

2013 SENATE JUDICIARY

SB 2305

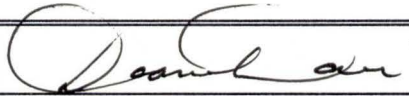
2013 SENATE STANDING COMMITTEE MINUTES

Senate Judiciary Committee
Fort Lincoln Room, State Capitol

SB2305
1/29/2013
Job #17921

Conference Committee

Committee Clerk Signature



Minutes:

Attached written testimony

Relating to limitations on physicians and abortion facilities

Senator David Hogue - Chairman

Senator Berry - District 27 - South Fargo - See written testimony (1)

Senator Hogue - Asks about hospital privileges that address physicians who perform abortions.

Senator Berry - Responds that the hospital privilege process, that it is up to that hospital to regulate who is working within that hospital and what they are able to do. He further explains the burden is on the physician to prove they have ability to do and perform the services that you are asking to perform.

Senator Hogue - States he assumes that abortion is performed in a clinical setting and would be admitted to a hospital in the event had complications.

Senator Berry - Explains abortions in ND performed after 12 weeks gestation must be performed in a hospital.

Senator Armstrong - Asks what happens right now at 14 weeks

Senator Berry - Replies it has to be performed in a hospital setting

Steve Cates - See written testimony - (2)

Yanna Myrdahl - State Director for Concerned Women of America - In support of this pro-woman bill

Tom Freier - ND Family Alliance - See written testimony (3)

Christopher Doddson - ND Catholic Conference - In support

Opposition

Tammi Kromenaker - Director of Red River Women's Clinic - See written testimony (4)
Also submits testimony from Siri Fiebiger (4). She takes questions from the Senators.

Senator Nelson - Asks her about the clinic's board of directors and who they are associated with.

Kromenaker - Says they are independent and not associated with anyone else.

The committee questions her on changes that could amend the bill.

Neutral

Steve Cates - Clarifies the concern of ND citizens. He said if the clinic were moved east 1600 feet then it would not be compelled by ND law.

Close the hearing on SB2305

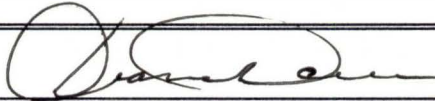
2013 SENATE STANDING COMMITTEE MINUTES

Senate Judiciary Committee
Fort Lincoln Room, State Capitol

SB2305
2/5/2013
Job #18327

Conference Committee

Committee Clerk Signature



Minutes:

Vote

Senator David Hogue - Chairman

Committee work

Senator Grabinger moves the amendment 13.0796.01001
Senator Nelson seconded

Discussion

Senator Grabinger proposes an amendment and thinks this amendment will still address Senator Berry's concern. He reads through the bill as it would read amended. Senator Berry said the essence of the bill is for the protection of women's health. He said this amendment does not allow for board certified. He said the issue is that you are qualified to perform the procedure that you are asking to perform. Senator Grabinger thinks it is pretty clear who is able to perform these procedures. Senator Berry said this bill is not about any specific clinic standing now or in the future, it is about good public policy for the performance of abortion procedures in ND. Senator Nelson argues that point and is concerned it is a move to close down the current clinic. The committee continues discussion on the amendment language. Senator Hogue explains hospital privileges. He says a hospital or any provider has the right to control the services they offer. The committee discusses what other states have enacted.

Vote on amendment 13.0796.01001
5 no, 2 yes
Motion fails

Senator Berry moves amendment 130796.01002
Senator Sitte seconded

Discussion

Senator Berry explains his amendment and says it is very reasonable to expect that the individual that provides the care be known to be competent at providing that care. He reads the bill as how it would read with the amendment. Senator Grabinger relates he is still concerned with the doctor's at the abortion clinic being able to get privileges. Senator Berry said this bill is not aimed at any clinic doing business now.

Vote on amendment
4 yes, 3 no
Motion passes

Senator Sitte motions on a do pass as amended
Senator Berry seconded
Vote 4 yes, 3 no

Senator Berry will carry

FISCAL NOTE
Requested by Legislative Council
02/04/2013

Bill/Resolution No.: SB 2305

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	\$0	\$0	\$0	\$0	\$0	\$0
Expenditures	\$0	\$0	\$300,000	\$0	\$0	\$0
Appropriations	\$0	\$0	\$300,000	\$0	\$0	\$0

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	\$0	\$0	\$0
Cities	\$0	\$0	\$0
School Districts	\$0	\$0	\$0
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill requires all physicians associated with an abortion facility to have local hospital admitting privileges and that they must be board certified in obstetrics or gynecology.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill requires all physicians associated with an abortion facility to have local hospital admitting privileges and that they must be board certified in obstetrics or gynecology. If none of the abortion clinics meet this standard abortions cannot be performed in that facility.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Not applicable

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

This bill would require an estimated \$300,000 general fund appropriation to defend if challenged. If the challenging party prevails, the state would need to reimburse the party for attorney's fees and other costs. In addition, the Office of Attorney General estimates there would be legal defense work completed by this office and would likely result in additional costs for depositions, travel, expert witness fees, etc.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Office of Attorney General anticipates a \$300,000 general fund appropriation would be needed to defend this bill if challenged.

Name: Kathy Roll

Agency: Office of Attorney General

Telephone: 701-328-3622

Date Prepared: 02/05/2013

FISCAL NOTE
Requested by Legislative Council
02/06/2013

Amendment to: SB 2305

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	\$0	\$0	\$0	\$0	\$0	\$0
Expenditures	\$0	\$0	\$0	\$0	\$0	\$0
Appropriations	\$0	\$0	\$0	\$0	\$0	\$0

- 1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	\$0	\$0	\$0
Cities	\$0	\$0	\$0
School Districts	\$0	\$0	\$0
Townships	\$0	\$0	\$0

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amendments to the bill appear to have removed the fiscal impact previously reported.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The amendments to the bill appear to have removed the fiscal impact previously reported.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Not applicable

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Not applicable

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Not applicable

Name: Kathy Roll

Agency: Office of Attorney General

Telephone: 701-328-3622

Date Prepared: 02/07/2013

February 4, 2013

FB
2-5-13

PROPOSED AMENDMENTS TO SENATE BILL NO. 2305

Page 1, line 8, replace "associated with an abortion facility" with "performing abortion procedures"

Page 1, line 8, remove "local"

Page 1, line 9, after "hospital" insert "located within thirty miles [42.28 kilometers] of the abortion facility"

Page 1, line 9, remove "local"

Page 1, line 9, after the first "physicians" insert "at that hospital"

Page 1, line 9, remove "All physicians"

Page 1, remove line 10

Page 1, line 11, replace "gynecology" with "These privileges must include the abortion procedures the physician will be performing at abortion facilities"

Page 1, line 12, after "open" insert "and abortions are scheduled to be performed"

Renumber accordingly

Date: 2-5-13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2305

Senate JUDICIARY Committee

Check here for Conference Committee

Legislative Council Amendment Number 13.0796.01001

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By J Grabinger Seconded By J Nelson

Senators	Yes	No	Senator	Yes	No
Chairman David Hogue		X	Senator Carolyn Nelson	X	
Vice Chairman Margaret Sitte		X	Senator John Grabinger	X	
Senator Stanley Lyson		X			
Senator Spencer Berry		X			
Senator Kelly Armstrong		X			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:
amend. fails

Date: 2-5-13
 Roll Call Vote #: 2

**2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2305**

Senate JUDICIARY Committee

Check here for Conference Committee

Legislative Council Amendment Number 13.0796.01002

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By S. Berry Seconded By 3 Sitte

Senators	Yes	No	Senator	Yes	No
Chairman David Hogue	X		Senator Carolyn Nelson		X
Vice Chairman Margaret Sitte	X		Senator John Grabinger		X
Senator Stanley Lyson		X			
Senator Spencer Berry	X				
Senator Kelly Armstrong	X				

Total (Yes) 4 No 3

Absent pass

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-5-13
 Roll Call Vote #: 3

**2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 2305**

Senate JUDICIARY Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By S Sitte Seconded By S Berry

Senators	Yes	No	Senator	Yes	No
Chairman David Hogue	X		Senator Carolyn Nelson		X
Vice Chairman Margaret Sitte	X		Senator John Grabinger		X
Senator Stanley Lyson		X			
Senator Spencer Berry	X				
Senator Kelly Armstrong	X				

Total (Yes) 4 No 3

Absent _____

Floor Assignment S Berry

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2305: Judiciary Committee (Sen. Hogue, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (4 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). SB 2305 was placed on the Sixth order on the calendar.

Page 1, line 8, replace "associated with an abortion facility" with "performing abortion procedures"

Page 1, line 8, remove "local"

Page 1, line 9, after "hospital" insert "located within thirty miles [42.28 kilometers] of the abortion facility"

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Page 1, line 9, after the first "physicians" insert "at that hospital"

Page 1, line 9, remove "All physicians"

Page 1, remove line 10

Page 1, line 11, replace "gynecology" with "These privileges must include the abortion procedures the physician will be performing at abortion facilities"

Page 1, line 12, after "open" insert "and abortions are scheduled to be performed"

Re-number accordingly

2013 HOUSE HUMAN SERVICES

SB 2305

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee Fort Union Room, State Capitol

SB 2305
March 13, 2013
Job 19846

Conference Committee

Kristie Helgler

Explanation or reason for introduction of bill/resolution:

Relating to limitations on physicians and abortion facilities.

Minutes:

Testimony 1,2,3,4,5,6,7,8

Chairman Weisz: Opened the hearing on SB 2305.

Sen. Spencer Berry, MD: Introduced and supported the bill. (See Testimony #1)

Rep. Mooney: 8:55 Why is there a fiscal note for \$1 million for an anticipated law suit? It's not a fiscal note, section 2 appropriations, or did that get removed?

Sen. Berry: That was removed.

Rep. Mooney: What happens when a woman comes into the ER? If an abortion has to be performed, how does that work if it's an emergency?

Sen. Berry: Only certain procedures are ok with certain privileged physicians.

Rep. Mooney: Do emergency room doctors have these privileges?

Sen. Berry: This is going to be case by case, as far as the emergency room, that staff is qualified to call in the correct physician.

Rep. Mooney: In reference to the twelve weeks, the ones that were performed were they hospital situations that we are looking at?

Sen. Berry: No, they are performed in the outpatient clinic. This bill is all about setting good policy now and going forward.

Rep. Mooney: Do we know how many post 12 week complications we have had in ND in the last decade.

Sen. Berry: Currently there are two forms are required to be filled out. Portions of the forms are not being filled out such as the medication abortions so that information is given to the state so we have no way of knowing that. 16:45

Rep. Mooney: Are any or all of these being litigated?

Sen. Berry: Currently AZ and MN, but the other 9, no.

Rep. Mooney: Lines 11 and 12 of the bill that refers to staff members being trained cardio pulmonary resuscitation be present at all time, aren't all facilities required to have that?

Sen. Berry: Not necessarily. This just means that during active medical care is being rendered.

Rep. Oversen: The percentage of complications that occur during abortion procedures, can we have some references on that?

Sen. Berry: Yes, I can get that for you, they come from several different references and within the different trimesters.

Rep. Oversen: What is the typical complication with pregnancies in general?

Sen. Berry: Absolutely. Medical care in any situation such as pregnancies can have complications but that is not the focus of this bill. The focus of this bill is very narrow; it has to do with abortion service providers in the state and making sure good public policy. 21:00

Rep. Oversen: What about mid wives would they have admitting privileges for any complications?

Sen. Berry: I refer back to the bill. This is about performing abortions.

Anna Higgins: 22:24 Director of the Center for Human Dignity at the Family Research Council testified in support of the bill. (See Testimony #2)

Rep. Mooney: 28:19 How does this bill mitigate the psychological damages?

Higgins: Psychological and physical complications, by putting that in here it is stating that abortion is harmful women in both forms, there are studies that prove that.

Christopher Dobson: 31:20 Executive Director of ND Catholic Conference testified in support of the bill. (See Testimony #3)

Paul Maloney: 34:00 Director of ND Right to Life testified in support of the bill.

Beth Brown: 35:30 Read testimony of Janne Myrdal, State Director of Concerned Women for America of ND. (See Testimony #4)

Tom Frier: 37:30 Director of Family Alliance of ND stated they are in support of SB 2305.

Steve Chase: 38:15 Testifying on his own behalf supports the bill. (See Testimony #5)

Shantel Schmitt: 44:15 Testified in support of the bill. (See Testimony #6)

Maria Wanchic: 48:40 Testified in support of the bill. (See Testimony #7)

Rep. Oversen: 57:47 Some of your testimony goes back to the 1800's are you familiar with what is more common today?

Wanchic: Yes, dictionaries refer to human life in the same way, then and now.

Helen Steckler: 1:00 Testified in support of the bill. (See Testimony #8)

Chairman Weisz: Closed hearing.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2305
March 18, 2013
Job #20073

Conference Committee

Committee Clerk Signature

Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to limitations on physicians and abortion facilities.

Minutes:

Chairman Weisz: Let's look at SB 2303.

Rep. Porter: I move a Do Pass.

Rep. Kiefert: Second.

Rep. Oversen: I'm voting against this bill. Abortion is not an unsafe procedure causing deaths. Talking to the clinic they only transported one individual to the hospital from their clinic over a 10 year period. This creates complications for the clinic in Fargo to have physicians willing to practice within their facility.

ROLL CALL VOTE: 11 y 2 n 0 absent

Bill Carrier: Rep. Laning

FISCAL NOTE
Requested by Legislative Council
02/06/2013

Amendment to: SB 2305

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

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Appropriations	\$0	\$0	\$0	\$0	\$0	\$0

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- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

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3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

- A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Not applicable

- B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Not applicable

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Not applicable

Name: Kathy Roll

Agency: Office of Attorney General

Telephone: 701-328-3622

Date Prepared: 02/07/2013

FISCAL NOTE
Requested by Legislative Council
02/04/2013

Bill/Resolution No.: SB 2305

- 1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

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Revenues	\$0	\$0	\$0	\$0	\$0	\$0
Expenditures	\$0	\$0	\$300,000	\$0	\$0	\$0
Appropriations	\$0	\$0	\$300,000	\$0	\$0	\$0

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- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill requires all physicians associated with an abortion facility to have local hospital admitting privileges and that they must be board certified in obstetrics or gynecology.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill requires all physicians associated with an abortion facility to have local hospital admitting privileges and that they must be board certified in obstetrics or gynecology. If none of the abortion clinics meet this standard abortions cannot be performed in that facility.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

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The Office of Attorney General anticipates a \$300,000 general fund appropriation would be needed to defend this bill if challenged.

Name: Kathy Roll

Agency: Office of Attorney General

Telephone: 701-328-3622

Date Prepared: 02/05/2013

Date: 3-19-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2305

House Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Rep. Porter Seconded By Rep. Kiefert

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY		✓
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA	✓	
REP. ANDERSON	✓		REP. OVERSEN		✓
REP. DAMSCHEN	✓				
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL	✓				

Total (Yes) 11 No 2

Absent _____

Floor Assignment Rep. Laning

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2305, as engrossed: Human Services Committee (Rep. Weisz, Chairman)
recommends **DO PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING).
Engrossed SB 2305 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

SB 2305

TESTIMONY ON SENATE BILL 2305
SENATE STANDING JUDICIARY COMMITTEE

1/29/2013

SENATOR SPENCER BERRY

Chairman Hogue and members of the Senate Judiciary Committee, SB 2305 is legislation with a narrow focus; to protect the health and safety of women receiving abortions. Chapter 14-02.1 of the NDCC is the North Dakota Abortion Control Act. One of the expressly stated purposes of this chapter (14-02.1-01 Purpose) is the protection of maternal health.

It is important for the state of North Dakota to develop good public policy as it relates to the regulation of abortion services. It is necessary to have guiding principles in place, both for now and in the future, as it pertains to assuring quality health care for our citizens. The issues addressed in this bill provide for that.

Currently, North Dakota law does not address local hospital privileges requirements for physicians performing abortions. Codifying this provision would ensure the ability of the physician performing the abortion to follow a patient to the hospital emergency room or operating room, and admit and care for the patient as necessary should any complications arise during or subsequent to the abortion procedure. The continuity of care this would provide is of great benefit to the patient, as the physician performing the abortion is specially trained in the specific procedure s/he is performing, and in recognizing and treating any complications or emergency situations that may arise. The credentialing process of the hospital would assure that only qualified physicians are providing abortion services in our state. Recognizing these principles of sound medical practice, similar requirements for continuity of care in abortion practice have been adopted in eleven other states.

The requirement that all physicians be board certified or board eligible in OBGYN would add an additional quality of care standard beneficial to patient care.

As a practicing physician in the state of North Dakota, quality patient care is my foremost concern. I believe adding the additional language that is proposed in this bill to our current Century Code is congruent toward that result.

Thank you for your consideration. I will stand for any questions you might have.

TESTIMONY SUBMITTED IN SUPPORT OF SB 2305

January 29, 2013

This proposed legislation **should be supported by all** who put the health and wellbeing of women who are patients seeking elective termination of a pregnancy above all else.

The safety of abortion is touted by it's advocates using **statistics and terms indicating infrequency** of problems. The number of procedures does, though, result in **significant incidents of harm to actual human beings** as a result of procedures executed by itinerate physicians.

This is a **preemptive measure intended to avoid** as much as is practicable unintended consequences of itinerate surgery.

Medical Privileges is a **BIG DEAL** for both physicians and the hospitals extending such privileges. The process has significant correlation with **risk management and legal exposure**. It is undertaken very, very thoroughly. For a REASON.

A more **rigorous vetting of itinerant physicians** by hospitals done by their professional peers **WILL** improve the care of women patients and thus the outcomes of their surgery or medically induced termination.

The constitutionality of a state's duty to protect it's citizens by establishing pre-emptive measures in general, and in this manner itinerate physician scrutiny specifically, is well established in case law.

Abortion **practitioners and academics** concur that establishment of **medical privileges** will result in **improved outcomes** following elective pregnancy termination.

ABORTION COMPLICATIONS – IN THEIR OWN WORDS

Red River Women's Clinic Website

<http://www.redriverwomensclinic.com/Medication%20abortion.htm>

It can take anywhere from about a day to 3-4 weeks from the time a woman takes the **first medication until the medical abortion is completed**. The length of time depends in part on the medications taken and when the misoprostol is used. The majority of women who take mifepristone will abort within four hours of using misoprostol. **About 95% of women will have a complete abortion within a week.**

Possible Complications: About 95-98% of women will have a successful medical abortion. Complications are rare. However, a small percentage of women (approximately

0.5-2%) will need a suction aspiration (similar to a surgical abortion) because of heavy or prolonged bleeding. Rarely, in approximately 0.1-0.2% of cases, a **blood transfusion might be required to treat very heavy bleeding.**

In about 1% of cases or fewer, the medications do not work and the embryo continues to grow. In these cases, a suction procedure (surgical abortion) must be done to empty the uterus and complete the abortion. Deciding to continue the pregnancy to term is not an option after taking the first medication because the medications can cause birth defects in the pregnancy.

SAFETY OF ABORTION

- Medication abortion accounted for 17% of all nonhospital abortions, and about one-quarter of abortions before nine weeks' gestation, in 2008.
- Fewer than 0.3% of abortion patients experience a complication that requires hospitalization.

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

North Dakota Abortion Numbers and Statistical Probabilities by Year

2011	2010	2009	2008	2007	2006	2005	2004	2003	2002
1,247	1,291	1,290	1,386	1,235	1,298	1,231	1,357	1,354	1,219

1,247 1,291 1,290 1,386 1,235 1,298 1,231 1,357 1,354 1,219 = 9 yr total = 12,3908

12,908 X 0.003 ≈ 38.24 (9 year estimate) or ≈ 4.3 per year requiring hospitalization

How many are complicated but do not require hospitalization?

Medical termination does not work...who finishes in the case of critical need?

What about the conscience of medical professionals that would have to complete the procedure should there be horrific problems as a result of an abortion.

A Google search of the two words "Ambulance Abortion" will yield insightful results.

ITINERANT PHYSICIANS – A SPECIAL CASE

"Itinerant surgery is defined in this inspection as the practice by a physician (normally residing in another city) of traveling to small rural hospitals to perform surgery. The surgeon typically is not available for follow-up care, having traveled to another rural hospital or returned to his or her home base all in the same day. The American College of Surgeons will and have excluded physicians from

fellowship for performing itinerate surgery". United States Department of Human Services, Office of Inspector General report (1988).

"The American College of Surgeons has long condemned the practice of "itinerant surgery," where doctors operate on patients and leave follow-up care to a family physician. But it has refrained from issuing guidelines on locum tenens. Paul Collicott, a director of the ACS, says it's "a necessary part of surgical practice today," given the overall shortage in the field. He says it's the responsibility of each temporary surgeon to make sure patients are handed off to another surgeon for postoperative care." - Wall Street Journal, January 13, 2009

"I pledge myself to pursue the practice of surgery with honesty and to place the welfare and rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position, and I will set my fees commensurate with the services rendered. I will take no part in any arrangement, such as fee splitting or **itinerant surgery**, which induces referral or treatment for reason other than the patient's best welfare". Portion of the Fellowship Pledge – American College of Surgeons, International Fellowship Requirements

ABORTION PROVIDERS CLAIM SIGNIFICANCE OF LEVEL OF CARE

Termination of pregnancy is not a benign medical procedure. In some cases, serious complications, even life-threatening ones, arise and necessitate optimal and evidence-based treatment.

According to John Thorp, Jr., an abortion provider who is the author of a leading abortion textbook and who is as well as a physician is a professor of obstetrics and gynecology at the University of North Carolina (Chapel Hill) School of Medicine:

“there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion.”

W.M. Hern, in ABORTION PRACTICE 101 (1990):

“Serious complications can only be evaluated in full service hospitals and often occur after regular business hours. Given the frequency of short-term complications from abortion (2-10%), follow-up medical care is often needed on an urgent basis to treat infection, bleeding, or organ damage. If recognized and attended to promptly, long-term consequences can be minimized. Often, though, abortion procedures are performed in freestanding clinics during weekday hours and complications are managed in urgent care centers or emergency departments after hours or on weekends.”

Dr. Thorp also asserts that:

“When the [abortion] provider is an ob-gyn and has admitting and treating privileges at a local hospital, he or she is more likely to effectively manage patient complications by providing continuity of care and decrease the likelihood of medical errors.”

Nationally, 73% of emergency departments report *inadequate* on-call coverage by specialist physicians, including obstetricians/gynecologists who are particularly difficult to secure. According to O'Malley, A., Draper, D. & Felland, L. in their publication *Hospital Emergency On-Call Coverage: Is There a Doctor in the House?*

AMERICAN COLLEGE OF SURGEONS

Code of Professional Conduct

II. RELATION OF THE SURGEON TO THE PATIENT

E. Postoperative Care

The responsibility for the patient's postoperative care rests primarily with the operating surgeon. The emergence of critical care specialists has provided important support in the management of patients with complicated systemic problems. It is important, however, that the operating surgeon maintain a critical role in directing the care of the patient. When the patient's postoperative course necessitates the involvement of other specialists, it may be necessary to transfer the primary responsibility for the patient's care to another physician. In such cases, the operating surgeon continues to be involved in the care of the patient until surgical issues have resolved. **Except in unusual circumstances, it is unethical for a surgeon to relinquish the responsibility for the postoperative surgical care to any other physician who is not qualified to provide similar surgical care.**

F. Continuity of Care of the Surgical Patient

The surgeon will ensure appropriate continuity of care of the surgical patient. An ethical surgeon should not perform elective surgery at a distance from the usual location where he or she operates without personal determination of the diagnosis and of the adequacy of preoperative preparation. Postoperative care should be rendered by the operating surgeon unless it is delegated to another physician who is as well qualified to continue this essential aspect of total surgical care.

It is recognized that for many operations performed in an ambulatory setting, the pattern of the patient's postoperative visits to the surgeon may vary considerably; it is, however, the responsibility of the operating surgeon to establish communication to maintain proper continuity of care.

MEDICAL PRIVILEGES – HIGH LEVEL PEER REVIEW – BIG DEAL

An entire legal specialty field

William and Mary Law Review [Vol. 29:609

A hospital with a respected staff and a reputation for high-quality care will be attractive to skilled physicians, who want access to the broad patient base and desire the prestige of membership on the hospital staff.

Staff privileges are one of the most important assets of a physician's practice.

Although specific procedures for review of staff privilege applications may differ at various hospitals, some general similarities exist. Several groups within the hospital structure participate in the process of considering an application for privileges. The medical staff plays a significant role in that process by evaluating the professional capabilities of the applicant. The physicians on the hospital's credentialing committee investigate the applicant's background to determine the extent of his past medical training and performance, whether he is licensed and board certified, whether he carries malpractice insurance, and any other information that they believe is relevant. The committee may report to the staff as a whole, to its executive committee, or directly to the governing board. The board is responsible for making the final decision, although many boards may give great weight to the findings of the committee. If the decision is unfavorable to the physician, the hospital generally provides an internal procedure for appeal and review.

Burdensome V. Life-Impacting Consequences

Abortionist Dr. Thorp acknowledges that “[a]ll competent physicians endure the ‘burdensome’ nature of applying for hospital privileges for the safety and well-being of their patients.”

Dr. James Anderson, a board-certified emergency medicine physician who serves as clinical professor at the Medical College of Virginia, opines regarding requiring physicians associated with abortion clinics to have hospital privileges, “[i]s consistent with the time-honored practice of requiring training and credentialing of physicians who are making decisions and doing procedures that have life-impacting consequences. If a physician cannot obtain privileges for the specific requested procedures at his or her local hospital, then in my expert opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact.”

Constitutionality of Proposed SB 2305

This proposed law would likely prove to be of no unconstitutional purpose. As *Casey* held, a regulation serves a “valid purpose” if it is “not designed to strike at the right [to abortion] itself” and furthers the State’s “legitimate interests...in protecting the health of the woman and the life of the fetus that may become a child.” 505 U.S. at 846.

Simopolous v. Virginia, 462 U.S. 506, 511 (1983) affirms that “[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient”.

Simopoulos, 462 U.S. at 516 affirms that , “In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities”.

Greenville Women's Clinic v. Bryant, 222 F.3d 157, 172 (4th Cir.2000), cert. denied, 531 U.S. 1191 (2001) (“*Greenville I*”), held that a “valid purpose” was served by a regulation requiring abortion clinics to be associated with a physician who has admitting privileges at a local hospital.

Gonzales, supra, 550 U.S. at 163 (“The Court has given state and federal legislatures wide discretion in areas where there is medical and scientific uncertainty.”); *id.*, at 157

Washington v. Glucksberg, 521 U.S. 702, 731 (1997) (“[t]here can be no doubt that the government ‘has an interest in protecting the integrity and ethics of the medical profession’”).

The Supreme Court has upheld health-related abortion-clinic rules that merely “may be helpful” and “can be useful.” *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 80, 81 (1976).

Two federal circuit courts have expressly found that “admitting privileges at local hospitals and referral arrangements with local experts” are “so obviously beneficial to patients” undergoing abortions as to easily withstand a facial constitutional challenge alleging them to be undue burdens.

Greenville Women's Clinic v. Commissioner, South Carolina Dept. of Health and 317 F.3d 357, 363 (4th Cir. 2002) (“*Greenville II*”); *Women’s Health Ctr. of West County, Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989).

Accord Tucson Woman's Clinic v. Eden, 379 F.3d 531, 547 (9th Cir. 2004) (holding that Arizona statute requiring only abortionists who performed a certain number of abortions per month to obtain admitting privileges did not violate equal protection because it was rationally related to achieving a legitimate end).

I would appreciate the opportunity to discuss what is presented above and/or supply additional information at your request.

Respectfully Submitted for your consideration,

January 29, 2013

Steve Cates

701 223-6172



Medication Abortion (The Abortion Pill)

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[Our Staff](#)

[Fees & Appointments](#)

[Walk-In Pregnancy Tests](#)

[Patient Comments](#)

[Surgical Abortion](#)

[Surgical Home-Care](#)

[Medication Abortion](#)

[Medication Home-Care](#)

[Birth Control](#)

[Directions](#)

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A medical abortion is one that is brought about by taking medications that will end a pregnancy. Red River Women's Clinic offers medication abortion in the first 63 days (less than 9 weeks) of pregnancy. Two medications are used as part of the medication abortion, mifepristone and misoprostol.

Mifepristone (the abortion pill or RU-486) is a medication that was developed and tested specifically as an abortion-inducing agent. It was first licensed in France and China in 1988. Since then it has been used safely by millions of women worldwide. It was approved for use in the U.S. in September, 2000.

Mifepristone is taken in the form of a pill. It works by blocking the hormone progesterone, which is necessary to sustain pregnancy. Without this hormone, the lining of the uterus breaks down, the cervix (opening of the uterus) softens, and bleeding begins.

Misoprostol Within 24-48 hours after taking the mifepristone, a second drug, misoprostol, is taken. Misoprostol tablets (which are placed in the cheek pouch between the cheek and gums) cause the uterus to contract and empty. This ends the pregnancy.

It can take anywhere from about a day to 3-4 weeks from the time a woman takes the first medication until the medical abortion is completed. The length of time depends in part on the medications taken and when the misoprostol is used. The majority of women who take mifepristone will abort within four hours of using misoprostol. About 95% of women will have a complete abortion within a week.

Some women have vaginal bleeding after the first drug. This bleeding may be light, or it may be like a heavy period. After taking the misoprostol, cramping and



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bleeding usually begin within a few hours, although it may take longer. The cramping and bleeding may be more than with a normal menstrual period.

The most common side effects of medical abortion are caused by misoprostol. In addition to cramps and bleeding, early side effects may include: headache, nausea, vomiting, diarrhea, fever, chills, or fatigue. If a woman experiences flu-like symptoms or abdominal pain more than 24 hours after using misoprostol, she is advised to call the clinic.

Most women have cramps for several hours, and many pass blood clots as they are aborting. Blood clots can be quite large, like a lemon or the palm of your hand. This is to be expected. Some women may see the grayish gestational sac. However, the embryo will probably not be seen among the blood clots. Cramps and bleeding usually begin to ease after the embryonic tissue has been passed, but bleeding may last for one to two weeks after medical abortion.

Possible Complications: About 95-98% of women will have a successful medical abortion. Complications are rare. However, a small percentage of women (approximately 0.5-2%) will need a suction aspiration (similar to a surgical abortion) because of heavy or prolonged bleeding. Rarely, in approximately 0.1-0.2% of cases, a blood transfusion might be required to treat very heavy bleeding.

In about 1% of cases or fewer, the medications do not work and the embryo continues to grow. In these cases, a suction procedure (surgical abortion) must be done to empty the uterus and complete the abortion. Deciding to continue the pregnancy to term is not an option after taking the first medication because the medications can cause birth defects in the pregnancy.

Medical abortion requires a follow-up visit to the clinic. This return visit is very important to be sure that the abortion has been completed. The follow up visit consists of a pregnancy test and a vaginal ultrasound. The follow-up visit usually takes about one hour, and is FREE.

**Senate Judiciary Committee
SB 2305
January 29, 2013**

Mr. Chairman and members of the Senate Judiciary Committee, I am Tom Freier with the North Dakota Family Alliance and I am here in support of SB 2305.

The North Dakota Family Alliance has always understood the serious nature of an abortion procedure and the need for licensed physicians and medical regulation to insure appropriate treatment throughout the procedure.

This bill, SB 2305 strengthens this protection by requiring the abortion doctor to have admitting and staffing privileges at a local hospital to provide care in the instance of complications after the procedure.

Mr. Chairman, I urge the committee to give SB 2305 a Do Pass.

Tammi Kromenaker - Testimony against SB 2305

Chairman Hogue, members of the Judiciary Committee, thank you for the opportunity to present testimony in opposition of Senate Bill 2305.

My name is Tammi Kromenaker and I am the Director of Red River Women's Clinic. Red River Women's Clinic is the only abortion provider in the state of ND and has provided safe abortion care and other reproductive health care services to women in North Dakota for almost 15 years. We are members in good standing of the National Abortion Federation and maintain the highest quality standards for our practice. Red River Women's Clinic mission is to not only provide medically safe reproductive health services, but to also provide those services in an emotionally supportive environment.

Red River Women's clinic provides abortion services to women from a broad range of backgrounds. Approximately sixty percent of our patients are already mothers, with at least one child at home. These women rely on their own personal experiences and understanding of pregnancy and parenting and to make careful, considered decisions about what is best for themselves and their families. In addition, most of our patients get abortions very early in pregnancy – 92% of all abortions performed at our clinic are in the first trimester. As I've described, many women, including many mothers, in the state from all different backgrounds have sought services at the clinic at some point in their lives. Our clinic provides safe, legal services in a supportive environment.

The committee today is considering four pieces of legislation that are designed to prohibit women from accessing abortion services in the state. While I believe that all four pieces of legislation would harm North Dakota women and prevent them from obtaining the reproductive health care they need, I am going to focus my testimony on SB 2305.

SB 2305 would prohibit a physician from performing an abortion in North Dakota unless he or she is a Board Certified OB/GYN and has certain privileges at a local hospital. This proposal fundamentally misunderstands how the scope of physician's practice is determined and is inconsistent with hospital practice.

We currently have three physicians who provide abortion services at our clinic. All three of our physicians are board certified in Family Medicine and have a combined total of over 30 years of practicing medicine. Our Medical Director, Dr. Kathryn Eggleston, has been trained and providing safe abortion care since 1999. She has been providing safe abortion services at Red River Women's Clinic since 2004. Dr. Eggleston also provides abortion services to women in Minnesota & South Dakota. Our other physicians also regularly provide abortion care in the states of Minnesota, South Dakota and Colorado. Dr. Eggleston has trained under some of the preeminent physicians specializing in abortion care in the United States and has herself

provided training to residents and medical students in reproductive health care methods, including abortion care. All of our physicians regularly attend National Abortion Federation meetings where best practices regarding abortion care are shared. All of our physicians are up to date on current evidence based medicine and best practices. Dr. Eggleston and all of our physicians treat our patients both with the highest level of professional competence, but also with care and concern for their emotional wellbeing. We are both proud and lucky to have such accomplished, highly skilled and competent physicians able and willing to provide abortion care at our clinic.

Abortion care is one of the safest medical procedures in the United States. Surgical abortion is one of the safest types of medical procedures. Complications from having a first-trimester aspiration abortion are considerably less frequent and less serious than those associated with giving birth. Early medical abortion has a similar safety profile. The risk of a woman experiencing a complication after an abortion is extremely low; less than one percent of the women who obtain abortions experience a serious complication. In the vast majority of cases, the types of complications that may occur following an abortion can be safely handled in an outpatient office setting.

Abortion care is also firmly within the scope of practice of family medicine. Family medicine physicians are trained to provide comprehensive health care – including obstetrical care – throughout a person’s life. Family physicians are capable of caring for any health care problem, but are experts in common problems. Furthermore, many family physicians provide prenatal care and deliver babies in addition to taking care of patients of all ages.

Family physicians are well prepared to provide abortion care. In particular, assessing the patient’s support system, emotional state, and understanding of the abortion process fits squarely within family medicine as a result of the extensive extensive training in counseling that family physicians are given. A recent study in the journal Annals of Family Medicine firmly validated “the safety and efficacy of early abortion care by family physicians,” and specifically noted that this care was well delivered without “reliance on emergency services or those of specialists.”

Nationally, there is a shortage of OB/GYNs as reported at the 2010 meeting of the American Congress of Obstetricians and Gynecologists. A 2011 report from the American College of Obstetricians and Gynecologists on North Dakota reported that there were only 52 total OB/GYNs in the entire state of North Dakota, serving a population of 263,602 women. This same report shows that there is no OB/GYN residency program located anywhere in the state of North Dakota.¹ By restricting the provision of abortion services to OB/GYNs, this bill would

¹<http://www.acog.org/~media/Departments/Government%20Relations%20and%20Outreach/WF2011ND.pdf?dmc=1&ts=20120728T0848147099>.

both impede the scope of practice of family physicians in this state, who are well qualified by experience and training to provide these services, as well as limit access to care because of a shortage of specialists in this state.

Another requirement in SB 2305 is that all physicians associated with an abortion facility must have admitting privileges at a local hospital and staff privileges to replace local hospital on-staff physicians. These admitting privileges are not medically necessary or reasonable. Because of the inherent safety of abortion procedures, abortion providers rarely if ever have to admit patients to a hospital. Further, Red River Women's clinic has been providing safe abortion care for fifteen years without needing such privileges. We have arrangements in place that are more than adequate for handling the **extremely** rare circumstance in which a woman needs to be hospitalized for post-abortion complications, and this will not add anything but barriers to the provision of safe high quality care to women seeking abortions in this state

Moreover, this requirement would improperly give the hospitals in North Dakota the power to decide whether abortion should be available in this state. That is not fair to women who need these services and who have a constitutional right to access them, and it's not fair to the hospitals, which are essentially being drafted by the legislature in the hopes that they will act to ban abortion. Abortion is a contentious and emotional issue. It is fully predictable that if this bill passes, local hospitals will be under pressure not to grant privileges to any physician who provides abortion, regardless of that physician's qualifications or experience. I should also note that, as many of you must also know, a bill almost identical to this was passed in the state of Mississippi in 2012 and it has been tied up in litigation ever since.

In conclusion, I want to reiterate the safety of abortion. Surgical abortion is one of the safest types of medical procedures. Having an abortion is safer than receiving a penicillin shot. Fewer than 1% of all U.S. abortion patients experience a major complication and the risk of death associated with abortion is at least ten times lower than that associated with childbirth. Because of the safety record of abortion, it is neither necessary nor appropriate to require for physicians providing abortion care to have hospital admitting privileges. Moreover, it is simply not necessary for physicians to be OB/GYN's to provide safe abortion care. The physicians providing abortion services here in North Dakota are highly trained, competent, board certified Family Medicine physicians who have safety records that are impeccable. This bill does nothing to ensure the safety of women seeking abortion.

I appreciate you giving me the opportunity to testify today and I would be happy to take any questions from the committee.

**Testimony to the Senate Judiciary Committee
From Dr. Siri Fiebiger of Fargo, N.D.
1/29/2013**

Chairman Hogue and members of the Senate Judiciary Committee I am Dr. Siri Fiebiger from Fargo, N.D.

I'm testifying in opposition to SB 2305.

Requiring inpatient admitting privileges for an abortion provider is an impractical impossibility. Our local hospitals require one uses their privileges (ie admits patients) in order to have/keep them.

Today's hospitals must require quality data (practical experience with a physician) to maintain privileges. As a practical example, I've relinquished mine at Sanford as I've used them rarely over the years.

For these reasons I urge a Do Not Pass recommendation on SB 2305.

Thank you.

2305 (1)

13.0796.01001
Title.

Prepared by the Legislative Council staff for
Senator Grabinger
January 30, 2013 *fail*

PROPOSED AMENDMENTS TO SENATE BILL NO. 2305

Page 1, line 7, remove "All"

Page 1, remove line 8

Page 1, line 9, remove "hospital and staff privileges to replace local hospital on-staff
physicians."

Page 1, line 10, remove "or eligible in obstetrics and"

Page 1, line 11, remove "gynecology"

Renumber accordingly

13.0796.01002
Title.

Prepared by the Legislative Council staff for
Senator Berry

February 4, 2013

PROPOSED AMENDMENTS TO SENATE BILL NO. 2305

Page 1, line 8, replace "associated with an abortion facility" with "performing abortion procedures"

Page 1, line 8, remove "local"

Page 1, line 9, after "hospital" insert "located within thirty miles [42.28 kilometers] of the abortion facility"

Page 1, line 9, remove "local"

Page 1, line 9, after the first "physicians" insert "at that hospital"

Page 1, line 9, remove "All physicians"

Page 1, remove line 10

Page 1, line 11, replace "gynecology" with "These privileges must include the abortion procedures the physician will be performing at abortion facilities"

Page 1, line 12, after "open" insert "and abortions are scheduled to be performed"

Renumber accordingly

#1

Testimony on Engrossed SB2305 House Standing Committee on Human Services

March 13, 2013

Senator Spencer Berry, MD

Chairman Weisz and members of the House Human Services Committee, SB2305 is legislation with a narrow focus; to protect the health and safety of women receiving abortions in North Dakota. Chapter 14-02.1 of the NDCC is the North Dakota Abortion Control Act. One of the expressly stated purposes of this chapter (14-02.1-01 Purpose) is the protection of maternal health.

SB2305 deals with the credentialing of abortion providers in the state of North Dakota. This is not an abortion rights bill; it is not a challenge to Roe. It is a bill that will bring significant benefits to the quality of care for the women undergoing this procedure. The intent of this legislation is to set in place good public policy for now and going forward as it relates to the regulation and oversight of abortion services in our state. Currently, ND does not have the proper regulations and safeguards in place to assure this.

Complication rates for abortions done in the first 12 weeks of pregnancy range from between 3% and 6%. This rate increases dramatically after 12 weeks of pregnancy, directly proportional to gestational age and the skill of the physician performing the abortion---with complication rates approaching nearly 50% in the 2nd trimester of pregnancy.

Testimony given previously this session to this legislature from abortion service providers in the state revealed that in 2011, 1247 abortions were performed in freestanding facilities. Of this number, 8% or 108 abortions were reported to have been done after 12 weeks, in the 2nd trimester of pregnancy. However, the state has no mechanism for verifying the accuracy of that statistic. What this means is that in ND, at least 8% of the abortions are being performed at the time when the complication rates are at their highest.

Ninety-six percent of 2nd trimester abortions are performed using the procedure referred to as "dilatation and extraction" (D&E). To perform this procedure safely, physicians need specialized training and an adequate caseload to maintain their skills.

This bill would require any physician performing abortion procedures in the state of ND to have obtained admitting privileges at a local hospital. This requirement would serve two very important functions:

First, the credentialing process and the obtaining of hospital privileges to perform specific procedures and render care of patients within the hospital would ensure that a physician's credentials have been scrutinized and verified as to his/her claim of being qualified to perform these services. This is crucial, as the physician performing the abortion is specially trained in the specific procedure s/he is performing, and in recognizing and treating any complications or emergency situations that may arise.

Secondly, continuity of care has been well established as being beneficial for patient outcomes. These privileges would allow the providing physician the ability to follow the patient to the hospital to render further care as necessary in the emergency department, operating room, or as an inpatient in the hospital. Recognizing these principles of sound medical practice, similar requirements for continuity of care in abortion practice have been adopted in 11 other states.

There is judicial precedent, including the United States Supreme Court, affirming the state's right to regulate abortion, so as to protect the health of the mother.

This committee will hear testimony in support of this legislation from Concerned Women for America, which is the largest public policy organization for women in the United States and in North Dakota.

We have a responsibility to the women of North Dakota to ensure that physicians providing abortion services in the state are qualified to perform the procedures necessary. We currently do not have a mechanism in place to do that. This legislation would create that mechanism. For example: If you were to go to an airport this morning to board a plane to fly from Bismarck to Los Angeles, you would assume that the individual in the cockpit was qualified to:

- A. Fly THAT plane and
- B. Fly that plane SAFELY to Los Angeles.

The women of ND presenting themselves for abortion services should also be able to expect that:

- A. The physician providing the abortion services is qualified to perform THAT specific procedure and
- B. That that physician can provide the procedure SAFELY.

Mr. Chairman and members of the committee, SB2305 will promote protection of maternal health in North Dakota, and I strongly urge a "do pass" recommendation.

Thank you for the opportunity to testify before you today, and I will stand for any questions.

#2

Sixty-Third Legislative Assembly of North Dakota
Engrossed Senate Bill No. 2305
Testimony of Anna Higgins, J.D.
Director of the Center for Human Dignity, Family Research Council
March 13, 2013

Mr. Chairman and honorable members of the committee, thank you for giving me the opportunity to testify before you today. My name is Anna Higgins. I am the Director of the Center for Human Dignity at the Family Research Council, a Christian public policy organization that since 1983 has promoted and defended human life, religious liberty, and family values in the United States. We represent more than 1.5 million people from Evangelical, Catholic, and other Christian denominations around the country. I speak today as a representative of Americans who support the sanctity of all human life, no matter the stage of development. Fundamentally, we believe that life begins at conception and that this life is worthy of respect and equality under the law.

Legality of Admitting Privileges

Requiring that abortion doctors gain admitting privileges at local hospitals is a commonsense regulation that protects the health of women. The Roe Court noted that States have a “legitimate interest in seeing to it that abortion, like any other medical procedure is performed under circumstances that ensure maximum safety for the patient.”¹ The Casey Court reiterated that idea.² Abortion is a serious surgical procedure that carries with it the possibility of serious complications like hemorrhage and infection. Thus, North Dakota, in putting the safety of

1 *Roe v Wade*, 410 U.S. 113, 150 (1973).

2 *Planned Parenthood v. Casey* 505 U.S. 833, 847 (1992)

#22

citizens first, is fully within its rights to require that all physicians who perform abortions are admitted to local hospitals.

Similar regulations have been instated in eleven states. Requirements in MS are enjoined pending litigation and requirements in MO and SC were upheld by the 8th and 4th circuit courts. To my knowledge, no court has actually struck down these requirements, likely because the State's interest in regulating health and safety- particularly in the area of abortion- is a necessary and legitimate police power, used to protect the health of its citizens.

In 1989, the 8th circuit concluded that Missouri's law requiring that physicians performing abortions maintain surgical privileges at a hospital providing obstetrical and gynecological care (Sec. 188.010) did not violate the Constitution.³

The 8th Cir. Court noted, "As the Supreme Court explained in *Akron*, a state may enact '[c]ertain regulations that have no significant impact on the woman's exercise of her right ... where justified by important state health objectives.'" The court found that the requirement did not violate any privacy standard set forth in *Roe* and that, "The State of Missouri, in exercising its police powers to protect the well-being of its citizens, has undoubted authority to regulate the conditions under which surgical procedures are performed. Such legitimate state regulation of surgical procedures is not rendered unconstitutional because it is specifically applied to abortion."

Additionally, the 4th Cir in *Greenville Women's Clinic v. Commissioner, South Carolina Dept of Health*, 317 F.3d 357, 363 (4th Cir. 2002) also found that admitting privileges easily withstood a Constitutional challenge because they are so beneficial to the patient.

Finally, even if the admitting privileges requirement is seen as burdensome by some parties, the Supreme Court has noted that states have the right to distinguish between abortion and other

³*Women's Health Ctr. Of West County, Inc. v. Webster*, 871 F.2d 1377, 1382 (1989).

23
P 3

medical procedures because “no other procedure involves the purposeful termination of a potential life.”⁴ Since the abortion procedure carries with it risks over and above those of other surgical procedures- namely the purposeful taking of another human life- States have the right and ability to single out the procedure for regulation.

Women’s Health:

The myth that abortion is good for women has slowly been exposed and dispelled by personal experience and medical science. Negative effects of abortion on women range from physical complications like infection, perforations and hemorrhage to serious psychological harm, such as depression, anxiety and even suicide.

Physical Complications: Surgical abortion is a serious medical procedure and its complications should not be diminished.

The most recent CDC Abortion Sureveillance, United States, 2009, reported that there have been 403 deaths resulting from legal abortions since 1972.⁵ This number is undoubtedly a low estimate due to the fact that several states, including California, do not report abortion statistics to the CDC.

Premature birthrates following abortions range from 36% increase to as much as 60% increase in cases where women have more than one abortion.⁶ Other international studies show pervious

4 *Harris v. McRae*, 448 U.S. 297 (1980).

5 Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, November 23, 2012, Surveillance Summaries, Vol. 61, No. 8, Table 25.

6 Dr. Byron Calhoun, “Induced abortion linked to Preterm Delivery, ”Dec 10 ObGyn News p. 10.

#2
p.4

abortions greatly increase the risk of premature birth.⁷ By 2008, at least 59 studies have demonstrated a statistically significant increase in premature birth or low birth weight risk in women with prior induced abortions.⁸

Medical abortion can be even more dangerous than surgical abortion, often due to the fact that women are not necessarily under the care of a doctor when the abortion is performed.

Complications from medical abortions range from undiagnosed ectopic pregnancy to significant blood loss and infection, often as a result of incomplete abortion.⁹

In his comprehensive analysis of RU-486, Chris Gacek notes, "Medical abortions fail frequently, and they often produce serious hemorrhage and infection. For example, according to the April 2011 RU-486 Adverse Events Summary there were reports to FDA that 339 American women had blood loss significant enough to require transfusions. There were 256 reported cases of infection reported in the United States. Approximately 15-20 known deaths have been associated

7

nrlc.org; *See also* Caroline Moreau, et al, "Previous induced abortions and the risk of very preterm delivery: results of the EPIPAGE study," *British Journal of Obstetrics and Gynecology*, Vol. 112 (April 2005): 430-437.

8

American Association of Pro-Life Obstetricians and Gynecologists, (<http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-pre-term-birth/general-comments-on-the-increased-risk/>)

9

See Chris Gacek, RU-486 (Mifepristone) Side-Effects 2000-2012, Family Research Council, May 2012 Issue Analysis.

#2
p5

with the regimen worldwide, but this number is almost certainly quite low since our data does not include countries like China and India where the regimen's use is heavy."¹⁰

Psychological Complications: At the time abortion was legalized not much was known about the psychological scars and risk of mental illness that affect women who have had abortion. Now, 40 years later, we know from the testimony of women themselves and from scientific and medical research that abortion does in fact carry significant psychological risk factors. Previous abortions put a woman at an increased risk for a variety of mental health problems such as panic attacks, panic disorder, agoraphobia, PTSD, bipolar disorder, major depression with and without hierarchy, and substance abuse disorders.¹¹

Dr. Priscilla Coleman, author of one of the most comprehensive studies of the mental health risks after abortion notes that,

Overall, women with an abortion history experience an 81% increased risk for mental health problems. The results showed that the level of increased risk associated with abortion varies from 34% to 230% depending on the nature of the outcome. Separate effects were calculated based on the type of mental health outcome with the results revealing the following: the increased risk for anxiety disorders was 34%; for depression it was 37%; for alcohol use/abuse it was 110%, for marijuana use/abuse it was 220%, and for suicide behaviors it was 155%.

10

Ibid at 15.

11

Coleman, P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009), *Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey*, *Journal of Psychiatric Research*, 43, 770-776.

#2
p6

When compared to unintended pregnancy delivered women had a 55% increased risk of experiencing any mental health problem. Finally, nearly 10% of the incidence of all mental health problems was shown to be directly attributable to abortion.¹²

Suicidal behaviors and actions are also an increased risk for women who have had abortions. Suicidal thoughts and behavior are very serious issues and can have devastating impacts on entire families.¹³

The 8th Circuit recently acknowledged the devastating impact that abortion has on women in *Planned Parenthood v. Rounds*, July 24, 2012 which involved a dispute over a South Dakota statute that required disclosure to patients seeking abortion of an increased risk of suicide.¹⁴ The 8th Circuit court upheld the statute, noting,

12

Coleman, P.K. (Sept. 2011) "Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009, *British Journal of Psychiatry*."

13

See Induced Abortion and Maternal Suicide, THE AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS ABORTION AND SUICIDE SUICIDE ATTEMPTS ASSOCIATED WITH INDUCED ABORTION, References: Garfinkle, B., et. al., "Stress, Depression, and Suicide: A study of Adolescents in Minnesota" (Minneapolis: Univ Minnesota Extension Service, 1986): <http://www.aaplog.org/complications-of-induced-abortion/induced-abortion-and-maternal-mortality/induced-abortion-and-maternal-suicide/>; For more stories from real women who have experienced pain associated with abortion, visit <http://www.abortionchangesyou.com/explore?exploreArtFilter=all> and Operation Outcry, <http://www.operationoutcry.com/?Page=personal>, an organization that "seeks to end the pain of abortion in America and around the world by mobilizing women and men hurt by abortion who share their true stories of the devastating effects of abortion."

14

<http://www.ca8.uscourts.gov/opndir/12/07/093231P.pdf>.

#2
p7

Based on the record, the studies submitted by the State are sufficiently reliable to support the truth of the proposition that the relative risk of suicide and suicide ideation is higher for women who abort their pregnancies compared to women who give birth or have not become pregnant. It also is worth noting that Planned Parenthood does not challenge the disclosure that “[d]epression and related psychological distress” is a “known medical risk[] of the [abortion] procedure.” S.D.C.L. § 34-23A-10.1(1)(e)(i); *see also Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (noting that “[s]evere depression and loss of esteem can follow” an abortion).¹⁵

In light of the health risks facing women who go through the abortion procedure, the State should assert its interest in regulating the procedure to protect these women. One way to ensure the safety of women is by requiring abortion doctors obtain admission requirements at local hospitals.

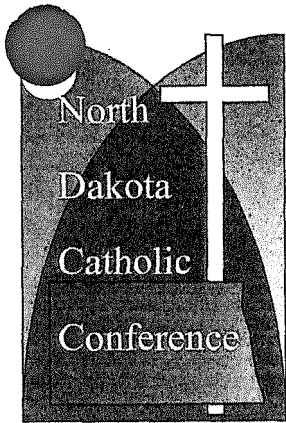
Conclusion:

There should be a legitimate question as to whether physicians who are unwilling or unable to comply with admitting regulations for the purpose of protecting patients should be performing dangerous surgical procedures such as abortion. In enacting these commonsense admitting requirements, the State of North Dakota is asserting its duty to establish and maintain important state health objectives, which include the safety and well-being of women who have abortions.

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Ibid at 14.

43



Representing the Diocese of Fargo and the Diocese of Bismarck

Christopher T. Dodson
Executive Director and
General Counsel

To: House Human Services Committee
Subject: SB 2305
Date: March 13, 2013

The North Dakota Catholic Conference supports Senate Bill 2305 to enhance the health and safety of women having abortions. We lament that taking the life of an unborn child is still legal in this country, but we have consistently held that until such time as the law protects all human life, government has an obligation to protect and advance the legitimate health interests of women receiving abortions. Their lives are just as precious as those destroyed in the act of abortion.

The courts have agreed that the state has a legitimate interest in ensuring the maximum level of safety for the woman receiving an abortion.¹ This interest exists no matter when during the pregnancy the abortion occurs.²

No matter what gloss abortion proponents put on it, abortion is an invasive, surgical procedure that can lead to numerous and serious (both short- and long-term) medical complications. Our own North Dakota Department of Health notes that potential complications for abortion include, among others, bleeding, hemorrhage, infection, uterine perforation, uterine scarring, blood clots, cervical tears, incomplete abortion (retained tissue), reactions to anesthesia, and even death.³ The risks are greater with surgical abortions and for second trimester abortions.

Add to this the fact that the abortion clinic in Fargo uses itinerant out-of-state physicians to perform a relatively high volume of surgical abortions during a short period of time, and the state has more than sufficient justification for protecting women's lives by the enacting the modest requirement that the physician have admitting privileges at a local hospital.⁴ It is the least we can do.

Opponents of these sensible expectations have claimed that SB 2305 will shut down the abortion center. Senate Bill 2305 will not shut down the clinic. If the clinic chooses to close because of its unwillingness to comply with this minimal requirement, the closure would be solely due to its own decision and not the passage of this bill.

Some have also claimed that SB 2305 would interfere with a hospital's policy for granting privileges. It would not. Nothing in SB 2305 requires a hospital to change any of its policies. Nor would SB 2305 infringe upon the independent judgment of a physician employed by a hospital.⁵

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p2

Senate Bill 2305 is not about abortion. It is about protecting the women who have abortions.

We urge a **Do Pass** recommendation on SB 2305.

¹ *Roe v. Wade*, 410 U.S. 113, 150 (1973); *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983).

² *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).

³ *Information About Pregnancy and Abortion*, North Dakota Department of Health, November 2012.

⁴ For a breakdown of the number of abortions the Red River Women's Clinic performs per day, see attachment.

⁵ That is already protected by North Dakota Century Code section 43-17-42.

#3
P3

How many abortions does the Red River Women's Clinic perform in a single day?

In 2011, the last year for which records are available, the clinic performed 1247 abortions.¹

It is generally accepted that the clinic does abortions only once a week, although they are closed some weeks during the year. Assuming, therefore, it performed abortions on at least 50 days last year, that would mean that it performed an average of 25 abortions per day. This is consistent, though more precise, than clinic director Tammi Kromenaker's own claim that the clinic "sees approximately 25 patients per week."²

According to Kromenaker, approximately 80% of the abortions are surgical.³ That would mean at least 20 a day are surgical abortions.

The clinic's website posts hours as between 9:00 a.m. to 5:00 p.m. If those are the actual hours, this equates to 3.1 abortions per hour, at least 2.5 of which are surgical.

How does this compare to other abortion facilities? According to one breakdown on abortions based on data from the Guttmacher Institute for 2008, the Red River Women's Clinic would have among the highest volume of abortions per day in the nation. It estimated that the highest volume abortion clinics - which represent less than four percent of the abortion clinics in the country - perform approximately 25 abortions per day.⁴

¹ <http://www.ndhealth.gov/vital/pubs/ITOP%202011.pdf>

² Bismarck Tribune, February 16, 2013.

³ Affidavit of Tammi Kromenaker in Support of Motion for Temporary Injunction, MKB Management vs. Birch Burdick, et al., East Central Judicial District, Case No. 09-2011-CV-02205.

⁴ The Throughput of Abortion Providers, http://finance.townhall.com/columnists/politicalcalculations/2012/01/19/the_throughput_of_abortion_providers/page/full/ based on data from Jones, Rachel K. and Kooistra, Kathryn. Guttmacher Institute. Abortion Incidence and Access to Services in the United States, 2008. Perspectives on Sexual and Reproductive Health. Volume 43, Issue 1. 10 January 2011.

Beverly LaHaye
Chairman



#4

March 13, 2013

Mr. Chairman and Members of the Committee, my name is Janne Myrdal, and I am the State Director for Concerned Women for America (CWA) of North Dakota. We are here today on behalf of our North Dakota members in support of SB2305.

As the nation's largest public policy women's organization, CWA strongly supports the provisions in SB2305 which would guarantee continuity of patient care for women having undergone the procedure of abortion. Policies that assure quality care for patients, and in this case women, is of the uttermost importance to the public at large and should have broad support. Continued medical care after such a seriously invasive procedure as abortion is the right of all patients, and CWA fails to see that this legislation would put an undue burden on any facility or physician engaging in the procedure of abortion.

This is pro-women legislation that applies common sense practical guidelines that are aimed at providing protection for women patients all across our state.

It may be worth noting this passage in the court records of the Roe v Wade decision (the quote comes from the section of the opinion dealing with the State's interest in protecting the life and health of the mother):

"The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances **that insure maximum safety for the patient**. This interest obviously extends at least to the performing physicians and his staff, to the facilities involved, to **the availability of after-care, and to adequate provision for any complication or emergency that might arise.**" (Emphasis added) Roe v Wade, 410 U.S. 113, pg.150 (1973).

We would urge a "do pass" on SB2305, as CWA and its members believe this should be an absolutely non debatable legislation.

CONCERNED WOMEN FOR AMERICA
OF NORTH DAKOTA

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TESTIMONY SUBMITTED IN SUPPORT OF SB 2305

This proposed legislation **should be supported by all** who put the health and wellbeing of women who are patients seeking elective termination of a pregnancy above all else.

The safety of abortion is touted by its advocates using **statistics and terms indicating infrequency** of problems. The number of procedures does, though, result in **significant incidents of harm to actual human beings** as a result of procedures executed by itinerate physicians.

This is a **preemptive measure intended to avoid** as much as is practicable unintended consequences of itinerate surgery.

Medical Privileges is a **BIG DEAL** for both physicians and the hospitals extending such privileges. The process has significant correlation with **risk management and legal exposure**. It is undertaken very, very thoroughly. For a REASON.

A more **rigorous vetting of itinerant physicians** by hospitals done by their professional peers **WILL** improve the care of women patients and thus the outcomes of their surgery or medically induced termination.

The **constitutionality** of a state's duty to protect its citizens by establishing pre-emptive measures in general, and in this manner itinerate physician scrutiny specifically, is **well established in case law**.

Abortion **practitioners and academics** concur that establishment of medical privileges will result in **improved outcomes** following elective pregnancy termination.

ABORTION COMPLICATIONS – IN THEIR OWN WORDS

Red River Women's Clinic Website

<http://www.redriverwomensclinic.com/Medication%20abortion.htm>

It can take anywhere from about a day to 3-4 weeks from the time a woman takes the first medication until the medical abortion is completed. The length of time depends in part on the medications taken and when the misoprostol is used. The majority of women who take mifepristone will abort within four hours of using misoprostol. **About 95% of women will have a complete abortion within a week.**

Possible Complications: About 95-98% of women will have a successful medical abortion. Complications are rare. However, a small percentage of women (approximately 0.5-2%) will need a suction aspiration (similar to a surgical abortion) because of heavy or prolonged bleeding. Rarely, in approximately 0.1-0.2% of cases, **a blood transfusion might be required to treat very heavy bleeding.**

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In about 1% of cases or fewer, the medications do not work and the embryo continues to grow. In these cases, a suction procedure (surgical abortion) must be done to empty the uterus and complete the abortion. Deciding to continue the pregnancy to term is not an option after taking the first medication because the medications can cause birth defects in the pregnancy.

SAFETY OF ABORTION

- Medication abortion accounted for 17% of all nonhospital abortions, and about one-quarter of abortions before nine weeks' gestation, in 2008.
- Fewer than 0.3% of abortion patients experience a complication that requires hospitalization.

From: Guttmacher Institute Facts on Induced Abortion in the United States, August 2011

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

NORTH DAKOTA ABORTION NUMBERS AND STATISTICAL PROBABILITIES BY YEAR

Abortions completed in ND by year:

2011	2010	2009	2008	2007	2006	2005	2004	2003	2002
1,247	1,291	1,290	1,386	1,235	1,298	1,231	1,357	1,354	1,219
= 9 yr total = 12,3908									
12,908 X 0.003 (Guttmacher 0.3%) ≈ 38.24 (9 year estimate) or ≈ 4.3 per year requiring hospitalization									

How many abortions result in complications that do not require hospitalization?

If medical termination does not work...who finishes in the case of critical need?

Is it possible that someone other than the itinerate surgeon who put in motion a medical (drug induced) abortion would have to deal with the complications that can require subsequent surgical abortion?

What about the conscience of medical professionals who are left to deal with a hospital necessitated situation (4.3 per year likely in ND) in the absence of the itinerate abortion surgeon who is responsible for the patient's health but is not physically available to continue care of that abortion patient?

#5 p3

A Google search of the two words "Ambulance Abortion" will yield insightful results.

ITINERANT PHYSICIANS – A SPECIAL CASE

"Itinerant surgery is defined in this inspection as the practice by a physician (normally residing in another city) of traveling to small rural hospitals to perform surgery. The surgeon typically is not available for follow-up care, having traveled to another rural hospital or returned to his or her home base all in the same day. The American College of Surgeons will and have excluded physicians from fellowship for performing itinerate surgery". United States Department of Human Services, Office of Inspector General report (1988).

"The American College of Surgeons has long condemned the practice of "itinerant surgery," where doctors operate on patients and leave follow-up care to a family physician. But it has refrained from issuing guidelines on locum tenens. Paul Collicott, a director of the ACS, says it's "a necessary part of surgical practice today," given the overall shortage in the field. He says it's the responsibility of each temporary surgeon to make sure patients are handed off to another surgeon for postoperative care." - Wall Street Journal, January 13, 2009

"I pledge myself to pursue the practice of surgery with honesty and to place the welfare and rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position, and I will set my fees commensurate with the services rendered. I will take no part in any arrangement, such as fee splitting or **itinerant surgery**, which induces referral or treatment for reason other than the patient's best welfare". Portion of the Fellowship Pledge – American College of Surgeons, International Fellowship Requirements

ABORTION PROVIDERS CLAIM SIGNIFICANCE OF LEVEL OF CARE

Termination of pregnancy is not a benign medical procedure. In some cases, serious complications, even life-threatening ones, arise and necessitate optimal and evidence-based treatment.

According to John Thorp, Jr., an abortion provider who is the author of a leading abortion textbook and who is as well as a physician is a professor of obstetrics and gynecology at the University of North Carolina (Chapel Hill) School of Medicine:

"there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion."

W.M. Hern, in ABORTION PRACTICE 101 (1990):

"Serious complications can only be evaluated in full service hospitals and often occur after regular business hours. Given the frequency of short-term complications from abortion (2-10%), follow-up medical care is often needed on an urgent basis to treat infection, bleeding,

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p4

or organ damage. If recognized and attended to promptly, long-term consequences can be minimized. Often, though, abortion procedures are performed in freestanding clinics during weekday hours and complications are managed in urgent care centers or emergency departments after hours or on weekends.”

Dr. Thorp also asserts that:

“When the [abortion] provider is an ob-gyn and has admitting and treating privileges at a local hospital, he or she is more likely to effectively manage patient complications by providing continuity of care and decrease the likelihood of medical errors.”

Nationally, 73% of emergency departments report *inadequate* on-call coverage by specialist physicians, including obstetricians/gynecologists who are particularly difficult to secure. According to O’Malley, A., Draper, D. & Felland, L. in their publication *Hospital Emergency On-Call Coverage: Is There a Doctor in the House?*

AMERICAN COLLEGE OF SURGEONS

Code of Professional Conduct

II. RELATION OF THE SURGEON TO THE PATIENT

E. Postoperative Care

The responsibility for the patient's postoperative care rests primarily with the operating surgeon. The emergence of critical care specialists has provided important support in the management of patients with complicated systemic problems. It is important, however, that the operating surgeon maintain a critical role in directing the care of the patient. When the patient's postoperative course necessitates the involvement of other specialists, it may be necessary to transfer the primary responsibility for the patient's care to another physician. In such cases, the operating surgeon continues to be involved in the care of the patient until surgical issues have resolved. **Except in unusual circumstances, it is unethical for a surgeon to relinquish the responsibility for the postoperative surgical care to any other physician who is not qualified to provide similar surgical care.**

F. Continuity of Care of the Surgical Patient

The surgeon will ensure appropriate continuity of care of the surgical patient. An ethical surgeon should not perform elective surgery at a distance from the usual location where he or she operates without personal determination of the diagnosis and of the adequacy of preoperative preparation. Postoperative care should be rendered by the operating surgeon unless it is delegated to another physician who is as well qualified to continue this essential aspect of total surgical care.

It is recognized that for many operations performed in an ambulatory setting, the pattern of the patient's postoperative visits to the surgeon may vary considerably; it is, however, the

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p5

responsibility of the operating surgeon to establish communication to maintain proper continuity of care.

MEDICAL PRIVILEGES – HIGH LEVEL PEER REVIEW – BIG DEAL

An entire legal specialty field

William and Mary Law Review [Vol. 29:609

A hospital with a respected staff and a reputation for high-quality care will be attractive to skilled physicians, who want access to the broad patient base and desire the prestige of membership on the hospital staff.

Staff privileges are one of the most important assets of a physician's practice.

Although specific procedures for review of staff privilege applications may differ at various hospitals, some general similarities exist. Several groups within the hospital structure participate in the process of considering an application for privileges. The medical staff plays a significant role in that process by evaluating the professional capabilities of the applicant. The physicians on the hospital's credentialing committee investigate the applicant's background to determine the extent of his past medical training and performance, whether he is licensed and board certified, whether he carries malpractice insurance, and any other information that they believe is relevant. The committee may report to the staff as a whole, to its executive committee, or directly to the governing board. The board is responsible for making the final decision, although many boards may give great weight to the findings of the committee. If the decision is unfavorable to the physician, the hospital generally provides an internal procedure for appeal and review.

Burdensome V. Life-Impacting Consequences

Abortionist Dr. Thorp acknowledges that “[a]ll competent physicians endure the ‘burdensome’ nature of applying for hospital privileges for the safety and well-being of their patients.”

Dr. James Anderson, a board-certified emergency medicine physician who serves as clinical professor at the Medical College of Virginia, opines regarding requiring physicians associated with abortion clinics to have hospital privileges, “[i]s consistent with the time-honored practice of requiring training and credentialing of physicians who are making decisions and doing procedures that have life-impacting consequences. **If a physician cannot obtain privileges for the specific requested procedures at his or her local hospital, then in my expert opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact.**”

#5
p. 6

PHYSICIAN PRIVILEGES REQUIREMENT LEGISLATION IN OTHER STATES

From Guttmacher Institute

<http://www.guttmacher.org/statecenter/updates/index.html>

Abortion Clinic Regulation

Requiring All or Some Abortion Providers to Have Hospital Privileges

Click [here](#) for current status of state policy

Introduced in 10 states

Bill Status:

Passed at least one chamber in IN

Enacted in AZ, MS and TN

(ENACTED) ARIZONA: In April, Gov. Jan Brewer (R) signed an omnibus abortion measure, which includes a provision that requires a provider who performs a surgical abortion to have admitting privileges at a hospital within 30 miles of the abortion facility. Current law requires an abortion provider to have admitting privileges at a hospital in the state. The bill, which also includes provisions on clinic regulations, limits on abortion at a specific gestational age, ultrasound, medication abortion and abortion counseling, goes into effect later this year.

INDIANA: In February, the Senate passed a measure that would require all medication abortion providers to have hospital privileges at a hospital that is in the same county as the abortion clinic or in an adjacent county to handle complications from an abortion. The bill also contains provisions on abortion counseling and medication abortion. No further action is expected since the legislature has adjourned its regular session.

MISSISSIPPI: In July, a U.S. district court judge allowed enforcement of a law that requires any abortion provider associated with an abortion facility to have admitting privileges at a local hospital. The law also requires abortion providers to be certified in obstetrics and gynecology or eligible for such certification. However, the judge ruled that Jackson Women's Health Organization, the only abortion clinic in the state, may not yet be penalized for "operating without the relevant privileges during the administrative process."

(ENACTED) TENNESSEE: In May, Gov. Bill Haslam (R) signed a measure that requires an abortion provider to have admitting privileges at a hospital located in the same county as the abortion facility or in an adjacent county. The new law goes into effect in July.

Constitutionality of Proposed SB 2305

This proposed law would likely prove to be of no unconstitutional purpose. As *Casey* held, a regulation serves a "valid purpose" if it is "not designed to strike at the right [to abortion] itself" and

#5
P7

further the State's "legitimate interests...in protecting the health of the woman and the life of the fetus that may become a child." 505 U.S. at 846.

Simopolous v. Virginia, 462 U.S. 506, 511 (1983) affirms that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient".

Simopoulos, 462 U.S. at 516 affirms that , "In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities".

Greenville Women's Clinic v. Bryant, 222 F.3d 157, 172 (4th Cir.2000), cert. denied, 531 U.S. 1191 (2001) ("*Greenville P*"), held that a "valid purpose" was served by a regulation requiring abortion clinics to be associated with a physician who has admitting privileges at a local hospital. *Gonzales, supra*, 550 U.S. at 163 ("The Court has given state and federal legislatures wide discretion in areas where there is medical and scientific uncertainty."); *id.*, at 157

Washington v. Glucksberg, 521 U.S. 702, 731 (1997) ("[t]here can be no doubt that the government 'has an interest in protecting the integrity and ethics of the medical profession'").

The Supreme Court has upheld health-related abortion-clinic rules that merely "may be helpful" and "can be useful." *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 80, 81 (1976).

Two federal circuit courts have expressly found that "admitting privileges at local hospitals and referral arrangements with local experts" are "so obviously beneficial to patients" undergoing abortions as to easily withstand a facial constitutional challenge alleging them to be undue burdens. *Greenville Women's Clinic v. Commissioner, South Carolina Dept. of Health* and 317 F.3d 357, 363 (4th Cir. 2002) ("*Greenville II*"); *Women's Health Ctr. of West County, Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989).

Accord Tucson Woman's Clinic v. Eden, 379 F.3d 531, 547 (9th Cir. 2004) (holding that Arizona statute requiring only abortionists who performed a certain number of abortions per month to obtain admitting privileges did not violate equal protection because it was rationally related to achieving a legitimate end).

#6

Hello, my name is Shantel Schmitt and I am a young Catholic who feels it is important to voice my opinion before these bills are voted on.

Abortion and the right to life have always pulled at my heart. It is a topic that I feel very strongly about and can make me quite upset. I am against abortion and believe human life should be protected from conception until natural death.

The human race is a strong population when we stick together. I believe a woman at certain points in her life can be stronger than anyone, but she can also be extremely fragile. Women need support from their family, friends, community, and state. In the past, women were respected and admired for their ability to not only carry a child in the safest place for their first nine months, but to also raise that child for another eighteen years or longer. Recently though, women are no longer admired for this beautiful gift of a human child that they bring into this world. Today, if a single or unmarried woman becomes pregnant, she feels as though she only has two options. The first option is that she can have the honor to give birth to this beautiful baby and have people frown upon her and be in disbelief at the fact that she would attempt to raise this child. It is extremely degrading to women that people think we are suddenly incapable of raising a child. We have been doing it for thousands of years. It is possible and even easier if the woman has the support of others. The state should be more supportive of organizations such as First Choice Clinic, which supports and educates women to help them make the right choice of giving birth to their child.

If women's rights are what we are concerned about, women deserve health care institutions that provide well rounded medical care & staff trained physicians who will be around in case a medical complication should arise.

With many things on the market today such as contraceptives, people believe that they are giving woman more power, but all they are doing is degrading her and taking away the most precious thing a woman does: take a major role in the beautiful miracle of life. God made

#6 p2

women this way and it is not our right or duty to stop that. When a woman has an abortion, we are killing the most important gift she can give to society. People don't really care about giving woman power; all they care about is taking their money. It has become an industry, and they are using women and innocent lives to make money.

Human life is a gift; it is not a choice or a right or a way to make money. More women would realize this if instead of being degraded and told we can't, we were supported and told we can. Abortion tells a woman, "You are not strong enough to handle this. You are not good enough." And if a woman believes this, she will start believing it in other aspects of her life, which will soon destroy her. Abortion not only kills the baby and stops a beating heart; it kills the woman's dignity, strength, and even a part of her very being.

3/13/2013

#7

Maria Wanchic District 35

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Bismarck ND 58501

255-3161 or 390-2377

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Testimony in favor of SB2303, 2305, 2368, 4009

Mr. Chairman and honorable members of the committee:

My name is Maria Wanchic and I've lived here in the Bismarck/Mandan area my whole life. I am honored to be here today testifying in support of Senate Bill 2303, 2305, 2368 and 4009. My testimony will last about 10 minutes.

I'd like to play a few short audio clips from the Roe vs Wade oral arguments. It's not my intention to construe the words of anyone in these clips but only to call attention to the number of times the question of the unborn as persons comes up. (you can listen to the entire audio clip at www.ovez.org)

(audio clip, tracks 1-7) [4]

Throughout the one hour of Roe vs. Wade oral arguments the question of personhood for the unborn is discussed over and over again. As Justice Potter Stewart says answering that question is "critical to this case". However, after the much anticipated ruling it was revealed that the Supreme Court would be silent on this critical question. In the final analysis, the Supreme Court contradicted itself, flipped a coin on the question of life and chose to make freedom of choice the law of the land completely wiping off the board decades of various state anti-abortion laws. [11]

Justices White and Rehnquist could not find a constitutional basis to allow for abortion on demand. Justice White wrote in his dissenting opinion:

"I find nothing in the language or history of the Constitution to support the Court's judgment. The Court simply fashions and announces a new constitutional right for pregnant women and, with scarcely any reason or authority for its action, invests that right with sufficient substance to override most existing state abortion statutes." [5]

In the Supreme Court's view state laws against abortion infringed upon the 14th amendment right to personal liberty. The court had twisted the concept of personal liberty to mean private choices. But private choices are limited when they adversely affect other people or even the individual person. This would be the case with abortion because it's a decision to end the life of another person. States restrict personal liberty all the time in the cases of suicide, drug use, smoking, underage drinking, seat belts, and speed limits. Personal liberty is trumped by the protection of human life. (see note A)

Later on in his career, Justice White made repeated attempts to overrule Roe vs Wade. In describing the right to abortion on demand he wrote,

"In so denominating that liberty, the Court engages not in constitutional interpretation, but in the unrestrained imposition of its own extraconstitutional value preferences." [6]

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p2

In other words, the Supreme Court fashioned this new so called right based on a the whim of the age and personal preference, not on the constitution or even on any prior court cases. [7]

The Ninth Amendment

Another argument for abortion on demand used the 9th amendment by stating that abortion was an unenumerated right (or a right not specifically spelled out in the constitution) retained by the American people. Under the meaning of the ninth amendment the state laws had already set the precedence that abortion was NOT a right retained by the American people. When the civil war ended in 1865, 26 out of 36 states had already banned abortion. [8] By the year 1900 every state had anti-abortion laws in place. [9] The people had spoken. The 1973 ruling nullified the strict anti-abortion laws of 20 states who defended the unborn for over a century. [10]

During the mid 1800's as medical research discovered that life begins at conception rather than at quickening (which is when the mother first feels the fetus move), it became a firm resolution in the minds of medical professionals that unborn life must be preserved and defended. [11] The American Medical Association in a declaratory statement presented to Congress in 1857 used strong language against the increasing practice of abortion on demand. I quote:

"...this body, representing, as it does, the physicians of the land, publicly express its abhorrence of the unnatural and now rapidly increasing crime of abortion; that it avow its true nature, as no simple offence against public morality and decency, no mere misdemeanor..." [12]

The Declaration of Independence

The Declaration of Independence, the foundation of the constitution, asserts that we are created equal, not born equal and nothing has to be done or accomplished to attain the right to life. Simply to be in existence is enough. **By condoning abortion on demand, the Supreme Court condoned the civil right (or privileged right guaranteed by a government) to take a human right (or God-given right bestowed by the Creator) away from those who can not speak for themselves. The right to be born is a human right.**

The 14th Amendment

The 14th amendment elaborates on the declaration's basis of human rights for persons. Mrs. Weddington, the attorney who argued the case against Texas in Roe vs. Wade admitted that if a fetus was a person with constitutional rights then she would have a very difficult case. She reasoned that fetus' have no protection under the 14th amendment because they are not yet born as citizens of the United States.

This reasoning assumes that because a person does not become a citizen until after birth that they have no rights guaranteed by the Constitution. However the framers of our constitution used both the words, citizen and person in the 14th amendment to describe who's life specifically is protected . You do not need to be a citizen to have your right to life protected. (see note B) Legal and even illegal immigrants to the US still have the same basic protection under the constitution. [13] If you are a person (born or unborn) and if you are within the borders of the US then your right to life specifically is protected by the 14th amendment.

#7
P3

An Appeal to Objective, (Self-evident) Truths

Over the last 20 years I have become grateful to those individuals who were pro-choice who were calm and respectful enough to have good dialogues. And what I've learned from those conversations is this: although there are many out there who believe abortion to be a right, when it comes down to it, the vast majority believe abortion to be a necessary wrong-doing or a necessary evil. I have heard over and over again a laundry list of social issues that make abortion on demand necessary in their eyes.

But this is my point: death should never ever be the answer to any social problem. Abortion on demand is not the way to deal with with unwanted human beings. When a society sees death as a solution to any issue then that society has lost it's wisdom and when a society raises death on a pedestal as a constitutional right, under the guise of personal liberty, indeed it has lost it's hope and when a people are pitted against their own future generation they are truly under some form of slavery.

George Washington said, liberty has an ordering to it. [14] We see this in the Declaration of Independence and the Constitution. Life is the first right mentioned, followed by liberty. Mr. Chairman, Committee Members, and fellow citizens, true freedom, true liberty, begins inside the heart of a person who chooses responsible citizenship which keeps the common good in mind and does not raise individual free will up as the highest moral good. Many in our current culture think free will is equal to freedom. Free will is only a tool that can be used for good and evil. A very very powerful tool that carries with it an awesome responsibility to act in truth and self-sacrifice. I think most North Dakota's understand this concept.

Through these pro-life bills we have a momentous opportunity to raise the dignity of the unborn to persons in North Dakota. We can become the first state in the nation to reclaim our true pro-life heritage. Although these bills are big step forward to ending abortion we also need to (both publicly and privately) always encourage an environment that supports family, community and personal responsibility.

Lastly I'd like to make an appeal to the same God that our founders constantly referred to. John Adams said,

"You have rights antecedent to all earthly governments; rights that cannot be repealed or restrained by human laws; rights derived from the Great Legislator of the Universe."

The right to life is a human right which surpasses all jurisdictions and national boundaries. It is given by God himself. It is our very soul, bequeathed by the Creator, that raises the dignity of life to that of God himself. It is this sacred gift which warrants the right to live and experience life on earth. It is a God-given right for each and every human being to be born into this world and to live out their own unique story within it.

I ask you once again to vote a DO PASS on these historic bills. Thank you for your time and attention.

Notes

A. In the case of assisted suicide personal liberty has been given a higher status then protecting life. Only three states allow assisted suicide: Washington, Oregon, Montana. I also believe this to be unconstitutional.

B. The rights protected by the constitution of foreign nationals have been abused in my opinion since the attacks of 9/11. In the pre-9/11 days immigrants were given much more freedom then they do now.

References

[1] <http://www.onelook.com/> "person"

#7
p4

[2] <http://www.onelook.com/> "human being"

[3] <http://www.princeton.edu/~prolife/articles/embryoquotes2.html>

[4] http://www.oyez.org/cases/1970-1979/1971/1971_70_18#reargument

Track 1:

Justice Byron R. White: Well, what if-- would you lose your case if the fetus was a person?

Track 2:

Ms Weddington: If the state could show that the fetus was a person under the Fourteenth Amendment or under some other amendment or part of the constitution, then you would have the situation of trying-- you would have a state compelling interest which, in some instances, can outweigh a fundamental right.

Track 3:

Justice Harry A. Blackmun: Well, do I get from this then that your case depends primarily on the proposition that the fetus has no constitutional rights?

Track 4:

Justice Potter Stewart: ... if you're correct in your basic submission that an unborn fetus is a person, then abortion law such as that which New York has is grossly unconstitutional, isn't it?

Mr. Flowers: That's right.

Yes, sir.

Justice Potter Stewart: Allowing the killing of people.

Mr. Flowers: Yes, sir.

Justice Potter Stewart: Of persons.

Track 5:

Justice Potter Stewart: Well, if it were established that an unborn fetus is a person within the protection of the Fourteenth Amendment, you would have almost an impossible case here, would you not?

Ms Weddington: I would have a very difficult case. [Laughter]

Justice Potter Stewart: You certainly would because you'd have the same kind of thing you'd have to say that this would be the equivalent to after the child was born.

Ms Weddington: That's right.

Justice Potter Stewart: If the mother thought that it bothered her health having the child around, she could have it killed.

Isn't that correct?

Ms Weddington: That's correct.

Track 6:

Justice Potter Stewart: How should we-- how should that question be decided?

Is it a legal question, a constitutional question, a medical question, a philosophical question, a religious question, what is it?

Track 7:

Justice Potter Stewart: And the basic constitutional question initially is whether or not an unborn fetus is a person, isn't it?

#7
P5

Mr. Flowers: Yes, and entirely to the constitutional perspective.

Justice Potter Stewart: It's critical to this case, is it not?

Mr. Flowers: Yes, sir, it is...

[5] Wikipedia "Roe v. Wade", http://en.wikipedia.org/wiki/Roe_vs._Wade

[6] <http://www.endroe.org/dissentswhite.aspx>

And again, the fact that many men and women of good will and high commitment to constitutional government place themselves on both sides of the abortion controversy strengthens my own conviction that the values animating the Constitution do not compel recognition of the abortion liberty as fundamental. In so denominating that liberty, the Court engages not in constitutional interpretation, but in the unrestrained imposition of its own extraconstitutional value preferences.

[7] http://scholar.google.com/scholar_case?case=7628572659420117309&hl=en&as_sdt=2&as_vis=1&oi=scholar

[8] https://bearspace.baylor.edu/Francis_Beckwith/www/Sites/RoeLiberty.pdf (pg. 52)

[9] http://en.wikipedia.org/wiki/Abortion_in_the_United_States

[10] <http://supreme.justia.com/cases/federal/us/410/113/case.html> (see footnote 3/2)

[10] <http://supreme.justia.com/cases/federal/us/410/113/case.html> (see footnote 3/2)

[11, 12] www.ama-assn.org, click on About AMA, click on Our History, click on AMA Digital Collection, The Transactions of the American Medical Association, Author: American Medical Association, Publication Date: 1859, Page 76

[13] <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1302&context=facpub>

For more than a century, the Court has recognized that the Equal Protection Clause is "universal in [its] application, to all persons within the territorial jurisdiction, without regard to differences of ... nationality." The Court has repeatedly stated that "the Due Process Clause applies to all 'persons' within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent."

[14] <http://www.acton.org/pub/religion-liberty/volume-8-number-5/renewing-our-experiment-ordered-liberty>

The Founding Fathers, he noted, "asserted their claim to freedom and independence on the basis of certain 'self-evident' truths about the human person: truths which could be discerned in human nature, built into it by 'nature's God.' Thus, they meant to bring into being, not just an independent territory but a great experiment in what George Washington called 'ordered liberty': an experiment in which men and women would enjoy equality of rights and opportunities in the pursuit of happiness and in service to the common good."

#8

1210 First Street NW

Mandan, ND 58554

I would like to introduce you to our family. Our three children and grandson were all adopted as infants. I have enclosed a photo of our family so you can meet us as I inform you of their importance and contributions to our family and society.

Todd is a Bachelor of Science in Mathematics graduate from Minot State University, and Master's of Mathematics graduate from the University of Texas. Todd is head of the math department at LaJoya High School, and is the coach of the LaJoya Math Team, winning several state awards with his students. He has taught at McAllen Community College; he is active in mentoring teachers through a state program, works nationwide with ACT testing, is a facilitator of Texas Instruments workshops and is working on a math video series for the Texas schools. Todd and his wife Mayra are the proud parents of Angela and their adopted son Jacob.

Scott has his Certifications in Process Plant Technology and Welding from Bismarck State College. Scott worked as a welder at Bobcat for over twenty years until the plant closed. He then worked at Coal Creek Power Plant as a temporary employee. Two years ago he was hired by Burlington Northern Santa Fe as a conductor. Scott's work ethic has earned him the respect of his coworkers and supervisors. He is on the Mandan to Dilworth or Mandan to Glendive routes, making several runs weekly. Scott decided to stay in North Dakota and enjoy our way of life, which includes great Walleye fishing and hunting.

Kelly graduated from the University of Mary, with a Bachelor of Science in Business Administration and Computers, and University of North Texas with her Masters in Library Administration. Kelly has struggled with health problems her entire life, beginning with Juvenile Rheumatoid Arthritis in infancy. This has impacted her with severe mobility limitation. Getting the Mandan Public Schools to admit her was a challenge; the Administration preferred to shuttle her off to the Jamestown Crippled Childrens' School! This was not acceptable for our family; we insisted that Kelly's right to an education was in Mandan! Kelly was the first physically handicapped student to be able to complete all her education in Mandan. The Junior High did not have an elevator, but many levels of stairs; she had to be carried up and downstairs by staff and sometimes by friends! After Kelly was gone, the elevator was installed at the Junior High. By the second semester of her freshman year of high school, the elevator was also operational there. These elevators, reluctantly installed, only at the insistence of Kelly's parents, have been a blessing to disabled students, faculty, and custodians! While in high school, Kelly started working at the Mandan Library. Immediately upon her graduation from the University of Mary, she was hired as Assistant Director. Kelly was instrumental in the move to the new library site, the old Railroad Freight Depot. Kelly was then promoted to Director. As Director, she worked with the city of Mandan and Morton County, for the merger of the two libraries, into the Morton Mandan Library. Kelly has also been active as the Legislative representative for the North Dakota Library Association, and Central Dakota Library Network.

Jacob, our five year old grandson, was adopted in Monterrey, Mexico. He is an adorable little guy, who loves kindergarten. We shudder to think of what kind of life he would have faced as a street urchin in Mexico.....

My view on abortion is greatly influenced by our adopted family. We have four dearly loved family members who could have been killed before birth, because of their inconvenience. Our children are extremely productive adults, a blessing to our state and nation. And, Jacob will be following right along in their footsteps!

Sincerely,

Helen Steckler

