Chair, Dr. Maria Bell, Vice Chair South Dakota Task Force to Study Abortion Agenda, Second Day.

⁶ John Leland, *Under Din of Abortion Debate, An Experience Shared Quietly*, N.Y. TIMES (Sept. 18, 2005 at A1) (citing a report of the Centers for Disease Control available <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5309a1.htm#tab12>).

⁷ R.K. Jones, J.E. Darroch & S.K. Henshaw, *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, 34(5) PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 226, 228-230 (2002) (reporting that 61% of women seeking abortions have already had 1 or more live births).

⁸ *In re A.C.*, 573 A.2d 1235, 1253 (D.C. 1990) (en banc) (vacating a court-ordered cesarean section that was listed as a contributing factor to the mother's death on her death certificate); see also, George Annas, *Foreclosing the Use of Force: A.C. Reversed*. THE HASTINGS CENTER REPORT 27, July 1, 1990.

⁹ *In re Madyun Fetus*, 114 Daily Wash. L. Rptr. 2233 col. 3 (D.C. Super. Ct., Oct. 27, 1986); Cynthia Gorney, *Whose Body Is It, Anyway*, THE WASHINGTON POST ("On July 26, at 3:32 a.m., Ayesha Madyun delivered a 61/2-pound baby boy who was born with excellent lungs and no sign of infection.").

¹⁰ *In re Fetus Brown*, 689 N.E.2d 397, 400 (Ill. App. Ct. 1997) (overturning a court-ordered blood transfusion of a pregnant woman). See also *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (holding that courts may not balance whatever rights a fetus may have against the rights of a competent woman, whose choice to refuse medical treatment as invasive as a cesarean section must be honored even if the choice may be harmful to the fetus).

¹¹ Both the American Medical Association and the Ethics Committee of the American College of Obstetricians and Gynecologists have taken express positions opposing court ordered interventions against pregnant women and against effort by hospitals and doctors to seek such orders. See American College of Obstetricians and Gynecologists Committee Opinion No. 55, Patient Choice: Maternal-Fetal Conflict (1987) ("Actions of coercion to obtain consent or force a course of action limit maternal freedom of choice, threaten the doctor/patient relationships, and violate the principles underlying the informed consent process."); Report of American Medical Association

Board of Trustees, Legal Interventions During Pregnancy, 264 JAMA 2663, 267 (1990) (“Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus.”)

¹² *WVHCS-Hospital, Inc. and Baby Doe, v. Jane Doe and John Doe*, Motion for Special Injunction Order and Appointment of Guardian at 3. (“Baby Doe, a full term viable fetus, has certain rights, including the right to have decisions made for it, independent of its parents, regarding its health and survival.”)

¹³ Lisa Collier Cool, BABYTALK MAGAZINE at 57 (May 2005); Terrie Morgan-Besecker, Judge’s and Hospital’s decision in the wrong, say legal experts, Wilkes-Barre Times Leader, Jan 16, 2004 www.timesleader.com/mid/timesleader/7722356.htm; David Weiss, Court delivers controversy, Mom rejects C-section; gives birth on own terms, Wilkes-Barre Times Leader (January 16, 2004) *WVHCS-Hospital, Inc. and Baby Doe, v. Jane Doe and John Doe*, Court of Common Pleas, Luzerne County, Pennsylvania, Civil Action-Equity Number 3-E 2004 Memorandum Opinion, Special Injunction Order and Appointment of Guardian (Jan 14, 2004) Motion For Special Injunction Order And Appointment of Guardian filed on behalf of WVHCS-Hospital (“The defendants Jan and John Doe are hereby temporarily restrained from refusing to consent to a C-section delivery of their unborn fetus . . .”)

¹⁴ *Id.* See also, *WVHCS-Hospital, Inc. and Baby Doe, v. Jane Doe and John Doe*, Motion for Special Injunction Order and Appointment of Guardian at 4. (Emphasis added).

¹⁵ *Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding a Virginia statute providing for sterilization of women, since “[t]hree generations of imbeciles are enough”); STEPHEN JAY GOULD, THE FLAMINGO’S SMILE 306-18 (1985) (revealing the truth about Carrie Buck and her daughter in a moving philosophical essay). *at* http://www.stephenjaygould.org/library/gould_eugenics.html (last visited Apr. 23, 2004); see also Eugenics Archive, *Image Archive on American Eugenics*, available at <http://www.eugenicsarchive.org> (last visited Apr. 23, 2004); DOROTHY ROBERTS, KILLING THE BLACK BODY 59-76 (1997); Michael Ollove, *The Lessons of Lynchburg*, BALT. SUN, May 6, 2001, at 7F (describing the rise of eugenic sterilization laws in the United States including interviews with some people who had been forcibly sterilized).

¹⁶ In 1976 the U.S. General Accounting Office revealed that the federally funded Indian Health Service had sterilized 3,000 Native American women in a four-year period using consent forms “not in compliance ... with regulations.” See also, WARD CHURCHILL, A LITTLE MATTER OF GENOCIDE: HOLOCAUST AND DENIAL IN THE AMERICAS 1492 TO THE PRESENT 249-50 (1997) (arguing as much as forty-two percent were sterilized); PAULA GUNN ALLEN, OFF THE RESERVATION: REFLECTIONS ON BOUNDARY-BUSTING, BORDER-CROSSING, LOOSE CANONS 38 (1998) (arguing more than twenty-five percent were sterilized).

¹⁷ Sterilization Abuse: A Task for the Women’s Movement by the Committee to End Sterilization Abuse (January-1977) (citing Laura Foner & Evelyn Machtinger, *Sterilization*, NEW AMERICAN MOVEMENT (June 1976). Angela Hooton reports that Black and Latina women have been required to undergo sterilization as a condition of their probation or receipt of welfare benefits. In one case, a 21 year-old defendant was indicted for being present in the same room as her boyfriend while he smoked marijuana but was allowed probation conditional on her acceptance of sterilization. *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL’Y & L. 59, 71 (2005).

¹⁸ *Relf v. Weinberger*, 372 F.Supp. 1196, 1199 (D.C.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977); Rosalind P. Petchesky, “Reproduction, Ethics, and Public Policy: The Federal Sterilization Regulations,” *Hastings Center Report*, October 1979.

¹⁹ DOROTHY ROBERTS, KILLING THE BLACK BODY (1997).

²⁰ John Leland, *Under Din of Abortion Debate, An Experience Shared Quietly*, N.Y. TIMES (Sept. 18, 2005 at A1). L.B. Finer & S.K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 2003; 35: 6-15

²¹ *Id.* citing NARAL ProChoice, <http://www.prochoiceamerica.org/yourstate/whodecides/index.cfm>

²² *Id.*; ARK. CODE ANN. § 20-16-602 (West 2003).

²³ Since 1977, there have been 80,000 acts of violence or disruption at clinics providing abortions. NATIONAL ABORTION FEDERATION, VIOLENCE AND DISRUPTION STATISTICS: INCIDENTS OF VIOLENCE AND DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. AND CANADA, (2005), available at http://www.prochoice.org/about_abortion/violence/2003.html

²⁴ Amicus Brief, *Richard Thornburg v. American College of Obstetricians and Gynecologists*, 9 WOMEN’S RTS. L. REP. 3 (1986).

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- ²⁵ See W. Hern, ABORTION PRACTICE 17020 (1984). See also M. Potts, P. Diggory, & J. Peel, Abortion 87-89 (1977).
- ²⁶ See J. Mohr, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, (1800-1900 at 20-45 (1978); K. Luker, ABORTION AND THE POLITICS OF MOTHERHOOD, 14 (1984).
- ²⁷ See e.g., E. & Mary K. Messer, BACK ROOM (1988); D. Schuler & F. Kennedy, ABORTION RAP (1971).
- ²⁸ Ward Cates, *Legal Abortion: The Public Health Record*, 215 SCIENCE 1586 (1982).
- ²⁹ To put this question in a broader perspective: 46 million women around the world have abortions each year. In some of these countries abortion is illegal. Women have abortions anyway. Worldwide, 78,000 women die annually from unsafe, *illegal* abortions Induced Abortion Worldwide. Alan Guttmacher Institute. http://www.agi-usa.org/pubs/fb_0599.html
- ³⁰ See e.g., Deb Berry, *Choose Lies*, ORLANDO WEEKLY (April 17, 2003) (describing misinformation, deception, and pressure exerted by state funded crisis pregnancy centers in Florida).
- ³¹ See Rickie Solinger, *Beggars and Choosers: How the Politics of Choice Shapes Adoption, Abortion, and Welfare in the United States* (2001).
- ³² See John Leland, *supra* at A28, describing one woman's experience: "She arrived at the [abortion] clinic with a cut on her nose and bruises on her forehead and lip, which she sustained after telling her boyfriend she was pregnant. "He flipped out because he wasn't ready," she said. She had thought, upon learning of the pregnancy, that she "was about to get married," she said. She came in with two fellow sergeants, who wore their uniforms. Her boyfriend was in jail, she said."
- ³³ <http://southdakotacoalition.org/statistics.html>
- ³⁴ Victoria Frye, 2001. Examining homicide's contribution to pregnancy-associated deaths. *JAMA* March 21. 285, 11, 1510-1511; Donna St. George, Many New or Expectant Mothers Die Violent Deaths, Washington Post (Dec 18, 2004).
- ³⁵ See, e.g., Kirstin Downey Grimsley, *Study: U.S. Mothers Face Stingy Maternity Benefits; U.N. Agency Finds Disparity With Other Nations*, WASH. POST, Feb. 16, 1998, at A10; Catherine Valenti, *Paid Leave for All? With California Taking the Lead, States Consider Paid Family Leave*, ABC NEWS, at http://www.abcnews.go.com/sections/business/US/paidleave_031009.html (last visited Apr. 25, 2004); Andrea Mahony, *Paid Maternity Leave Entitlements Around the World*, PROFESSIONAL UPDATE, at http://www.apesma.asn.au/newsviews/professional_update/2001/june/paid_maternity.htm (June 2001) ("In fact the United Nations Convention on the Elimination of all Forms of Discrimination Against Women states: "'Parties shall take all appropriate measures ... to introduce maternity leave with pay or with comparable social benefits without loss of former employment seniority or social allowances.'").
- ³⁶ Unfortunately, the Pregnancy Discrimination Act includes several sizable exemptions. See 42 USCS § 2000e -(k). It does not apply to employers of less than 15 people. It does not apply to women who work part time. Nor does it apply to new mothers or federal government employees or employees of private clubs and religious organizations. According to the National Bureau of Labor Statistic, there were approximately 10,558,000 women of childbearing age (16-44) who worked part time in 2002. 7,150 women worked at a firm that employed less than 10 people; another 4368,000 women worked at firms that employed 10-24 people. Excluding the military, 728,000 women worked for the government and 2,148,000 worked for private clubs or religious organizations. The number of women of childbearing age who are not protected by the Pregnancy Discrimination Act is somewhere between 10 and 23 million. To put this in perspective, the total number of women of child bearing age in the labor force as of December 2002 was approximately 50,587,000 million. (www.bls.gov). This means that between 20 and 40 percent of working women are not covered by the Pregnancy Discrimination Act.
- ³⁷ See e.g., S.D. Codified Laws § 28-6-4.5 (2005) (preventing use of state funds for abortions unless life of the mother is at stake); §§ 34-23A-1-45 (current through 2005) (delineating 59 different regulations and definitions related to abortion); cf. §§ 34-23B-1 - 5 (2005) (setting out 5 provisions for pre-natal education).
- ³⁸ Catholic Campaign for Human Development, *Poverty USA: The Faces of American Poverty*, at <http://www.usccb.org/cchd/povertyusa/povfact2.htm>. (Dec. 5, 2003) (stating that "the total number of children in poverty increased to 12.1 million in 2002, up from 11.7 million in 2001." (U.S. Census Bureau, *Poverty in the United States: 2002*, Current Population Reports, Sept. 2003.)).
- ³⁹ Nicholas Kristoff, *Katrina, The Aftermath, Nation Lets Down Its Most Vulnerable*, THE ATLANTA JOURNAL CONSTITUTION (Sept 7, 2005); See also Erin McCormick & Reynolds Holding, *Too Young to Die: Part I: Life's Toll*, San Francisco Chronicle at A-16 (Oct. 3, 2004) available at <http://www.sfgate.com/cgi->

bin/article.cgi?f=/c/a/2004/10/03/MNINFANTMO.DTL (citing researchers' concerns that the abnormally high infant mortality rate, even when adjusted for increased likelihood based on race and economic status, was due to a confluence of factors including endemic unemployment and nearby industrial pollution).

⁴⁰ Vital and Health Statistics, Trends in Pregnancy and Pregnancy Rates by Outcome. CDC. January 2000.

Stephanie J. Ventura et al, Trends in Pregnancy Rates for the United States, 1976-97: An Update." NATIONAL VITAL REPORTS 49(4) (2001).

⁴¹ LINDA LAYNE, MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA (2003)

⁴² The most frequently cited figures for miscarriages and stillbirths are 15-20 percent of all pregnancies with a much higher ratio of one includes pregnancy that end during the first two weeks after conception. MOTHERHOOD LOST at 3.

⁴³ Chris Mooney, *Research and destroy: how the religious right promotes its own "experts" to combat mainstream science*, Sidebar, *Bucking the Gipper*, WASHINGTON MONTHLY, (Oct. 2004).

⁴⁴ N. Stotland, *The myth of the abortion trauma syndrome*, 268 JAMA, 2078-2079 (1992).

⁴⁵ In 1989, the American Psychological Association (APA) convened a panel of psychologists with extensive experience in this field to review the data. They reported that the studies with the most scientifically rigorous research designs consistently found no trace of "post-abortion syndrome" and furthermore, that no such syndrome is scientifically or medically recognized. American Psychological Association. "APA research review finds no evidence of 'post-abortion syndrome' but research studies on psychological effects of abortion inconclusive." Press Release, January 18, 1989.

⁴⁶ See, e.g., HEATHER CARLINI, BIRTH MOTHER TRAUMA (1992); ADOPTEE TRAUMA (1997).

⁴⁷ 1-866-4-EXHALE, www.4exhale.org.

⁴⁸ *State v. Christensen*, Minnehaha County, No. CR 90-377 (S.D. Cir. Ct. Mar. 12, 1990).

⁴⁹ *Jaurigue v. Justice Court*, No. 18988, Excerpts of Transcript (Super. Ct. San Benito Cty, Cal. Aug. 21, 1992 (dismissing fetal homicide when a stillbirth occurred), writ denied, (Cal. App. 1992); *People v. Jones*, No. 93-5 Transcript of Proceedings (J. Ct. Siskiyou Cty, Cal. July 28, 1993 (dismissing fetal homicide charges brought against Lynda Jones, a 36 year old woman with no prior criminal record other than minor traffic violations, after she gave birth prematurely and the infant died).

⁵⁰ Peter Franceschina, *Teen Whose Baby Died Gets Prison, Treatment*, SUN SENTINEL (Ft. Lauderdale), Jan. 4, 2002, at 1B; Susan Spencer-Wendel, *Mom Who Did Drugs Before Giving Birth Gets Deal*, PALM BEACH POST (Florida), Jan. 4, 2002, at 1B.

⁵¹ Richard L. Berkowitz, M.D., *Should Refusal to Undergo A Cesarean Section Be A Criminal Offense?* 140 AM. J. OBSTET. & GYNECOL. 1220 (2004).

⁵² See *State v. McKnight*, 352 S.C. 635; 576 S.E.2d 168 (2003).

⁵³ *State v. Ferguson*, 2004, Don Jacobs, *Baby's mother sought; Woman faces murder charge after son stillborn from her alleged cocaine use*, KNOXVILLE NEWS-SENTINEL, June 10, 2004, at B1; Bryan Mitchell, *Baby to be laid to rest; mom arrested*, KNOXVILLE NEWS-SENTINEL, June 12, 2004, at B2.

⁵⁴ *State Briefs*, THE DAILY OKLAHOMAN (Oct. 6, 2004) at 4A ("Oklahoma City police are investigating the death of a stillborn girl as a homicide - marking the second time in less than a month that a mother could be charged with murder. . .").

⁵⁵ *State v. Bedgood*, Wilson County, Case no. 05CR53615 (2005)

⁵⁶ *State v. Stephens*, Horry County, No. 01-GS-26-2964 (Oct. 17, 2001); Arrest Warrant No. F-872732 (Feb. 18, 1999).

⁵⁷ Richard L. Berkowitz, M.D., *supra* n.51.

⁵⁸ "The March of Dimes believes that targeting substance-abusing pregnant women for criminal prosecution is inappropriate and will drive women away from treatment." MARCH OF DIMES, STATEMENT ON MATERNAL DRUG ABUSE (1990); "Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians' knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment." American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2667 (1990); "The American Academy of Pediatrics is concerned that [arresting drug addicted women who become pregnant] may discourage mothers and their infants from receiving the very medical care and social support systems that are crucial to their treatment." American Academy of Pediatrics, Committee on Substance Abuse, *Drug Exposed Infants*, 86 PEDIATRICS 639, 641 (1990); The American Public Health Association's Policy recognizes that: . . . that pregnant drug-dependent women have been the object of criminal

prosecution in several states, and that women who might want medical care for themselves and their babies may not feel free to seek treatment because of fear of criminal prosecution related to illicit drug use . . . [the Association] recommends that no punitive measures be taken against pregnant women who are users of illicit drugs when no other illegal acts, including drug-related offenses, have been committed. Am. Pub. Health Ass'n, *Public Policy Statement No. 9020, Illicit Drug Use by Pregnant Women*, 8 AM. J. PUB. HEALTH 240 (1990); "[The American Nurses Association] recognizes alcohol and other drug problems as treatable illnesses. The threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment for their alcohol and other drug problems." AMERICAN NURSES ASSOCIATION, POSITION STATEMENT ON OPPOSITION TO CRIMINAL PROSECUTION OF WOMEN FOR USE OF DRUGS WHILE PREGNANT AND SUPPORT FOR TREATMENT SERVICES FOR ALCOHOL AND DRUG DEPENDENT WOMEN OF CHILDBEARING AGE (1991); "Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing, harm to children and to society as a whole." American Society of Addiction Medicine, PUBLIC Policy Statement on Chemically Dependent Women and Pregnancy 47 (1989).

⁵⁹ See e.g., Associated Press, *Woman Given Labor Sedative Loses Custody of Children*, THE SACRAMENTO BEE, Feb. 11, 2000 (describing a California woman who lost custody of her newborn and other children for three months based on a drug test of the newborn that reflected a sedative given to the woman during labor); Jan Hoffman, *Challenge Drug Tests*, THE VILLAGE VOICE, July 10, 1990, at 11; Class Action Complaint, Ana R. v. New York City Dep't of Social Services (S.D.N.Y. filed on June 7, 1990) (describing numerous cases of children removed without notice based on false positives or positive test results for drugs administered by physicians during labor). See also Cathy Singer, *The Pretty Good Mother*, LONG ISLAND MONTHLY, Jan. 1990, at 46 (reporting that a mother who had smoked marijuana to ease labor pain lost custody of her baby even though all involved agreed that the mother had acted responsibly throughout her entire pregnancy and would make a good parent).

⁶⁰ Despite the proven efficacy of treatment programs, and notable attempts to improve access to treatment, the lack of adequate treatment for women is a significant and ongoing problem that has been well documented by a variety of measures. See, e.g., Wendy Chavkin, *Mandatory Treatment for Drug Use During Pregnancy*, 266 JAMA 1556 (1991); Julie Petrow, *Addicted Mothers, Drug Exposed Babies: The Unprecedented Prosecution of Mothers Under Drug-Trafficking Statutes*, 36 N.Y.L. Sch. L. Rev. 573, 604-06 (1991) (arguing for an increase in federal and state funding for drug treatment programs for women); Molly McNulty, Note, *Pregnancy Police: The Health Policy and Legal Implications of Punishing Pregnant Women for Harm to Their Fetuses*, 16 N.Y.U. Rev. L. & Soc. Change 277, 292-303 (1987) (discussing the lack of access to adequate health care); Wendy Chavkin et al., *National Survey of the States: Policies and Practices Regarding Drug-Using Pregnant Women*, 88 Am. J. Pub. Health 117 (1998); Legal Action Center, *Steps to Success 3* (May 1999); Drug Strategies, *Keeping Score, Women And Drugs: Looking at the Federal Drug Control budget 16-17* (1998); Vicki Breitbart et al., *The Accessibility of Drug Treatment for Pregnant Women: A Survey of Programs in Five Cities*, 84 Am. J. Pub. Health 1658 (1994); see also Elaine W. v. Joint Diseases N. Gen. Hosp., Inc., 613 N.E.2d 523, 524 (N.Y. 1993) (discussing a New York hospital's refusal to admit pregnant women into its drug detoxification program). In fact, numerous state commissions have found that their states have inadequate services. See, e.g., 2 State Council on Maternal, Infant & Child Health, 1991 South Carolina Study of Drug Use Among Women Giving Birth: Prevention and Treatment Services 2, 10 (1992) (reporting that "specific resources designed to meet the needs of women of childbearing age, especially pregnant women, are not widely available" and that lack of child care and transportation are seemingly insurmountable obstacles to treatment for many women); Substance Abuse & Pregnancy Work Group, *A Report to The Secretary of the Kentucky Cabinet for Human Resources And the Legislative Research Commission 17* (1994) (noting the lack of treatment services "especially those that provide specific services for pregnant women").

⁶¹ *Guidelines for Monitoring the Availability and Use of Obstetric Services*, 2nd ed. United Nations Children's Fund: UNICEF, WHO, UNFPA, 1997, pp. 25 and 35.

⁶² *Vaginal birth After C-Section (VBAC)*, Women's Health Channel at <http://www.womeshealthchannel.com/vbac/index.shtml>, Sept 23, 2004; *The Risks of Cesarean Delivery to Mother and Baby*, A CIMS Fact Sheet. Coalition for Improving Maternity Services, at www.motherfriendly.org, June 3, 2005.

⁶³ The Maternity Information Act, NY Pub Health § 2803-j (1989); Public Advocate for the City of New York, *A Mother's Right to Know: New York City Hospitals Fail to Provide Legally Mandated Maternity Information* (July 2005).

⁶⁴ International Cesarean Awareness Network, Inc, *Your Right to Refuse, What to Do if Your Hospital Has “Banned” VBAC*. Available at: http://www.ican-online.org/resources/white_papers/wp_vbacbanqa.pdf (visited Sept 2005)

⁶⁵ Furthermore, the degradation of care for pregnant women also reflects racist attitudes in American society and healthcare. See Larry J. Pittman, *A Thirteenth Amendment Challenge to both Racial Disparities in Medical Treatments and Improper Physicians’ Informed Consent Disclosures*, 48 ST. LOUIS U. L.J. 131, 144 (2003) (noting that African-American females receive fewer amniocentesis, fewer ultrasonography, and less tocolysis for treatment of plural births than white women despite having plural births more frequently than white women) (citing Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Brian D. Smedley et al., eds., 2003)).

⁶⁶ Susan Hodges, *Unhappy with Your Maternity Care?* (2003) available at: <http://www.cfmidwifery.org/Resources/Item.aspx?ID=1>

⁶⁷ Rachel Roth, *Searching for the State: Who Governs Prisoner’s Reproductive Rights?* 3 SOCIAL POLITICS 411, 418, 428-29 (Fall 2004); UNITED STATES OF AMERICA RIGHTS FOR ALL, AMNESTY INTERNATIONAL’S CAMPAIGN ON THE UNITED STATES, AI INDEX NO. AMR 51/01/99, “NOT PART OF MY SENTENCE,” VIOLATIONS OF THE HUMAN RIGHTS OF WOMEN IN CUSTODY 23 (Mar. 1999). The imprisonment of pregnant women and new mothers is a violation of international standards, and the Eighth United Nations Congress has recommended that “[t]he use of imprisonment for certain categories of offenders, such as pregnant women or mothers with infants or small children, should be restricted and a special effort made to avoid the extended use of imprisonment as a sanction for these categories.” *Id.* (quoting *Report of the 8th UN Conference on the Prevention of Crime and Treatment of Offenders*, U.N. Doc. A/Conf. 144/28, rev. 1 (91.IV.2), Res. 1(a), 5(b) (1990))

⁶⁸ Health care providers often do not inform women of the possibility of loss or give women information about medical options until the crisis is upon them. Linda Layne, Chapter Author, *Childbearing Loss*, OUR BODIES OURSELVES, Chapter 24 495-505 (2005).

⁶⁹ Family Violence Prevention Fund, *The Facts on Health Care and Domestic Violence*, citing, Parsons, L., et. al. *Violence Against Women and Reproductive health: Toward Defining a Role for Reproductive Health Care Services*, 4 MATERNAL AND CHILD HEALTH JOURNAL 135 (2000); Rodriguez, M. Bauer, H., McLoughlin, E., Grumbach, K 1999, *Screening and Intervention for Intimate Partner Abuse: Practices and Attitude of Primary Care Physicians*, THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 282(5).

⁷⁰ *Id.*

⁷¹ Ruth A. Sidel, *Needed: A National Commitment to Families*, UNCOMMON SENSE, available at <http://www.njfac.org/us17.htm> (Feb. 1997).

⁷² See <http://www.americansforhealthcare.org/facts/groups/glance.cfm> (last visited Apr. 23, 2004) (“There are nearly 44 million Americans living without health coverage -- including 8.5 million children. In 2002, the number of people without health coverage increased by more than 2 million, the largest one-year increase in a decade.”); Press Release, Center on Budget and Priorities, Number of Americans Without Health Insurance Rose in 2002 (Oct. 8, 2003), at <http://www.cbpp.org/9-30-03health.htm> (last visited Apr. 23, 2003); Special Report, Families USA, *Working Without a Net: The Health Care Safety Net Still Leaves Million of Low Income Workers Uninsured* (Apr. 2004), at http://www.familiesusa.org/site/DocServer/Holes_2004_update.pdf?docID=3304.

⁷³ The Alan Guttmacher Institute, *Medicaid: A Critical Source of Support for Family Planning in the United States*, (April 2005), available at <http://www.guttmacher.org/pubs/medicaid-IB-Gold.pdf>.

⁷⁴ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys. www.Statehealthfacts.org.

⁷⁵ Indigenous Women’s Health Book, *Within the Sacred Circle*, Native American Women’s Health Resource Center Presentation

⁷⁶ Amy S. Bernstein, *March of Dimes, Insurance Status and Use of Health Services by Pregnant Women* (1999) http://www.marchofdimes.com/files/bernstein_paper.pdf.

⁷⁷ Marsden Wagner, *Real revealing the risks: obstetrical interventions and maternal mortality*, PREGNANCY, BIRTH & MIDWIFERY MAGAZINE (May-June 2003).

⁷⁸ The Clearinghouse, *Parity* (“There are two types of parity legislation, comprehensive parity and partial (or limited) parity. Comprehensive parity simply means that health insurance companies must

provide the same degrees and types of coverage for any mental illness and substance abuse treatment that they provide for physical conditions. Partial parity (which many advocates argue is *not* parity) limits equal coverage to certain types of psychiatric diagnoses (e.g., depression, bipolar disorder, and schizophrenia.”) <http://www.mhselfhelp.org/resources/parity.pdf> (Visited Oct. 1, 2005).

⁷⁹ Alan Guttmacher Institute, Facts in Brief, Induced Abortion in the United States (May 18, 2005)

http://www.guttmacher.org/pubs/fb_induced_abortion.html#23.

⁸⁰ L.A. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, 2004, OBSTET. & GYNECOL., 103(4):729-737.

⁸¹ JOAN WILLIAMS, UNBENDING GENDER, WHY FAMILY AND WORK CONFLICT AND WHAT TO DO ABOUT IT (2000) at 2.