No. _____

# In The
# Supreme Court of the United States

WAYNE STENEHJEM, in his official capacity as Attorney General for the State of North Dakota, *et al.*,

*Petitioners,*

v.

MKB MANAGEMENT CORP., doing business as Red River Women's Clinic; KATHRYN L. EGGLESTON, M.D.,

*Respondents.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit**

## PETITION FOR WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

At issue is the constitutionality of House Bill 1456, codified at N.D.C.C. §§ 14-02.1-05.1 and 14-02.1-05.2, prohibiting an abortion, other than to save the life of the mother or another unborn child, after the unborn child possesses a detectable heartbeat.

The petitioners present two questions:

1. Whether this Court should reevaluate its abortion jurisprudence in light of extensive evidence in the record of 1) new scientific advances on viability, 2) increasing evidence of the devastating physical and psychological consequences of abortion, and 3) society's willingness to remove from pregnant women the burden of child care for every unwanted child, and uphold the constitutionality of North Dakota's law restricting abortion where there is a detectable human heartbeat?

2. Is the liberty interest in a woman's freedom to terminate a pregnancy recognized in *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), but merely assumed in *Gonzales v. Carhart*, 550 U.S. 124 (2007), adequately protected by North Dakota's removal of the burden of caring for an unwanted child, thus allowing society to protect the right to human life by restricting abortion after the unborn child has a detectable heartbeat, and protecting women from the devastating physical and psychological injuries of abortion?

## PARTIES TO THE PROCEEDING

**Petitioners:** Wayne Stenehjem, in his official capacity as Attorney General for the State of North Dakota; and Larry Johnson, M.D.; Robert Tanous, D.O.; Kate Larson, P.A.C.; Norman Byers, M.D.; Cory Miller, M.D.; Kayleen Wardner; Gaylord Kavlie, M.D.; Kent Martin, M.D.; Kent Hoerauf, M.D.; Burt Riskedahl; Jonathan Haug, M.D.; Genevieve Goven, M.D.; and Robert J. Olson, M.D., in their official capacities as members of the North Dakota Board of Medical Examiners, were defendants in the District Court and appellants in the Court of Appeals.

**Respondents:** MKB Management Corp., d/b/a Red River Women's Clinic; and Kathryn L. Eggelston, M.D., were plaintiffs in the District Court and appellees in the Court of Appeals.

**Other Parties:** Birch Burdick, in his official capacity as State's Attorney for Cass County, North Dakota was a defendant in the District Court.

## RELATED CASES

The questions presented in this petition may be related to the following cases currently pending before the Court:

1. **No. 15-448:** *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015) (regulation of abortion beginning 12 weeks after gestation, where the heartbeat of the unborn child is detected).

2. **No. 14-997:** *Jackson Women's Health Org., et al. v. Currier, et al.*, 760 F.3d 448 (5th Cir. 2014) (regulation of abortion at all stages of pregnancy).

3. **No. 15-274:** *Whole Woman's Health, et al. v. Cole, et al*., 790 F.3d 563 (5th Cir. 2015) (regulation of abortion at all stages of pregnancy).

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## PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully petition for a writ of certiorari to review the decision of the United States Court of Appeals for the Eighth Circuit holding unconstitutional North Dakota's law prohibiting abortions, other than to save the life of the mother or another unborn child, after detection of an unborn child's heartbeat.

## OPINIONS BELOW

The Eighth Circuit's opinion is reported at 795 F.3d 768. Pet.App.1a-18a. The District Court's opinion ordering summary judgment for the plaintiffs, and granting their requested declaratory and injunctive relief, is reported at 16 F.Supp.3d 1059. Pet.App.19a-57a. The District Court's preliminary injunction is reported at 954 F.Supp.2d 900.

## STATEMENT OF JURISDICTION

The Eighth Circuit's judgment was entered July 22, 2015. District Court Doc. 123. A timely request for an extension was granted by Justice Alito, extending the time in which to file this petition until November 30, 2015. This Court has jurisdiction under 28 U.S.C. § 1254(1). The Court of Appeals had jurisdiction under 28 U.S.C. § 1291, and jurisdiction

in the District Court was invoked under 28 U.S.C. §§ 1331, 1343(a)(3), and 1343(a)(4).

## PERTINENT CONSTITUTIONAL AND STATUTORY PROVISIONS

The relevant constitutional and statutory provisions are set forth in Pet.App.58a-64a. They are: U.S. CONST. Amend. XIV, § 1; North Dakota House Bill 1456 as codified at North Dakota Century Code ("N.D.C.C.") Chapter 14-02.1 (more specifically, N.D.C.C. § 14-02.1-05.2); and North Dakota's Safe Haven law found at N.D.C.C §§ 27-20-02, 50-25.1-15.

## STATEMENT OF THE CASE

Following receipt of testimony and evidence of physical and emotional harm to women from abortion, the 2013 North Dakota legislature, with bipartisan support, enacted House Bill ("HB") 1456, codified at N.D.C.C. §§ 14-02.1-05.1 and 14-02.1-05.2, prohibiting an abortion, other than to save the life of the mother or another unborn child, after the point in pregnancy when the unborn child possesses a detectable heartbeat.[1] Pet.App.59a-61a.

[1] The legislative history to HB 1456 was filed with the district court and is found at APP-45-116. "APP" refers to the record below, on file with the Court of Appeals.

Respondents, abortion providers in Fargo, North Dakota, sued petitioners alleging, *inter alia*, that HB 1456 violated the substantive due process rights of their patients and equal protection guaranteed by the Fourteenth Amendment of the United States Constitution. APP-25-44. Respondents were granted a preliminary injunction preventing HB 1456 from taking effect. Respondents then brought a summary judgment motion seeking a permanent injunction enjoining HB 1456.

In attacking the constitutionality of HB 1456 respondents alleged as the "critical material fact" that HB 1456 prevents abortions before viability, which respondents asserted typically occurs around twenty-four weeks of pregnancy. APP-215, ¶ 6. APP-208, ¶ 11. Respondents asserted that if HB 1456 were upheld, it would prevent approximately 89% of pre-viability abortions from taking place in North Dakota, thus placing an undue burden on women from obtaining pre-viability abortions. APP-30, ¶ 29.

Petitioners presented a two-pronged defense of HB 1456.

First, petitioners presented expert medical evidence from Dr. Jerry M. Obritsch,[2] establishing that

[2] Dr. Obritsch is certified by the American Board in Obstetrics and Gynecology, licensed to practice Medicine in North Dakota, South Dakota, and Missouri, and has practiced Obstetrics and Gynecology in North Dakota continuously since 1991. Dr. Obritsch earned Bachelor's degrees in Biology and Chemistry from Dickinson State University, Dickinson, ND, in 1979; a

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viability of an unborn child begins at conception; hence, HB 1456 is a constitutional regulation of abortion by North Dakota under current Supreme Court abortion jurisprudence.

Second, petitioners presented substantial evidence that the legal and factual underpinnings of *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) are now invalid and should be abandoned. Petitioners submitted hundreds of affidavits and declarations from women who were harmed by their abortions. *See* Exhibits B-1 and B-2 to declaration of Dr. Shuping, APP-655-887, as well as affidavits and declarations attached to affidavit of Allan E. Parker, APP-1067-1560. In addition, petitioners presented testimony from experts in women's health (Priscilla K. Coleman, Ph.D.,[3] Martha

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Master of Science degree in Microbiology from the University of Nebraska, Lincoln, NE, in 1980; and completed his Medical Doctor (M.D.) degree at the University of North Dakota School of Medicine and Health. Dr. Obritsch is Vice Chairman and Clinical Professor in the School of Medicine, University of North Dakota School of Medicine and Health Sciences, a Fellow in the American Congress of Obstetricians and Gynecologists (ACOG), the Nation's leading organization in women's health care, and a member of the North Dakota Society of Obstetricians and Gynecologists. Pet.App.80a-81a.

[3] Dr. Coleman is a developmental psychologist and a Professor of Human Development and Family Studies at Bowling Green State University in Ohio. She has a B.A. in psychology, an M.A. in general psychology and a Ph.D. in life-span developmental psychology. Dr. Coleman has published over 50 peer-reviewed scientific articles, of which 37 are on the psychology of abortion. Based on her expertise, having published more peer-reviewed

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W. Shuping, M.D.,[4] and John Thorp, Jr., M.D., M.H.S.[5]) regarding the growing body of scientific and

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studies on abortion and mental health than any other researcher in the world, Dr. Coleman is often called upon to serve as a content expert in state and civil cases involving abortion. Dr. Coleman currently serves on the editorial boards of five international psychology and medicine journals. *See* APP-370-478 for Dr. Coleman's declaration.

[4] Dr. Shuping is a medical doctor specializing in psychiatry licensed to practice in the State of North Carolina. She graduated from the Wake Forest University School of Medicine with an M.D. degree in 1984, and completed psychiatry residency at the Wake Forest University Baptist Medical Center in 1988. *See* APP-479-949 for Dr. Shuping's declaration.

[5] Dr. Thorp received his M.D. degree from East Carolina University Medical School in 1983. Since 1991, he has been a board-certified obstetrician/gynecologist. Since 1992 he has had a certification in the sub-specialty of maternal-fetal medicine. He is a Fellow of the American Gynecological and Obstetrics Society and a member of the American College of Obstetricians and Gynecologists. Dr. Thorp is a Hugh McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina (Chapel Hill) School of Medicine. He is also a Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. Dr. Thorp teaches both medical students and residents in Obstetrics and Gynecology. Until recently, Dr. Thorp had administrative oversight of the Family Planning Fellowship and Residency training programs at UNC. He is also the Deputy Director of the Center for Women's Health Research, at the University of North Carolina School of Medicine and School of Public Health (Department of Obstetrics and Gynecology and Department of Epidemiology, respectively). Dr. Thorp is Vice-Chair for Research and Division Director of Women's Primary Healthcare, University of North Carolina School of Medicine. Dr. Thorp is a Fellow of the Carolina Population Center and has been the Director of the Biomedical Core of the Carolina Population Center of the University of North Carolina

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medical evidence of the significant physical and psychological harm caused to women by abortion.

The District Court rejected Dr. Obritsch's definition of viability as being different than the one used by the Court in *Roe* and *Casey*. Pet.App.51a. The District Court failed to comment on the extensive evidence presented by North Dakota showing the physical and psychological harm to women from abortion. Rather, the court observed: "[t]he controversy over a woman's right to choose to have an abortion will never end. The issue is undoubtedly one of the most divisive of social issues. The United States Supreme Court will eventually weigh in on this emotionally-fraught issue but, until that occurs, this Court is obligated to uphold existing Supreme Court precedent." Pet.App.56a.

North Dakota appealed the District Court's decision to the Eighth Circuit Court of Appeals. Like the District Court, the Court of Appeals rejected Dr. Obritsch's definition of viability as being inconsistent with the definition of this Court. Pet.App.10a. Regarding North Dakota's argument that *Roe* and *Casey*

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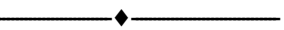
at Chapel Hill since 2003. Dr. Thorp has authored 21 book chapters and served as a journal referee (reviewer) for 39 different medical journals, including *The New England Journal of Medicine*, *Mayo Clinic Proceedings, Obstetrics & Gynecology*, and the *American Journal of Obstetrics and Gynecology.* Dr. Thorp is currently the deputy editor-in-chief of the *British Journal of Obstetrics & Gynecology*, an international journal which is considered one of the most prestigious in his field. Pet.App.102a-144a. APP-950-1044.

should no longer be followed, the Court of Appeals stated: "[a]lthough controlling Supreme Court precedent dictates the outcome in this case, good reasons exist for the Court to reevaluate its jurisprudence." Pet.App.11a.



## REASONS FOR GRANTING CERTIORARI

### I. Certiorari is warranted because the viability standard of *Roe* and *Casey* fails to account for advancements in medical science establishing that an unborn child is viable from conception.

When this Court decided *Roe v. Wade* in 1973, it announced that "the judiciary, at [that] point in the development of man's knowledge, [was] not in a position to speculate as to the answer" to "the difficult question of when life begins." *Roe*, 410 U.S., at 159. Whether or not the Court's caution was warranted at the time, more recent scientific advances in the fields of fetal development, neurobiology, perinatology, and human genetics have demonstrated beyond peradventure that the "unborn child," using this Court's language in *Gonzales*, 550 U.S., at 134, 160, is a unique human being from the moment of his or her conception, not merely from the moment of "viability" outside the womb. An unborn child is a human person, and as this Court recognized in *Gonzales*, it is now "uncontested" that an unborn child "is a living organism while within the womb, whether or not it is viable outside the womb." 550 U.S., at 147. An unborn

child is entitled to "respect for the dignity of [its] human life." *Id*., at 157.

The viability line that developed out of *Roe* and its progeny was always, as Justice O'Connor recognized, "on a collision course with itself"[6] because it failed to give full credence to the fact "that the State's interest in protecting potential human life exists throughout the pregnancy." *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 458, 461 (1983) (O'Connor, J., dissenting).

In addition to announcing that it was in no position to speculate as to when life began, the Court in *Roe* went on to state (again based upon the state of medical science at that time) "that **conception** is a 'process' over time, rather than an event." *Roe*, 410 U.S., at 161 (emphasis added). In the 42 years since *Roe* was decided, and based upon the substantial uncontested evidence presented by North Dakota in

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[6] As observed in Justice O'Connor's dissenting opinion in *City of Akron v. Center for Reproductive Health, Inc*., 462 U.S. 416, 457-458 (1983) "[W]e recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability, and we preserved the flexibility of the term. *Danforth*, *supra*, 428 U.S., at 64, 96 S.Ct., at 2838-2839. The *Roe* framework, then, is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception."

this case, it can no longer be denied that human life begins at conception.

As testified by Dr. Obritsch in his Declaration (Pet.App.83a), "Human development is a continuous process that begins (being conception) when an oocyte (ovum) from a female is fertilized by a sperm (spermatozoon) from a male. Moore, et al., *The Developing Human 9E,* Clinically Oriented Embryology, 9th edition, 2013, Chapter 1, *Introduction to the Developing Human*, page 1."[7]

Thus, when the Court in *Roe v. Wade* said that conception is a process over time, the Court was incorrect. Rather, it is human development that is a process over time. Conception takes place as a singular event, at a specific time, and is complete at that moment. Thereafter, human development occurs and continues until the heart stops beating (one of the long used measurements of death). Indeed, one can look at a newly delivered infant, and compare it to what that infant will be like 5 years later, 10 years later, 20 years later, and so forth until death, and one can see the process of that continued human

[7] "[T]he life of a new human being commences at a scientifically well-defined event; the fusion of the plasma membranes of sperm and egg. This conclusion is not a matter of religious belief or societal convention; it is a matter of objective, scientific observation." Maureen L. Condic, Ph.D., *When Does Human Life Begin? The Scientific Evidence and Terminology Revisited*, University of St. Thomas Journal of Law & Public Policy, Vol. VIII, No. 1, page 44 (June 2014).

development all put in motion by the singular event of conception.

Concluding that an unborn child is viable from the point of conception, North Dakota's expert, Dr. Obritsch, testified:

> (i) At the moment of conception, an unborn child has a unique set of DNA that never previously existed in the history of the world. Also, the hair and eye color, along with facial features are established at conception.
>
> (ii) By 22 days after conception, the unborn child's heart was already beating and for some, with a different blood type than the unborn child's mother.
>
> (iii) At 6 weeks after conception, an unborn child has brain function because the unborn child has detectable brain waves. Neurological development of the unborn child begins as early as the fourth week of development. The processes involved in the formation of the neural plate and neural folds and closure of the folds to form the neural tube constitute neurulation. Neurulation is completed by the end of the fourth week. Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 4, Third Week Of Human Development, page 61. Neurological development not only involves the development of the central nervous system (brain and spinal cord), but the peripheral nervous system as well (sensory and motor (muscle)).

> (iv) By the 8th week of development, the unborn child experiences pain in any capacity. (Testimony of Maureen L. Condic, Ph.D., University of Utah, School of Medicine, Department of Neurobiology and Anatomy, before the Subcommittee on the Constitution and Civil Justice, Committee on the Judiciary, U.S. House of Representatives, May 23, 2013 (judiciary.house.gov/hearings/113th/05232013/Condic%2005232013.pdf).[8] Therefore, by the 8th week of development, at the latest, the unborn child has brain function.
>
> (v) Further, by 8 weeks after conception, every major organ of the unborn child is in place.

Pet.App.92a-93a. Dr. Obritsch went on to note that:

> Viability in Obstetrics and Human Reproduction has vastly changed over the past decades. Viability was once thought to mean or be defined as only the ability of the unborn child to survive outside the uterus, albeit under the sophisticated care of the Neonatologist in the highly complex medical environment of the Neonatal Intensive Care unit (NICU). In modern and current medical and clinical practice, the embryo is able to survive as a human being independently at conception. This occurred for the first time in

[8] This web address is incorrect. The correct web address for the congressional testimony cited by Dr. Obritsch is: http://judiciary.house.gov/_files/hearings/113th/05232013/Condic%2005232013.pdf.

> 1978 with the successful birth of Louise Brown and was known as the "test tube baby." Dr. Robert G. Edwards, the physiologist who developed the technology to successfully achieve this goal, was awarded the Nobel Prize in Medicine in 2010. Today in vitro fertilization (IVF) is commonly practiced and actually, Reproductive Endocrinology and Infertility (REI) has evolved into a well recognized subspecialty of the field of Obstetrics and Gynecology. It is my medical opinion that the development of Reproductive Technology has caused and allowed an embryonic unborn child to live outside the human uterus (womb) for 2-6 days after conception – which is viability as defined by the United States Supreme Court and in the North Dakota statutes because this embryonic unborn child is not just potentially but is in fact living outside the woman's womb, albeit through artificial means.

Pet.App.89a-90a.

Dr. Obritsch further supported his opinion with Dr. Alexander Tsiaras' "*Conception to Birth – visualized,*" attached as Exhibit B to Dr. Obritsch's Declaration. APP-331 at ¶ 19, APP-369 [*see* http://www.ted.com/talks/alexander_tsiaras_conception_to_birth_visualized?language=en].

Dr. Obritsch noted that once a heartbeat is detected in an unborn child within the womb, there exists a medically recognized 98% rate of survival and live birth, and this medically recognized rate of

survival and live birth drops slightly to 82% when the woman has a history of recurrent pregnancy loss (being three or more consecutive spontaneous losses of an unborn child). Pet.App.90a. *See* "*Predictive value of the presence of an embryonic heartbeat for live birth: comparison of women with and without recurrent pregnancy loss.*" Hyer, et al., Sterility and Fertility, vol. 82, no. 5, November, 2004. APP-118-122.

While the Court of Appeals rejected Dr. Obritsch's definition of viability as being inconsistent with the definition of this Court, the Court of Appeals went on to state that "good reasons exist for the Court to reevaluate its jurisprudence":

> To begin, the Court's viability standard has proven unsatisfactory because it gives too little consideration to the "substantial state interest in potential life throughout pregnancy." *Casey*, 505 U.S., at 876 (plurality opinion). By deeming viability "the point at which the balance of interests tips," *id.* at 861, the Court has tied a state's interest in unborn children to developments in obstetrics, not to developments in the unborn. This leads to troubling consequences for states seeking to protect unborn children. For example, although "states in the 1970s lacked the power to ban an abortion of a 24-week-old-fetus because that fetus would not have satisfied the viability standard of that time, [t]oday . . . that same fetus would be considered viable, and states would have the power to restrict [such] abortions." *Edwards*, 786 F.3d at 1118 (final alteration in original)

> (citation and internal quotation marks omitted). How it is consistent with a state's interest in protecting unborn children that the same fetus would be deserving of state protection in one year but undeserving of state protection in another is not clear. The Supreme Court has posited there are "logical and biological justifications" for choosing viability as the critical point. *Roe*, 410 U.S. at 163. But this choice is better left to the states, which might find their interest in protecting unborn children better served by a more consistent and certain marker than viability. Here, the North Dakota legislature has determined that the critical point for asserting its interest in potential life is the point at which an unborn child possesses a detectable heartbeat. "To substitute its own preference to that of the legislature in this area is *not* the proper role of a court." *Edwards*, 786 F.3d at 1119 [emphasis in original].

Pet.App.11a-13a.

Rather than establishing viability as a random moving target, on a "collision course with itself," dependent, for each unborn child, upon the state of medical science at any given time, and at any given hospital (some having neonatal units and others not), Dr. Obritsch's definition of viability commencing at conception is consistent with modern medical science

and is a bright line from which states can and should be allowed to prohibit abortions.[9]

As noted by the Court of Appeals, by merely "assuming" rather than "affirming" the holdings of *Roe* and *Casey*, this Court in *Gonzales v. Carhart* may have signaled a willingness to reevaluate its abortion jurisprudence. Pet.App.8a. Moreover, as Justice Ginsburg expressly acknowledged in her dissent, *Gonzales* "blur[red] the line" between "previability and postviability abortions." *Gonzales*, 550 U.S., at 171, 186 (Ginsburg, J., dissenting).[10]

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[9] "Yet both viability and higher neural function are fundamentally arbitrary. While the age of a fetus clearly affects the ability to survive following preterm birth, [footnote omitted] survival also depends on a large number of factors that have nothing to do with the fetus itself, including the sophistication, proximity and affordability of neonatal intensive care facilities. [footnote omitted] Consequently, linking human rights to "viability" provides an almost purely technological definition of who is and who is not the subject of basic human rights. Moreover, this definition fundamentally discriminates against those members of the human species who happen to be born in rural areas or in families without generous medical insurance policies. [footnote omitted] While it is unfortunate that all infants do not have equal access to sophisticated medical care, this can hardly be the basis for determining who is a human person and who is not." Maureen L. Condic, Ph.D., *When Does Human Life Begin? The Scientific Evidence and Terminology Revisited*, University of St. Thomas Journal of Law & Public Policy, Vol. VIII, No. 1, page 71 (June 2014).

[10] Legal scholars have agreed with this assessment. *See, e.g.*, Khiara M. Bridges, *Capturing the Judiciary: Carhart and the Undue Burden Standard*, 67 Wash. & Lee L. Rev. 915, 941 (2010) ("the majority [in *Gonzales*] asserts the insignificance of

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*Roe* has never enjoyed wide support among the American public, and even today, 42 years after this Court created a constitutional right to abortion, *Roe* conflicts with prevailing public opinion.[11] Scholarship has been no less harsh in its reception of *Roe*. The decision has frequently been criticized by scholars and commentators, including those who favor legalized abortion.[12]

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viability. . . . As such, Carhart can be read to eliminate the significance of viability as a marker, and therefore eliminate the significance of the distinction between the pre-viable and post-viable stages of pregnancy"); Randy Beck, *Gonzales, Casey, and the Viability Rule*, 103 Nw. U. L. Rev. 249, 253, 276 n.152 (2009) (noting that the *Gonzales* decision, which merely "assumed" the continued application of the viability rule, "undermines *Casey's* attempted defense of the viability rule"); *cf.*, *e.g.*, John Hart Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L.J. 920, 924 (1973) (describing *Roe's* defense of the viability line as "simply not adequate"; "mistak[ing] a definition for a syllogism"); Mark Tushnet, *Two Notes on the Jurisprudence of Privacy*, 8 Const. Comment. 75, 83 (1991) (describing *Roe's* viability line as "entirely perverse").

[11] *See*, for example, a recent CNN poll showing a majority of those surveyed were of the opinion that abortion should be illegal under most circumstances: http://www.cnn.com/2015/09/14/politics/abortion-poll-cnn-orc/index.html.

[12] Among the extensive literature, *see, e.g.*, Laurence H. Tribe, *Toward a Model of Roles in the Due Process of Life and Law*, 87 Harv. L. Rev. 1, 7 (1973) ("One of the most curious things about *Roe* is that, behind its own verbal smokescreen, the substantive judgment on which it rests is nowhere to be found"); John Hart Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L.J. 920, 947 (1973) (*Roe* is a "very bad decision" because "it is bad constitutional law, or rather because it is not constitutional law and gives almost no sense of an obligation to

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Unlike other landmark decisions of this Court, such as *Brown v. Board of Education*, 347 U.S. 483 (1954), *Roe* has never gained wide acceptance; and opposition to the decision has only solidified and intensified as time has passed. Perhaps the best evidence of this is that political majorities across the Nation continue to regulate and, to the extent permitted by this Court, restrict abortion. *See*, Guttmacher Institute, *State Policies in Brief, An Overview of Abortion Laws*,[13] as of October 1, 2015:

- ***Physician and Hospital Requirements*:** 38 states require an abortion to be performed by a licensed physician, 21 states require an abortion to be performed in a hospital after a specified point in pregnancy, and 18 states require the involvement of a second physician after a specified point.
- ***Gestational Limits:*** 43 states prohibit abortions after a specified point during the pregnancy, except when necessary to preserve and protect the life or health of the mother.
- ***"Partial-Birth" Abortion:*** 19 states prohibit "partial-birth" abortions, and the prohibitions in 16 of the 19 states apply to both pre-viability and post-viability abortions.

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try to be"); Benjamin Wittes, *Letting Go of Roe*, Atlantic Monthly 48 (Jan./Feb. 2005) ("Since its inception *Roe* has had a deep legitimacy problem, stemming from its weakness as a legal opinion").

[13] http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

- ***Public Funding:*** 32 states prohibit the use of state funds for medically necessary abortions for Medicaid enrollees in the state except where federal funds are available (where the women's life is in danger or the pregnancy is the result of rape or incest).
- ***Coverage by Private Insurance:*** 11 states restrict coverage of abortion in private insurance plans.
- ***Refusal:*** 45 states allow individual health care providers to refuse to participate in an abortion. 42 states allow individual institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions.
- ***State-Mandated Counseling:*** 17 states mandate that women be given counseling before an abortion that includes information on at least one of the following: the link between abortion and breast cancer (5 states), the ability of a child-in-the-womb to feel pain (12 states), and long-term mental health consequences for the women (7 states).
- ***Waiting Periods:*** 28 states require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between the time she receives counseling and the time the procedure is performed.
- ***Parental Involvement:*** 38 states require some type of parental involvement in a minor's decision to have an abortion. 25 states require one or both parents to consent to the

> procedure, while 13 require that one or both parents be notified.

Through the legislative process, the people of North Dakota have selected the commencement of an unborn child's heartbeat as the point at which abortions can no longer occur in the State, other than to save the life of the mother or another unborn child. The presence of a beating heart has been used by both medical doctors and lay people alike for millennia in determining whether a human being is alive or dead. The presence of a beating heart in an unborn child should likewise serve as a legitimate point at which a state can ban abortions. This is particularly true given the growing (and on this record, undisputed) medical evidence of significant physical and psychological harm to women from abortion, and the readiness of the state to assume complete responsibility for any unwanted child, without any civil or criminal liability to the mother.

## II. Certiorari is warranted because the individual liberty interest recognized in *Roe v. Wade* and *Planned Parenthood v. Casey*, but merely assumed in *Gonzales v. Carhart*, is adequately protected by North Dakota's statutory removal of the burden of child care for unwanted children, thus allowing society to protect the right to human life by restricting abortion after the unborn child has a detectable heartbeat, and protect women from the devastating physical and psychological injuries of abortion to themselves.

### A. North Dakota presented substantial evidence of the physical and emotional harm to women caused by abortion.

A significant portion of the 2092-page record is composed of affidavits and declarations from women harmed by their abortions. *See* Exhibits B-1 and B-2 to the declaration of Dr. Shuping, APP-655-887, as well as affidavits and declarations attached to affidavit of Allan E. Parker, APP-1067-1560. In reviewing and commenting on that evidence the Court of Appeals said that it: "'goes to the heart of the balance *Roe* struck between the choice of a mother and the life of her unborn child.' *McCorvey*, 385 F.3d at 850 (Jones, J., concurring)."[14] Pet.App.14a-15a.

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[14] It did not escape notice by the Court of Appeals that both women who were at the epicenter for legalized abortion in this country later sought to undo those decisions: "We further

(Continued on following page)

In addition to the affidavits and declarations from women harmed by abortions, North Dakota presented testimony from women's health experts.

Priscilla K. Coleman, Ph.D., testified that there is consensus among most social and medical science scholars that a minimum of 20% of women who abort suffer from serious, prolonged negative psychological consequences (Bradshaw & Slade, 2003; Major & Cozzarelli, 1992; Zolese & Blacker, 1992). Coleman Declaration, ¶29, APP-383-384.

Martha W. Shuping, M.D., testified about the psychological harms women experience from abortion. APP-479-624. Within her clinical experience as a practicing psychiatrist, Dr. Shuping has spoken with

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observe that the pseudonymously named plaintiffs in two of the Supreme Court's foundational abortion cases later advocated against those very decisions. Norma McCorvey, the "Jane Roe" of *Roe v. Wade*, sought relief from the judgment in her case on the ground that changed factual and legal circumstances rendered *Roe* unjust. *See McCorvey*, 385 F.3d at 850 (affirming denial of *McCorvey*'s Federal Rule of Civil Procedure 60(b) motion). Sandra Cano, the "Mary Doe" of *Doe v. Bolton*, 410 U.S. 179 (1973), *Roe*'s companion case, similarly sought relief from the judgment in her case. *See Cano v. Baker*, 435 F.3d 1337, 1342 (11th Cir. 2006) (per curiam) (affirming denial of Cano's Rule 60(b) motion). Cano also filed an amicus brief in this case arguing "that abortion is psychologically damaging to the mental and social health of significant numbers of women." Women Injured By Abortion, et al., Br. of Amici Curiae, at 5; *see also Gonzales*, 550 U.S., at 159 (citing Cano's amicus brief in that case). McCorvey's and Cano's renunciations call into question the soundness of the factual assumptions of the cases purportedly decided in their favor." Pet.App.16a.

more than a thousand women who have requested help regarding abortion related mental health problems. Dr. Shuping has treated many women who have experienced coerced, pressured, and forced abortions, women who have been victims of rape and incest who have carried a pregnancy to term, and women in these situations who have chosen abortion. Shuping Declaration ¶2, APP-480.

Dr. Shuping noted a large record-based study reporting that women who had an abortion had a *650%* higher risk of death from suicide compared to women who carried to term. *Id*., at ¶26, APP-492. Teens are at much higher risk of a suicide attempt after abortion. Researchers at the University of Minnesota found suicide attempts increased *ten-fold* for teens who were post-abortive in the preceding 6 months (Garfinkel, et al., 1986). *Id*., at ¶33, APP-494.

North Dakota also presented expert testimony from John Thorp, Jr., M.D., M.H.S., about the negative physical and psychological effects of abortion. *See* Thorp Declaration Pet.App.102a-144a; APP-950-1043. Dr. Thorp stated that termination of pregnancy (TOP) is unlike anything else in the provision of medical care and thus requires special statutory safeguards to protect mothers from increased risks of harm:

> a. The relationship between a TOP provider and a pregnant woman begins and ends on the same day of the TOP procedure, there generally being no prior physician-patient relationship;

b. Pre-TOP counseling at these clinics is generally not provided by a licensed health care or mental health professional;

c. Often screening for risk factors for adverse post-TOP outcomes is not provided;

d. Pre-TOP counseling is often deficient, excessively time-constrained, minimal or non-existent thereby reducing the likelihood of providing high quality counseling and meeting the needs of the pregnant woman;

e. In the absence of a physician-patient relationship and given the poor quality of pre-TOP counseling, the likelihood of exploring the unique circumstances of the mother is minimal, increasing the risk that coercion or pressure in her decision-making will go unaddressed;

f. The patient is unlikely to be counseled on pregnancy outcome options other than TOP as this is optional or not provided;

g. Because the physician provides diagnosis, counseling and surgery on the same day when the patient presents for treatment, the pregnant woman is at increased risk for being "rushed" into treatment;

h. Not being able to obtain the patient's fully informed consent is more likely given the above circumstances;

i. TOP services generally require payment prior to being rendered, thus inducing

> pressure to proceed which can override patient ambivalence or contraindications;
>
> j. The procedure is intended to terminate the life of the mother's child resulting in the deliberate death by the physician by his or her other patient to whom he owes a legal and professional duty;
>
> k. TOP intentionally ends the legally protected relationship of a mother and her child which has life-long consequences;
>
> l. The physical and psychological health risks of TOP are serious and significant;
>
> m. Due to the scenarios described above, the likelihood of physician bias and conflict of interest with TOP is more than in any other field of medicine.

Pet.App.107a-109a.

Dr. Thorp testified that a recently published study of 463,473 women linked birth and death registry records for an epoch of 25 years. When compared to women who delivered, women with TOP less than 12 weeks gestation had higher cumulative mortality rates from 180 days to 10 years later.[15] In a second study using the same national registries, the researchers again found increased risks of death for

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[15] Reardon, D. & Coleman, P. *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004. Medical Science Monitor*, 2012, 18: PH71-PH76.

women electing abortion compared to childbirth.[16] Record linkage studies of the population of Finland and of low income women in California have also reported higher death rates associated with abortion than childbirth.[17] Pet.App.125a-126a.

Dr. Thorp took issue with respondents' unsupported assertion that abortion is one of the safest medical procedures in the United States. Pet.App.113a-128a. Dr. Thorp provided testimony that TOP causes, among other things: (a) increased risk of breast cancer; (b) increased risk of pelvic inflammatory disease and a subsequent ectopic pregnancy that is itself life

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[16] Coleman, P. Reardon, D. & Calhoun, B. *Reproductive History Patterns and Long-term Mortality Rates: A Danish Population-Based Record Linkage Study*, European Journal of Public Health (September 5, 2012, Epub ahead of print).

[17] Post-pregnancy death rates within one year were nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000). Gissler, M., et al., *Pregnancy Associated Deaths in Finland* 1987-1994: *Definition Problems and Benefits of Record Linkage.* 76 A Acta Obstetricia et Gynecologica Scandinavica. 1997, 76: 651-7; mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000). Gissler, M., Berg, C., Bouvier-Colle, M., Buekins, P. *Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland*, 1987-2000. American Journal of Obstetrics and Gynecology, 2004, 190: 422-427; women who aborted, when compared to women who delivered, were 62% more likely to die over an 8-year period from any cause after adjustments were made for age. Reardon, D., et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, Southern Medical Journal, 2002, 95: 834-841.

threatening; and (c) a greatly elevated risk of subsequently bearing a premature child. Pet.App.128a-135a. Dr. Thorp also testified that undue pressure on women to have abortions occurs frequently, and results in a risk factor for negative post-abortion emotional distress. Pet.App.135a-138a.

Dr. Thorp's testimony completely undercuts the assumption in *Roe v. Wade* that abortion in the first trimester, while not without risk, is as safe if not safer than normal childbirth. *Id*.; *Roe*, 410 U.S., at 149.[18]

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[18] The *Roe* Court did not consider long-term risks from abortion before making its assumption that abortion is safer than childbirth. *See, e.g.*, Clarke D. Forsythe & Bradley N. Kehr, *A Road Map Through the Supreme Court's Back Alley, 57 Vill. L. Rev. 45, 48 (2012).* Since this Court's decision in *Casey*, though, dozens of studies have been published in international medical journals documenting the existence of several long-term risks from abortion, especially the increased risk of pre-term birth after abortion. A landmark analysis published in 2003, for example, concluded that women should be informed of the increased risk of pre-term birth as a "major long-term health consequence" of abortion. Thorp*, Long-Term Health Consequences*, 58 Obst. & Gyn. Survey. And in 2009, three systematic-evidence reviews demonstrating the increased risk of pre-term birth after abortion were published. P. S. Shah & J. Zao, *Induced Termination of Pregnancy and Low Birthweight and Preterm Birth: A Systematic Review and Meta-analyses*, 116 Brit. J. of Ob. Gyn. 1425 (2009); Hanes M. Swingle, et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. Reprod. Med. 95 (2009); R. Freak-Poli, et al., *Previous Abortion and Risk of Preterm Birth: A Population Study*, 22 J. Maternal-Fetal Med. 1 (2009).

Significantly, Dr. Thorp's unrefuted testimony brings to light another erroneous assumption at the heart of *Roe v. Wade*: that the abortion decision would be between the pregnant woman and her doctor. *See Roe*, 410 U.S., at 153 ("All these are factors the woman and her responsible physician necessarily will consider in consultation"). As the overwhelming evidence presented by North Dakota in this case establishes, abortion practice does not usually involve a normal doctor-patient relationship, nor is it a voluntary, informed private decision between a woman and her doctor as envisioned by the Court in *Roe*. In fact, women generally do not see the person performing the abortion until the procedure is being performed, and have little to no interaction with that person.

As already noted, the record in this case contains many affidavits and declarations of women willing to come forward and make public the physical and psychological harm they've suffered because of legal abortions. None of those affidavits and declarations better describes the long term harm of abortion than the declaration of Jennifer Kraft. Pet.App.65a-79a.

From childhood, Jennifer had a history of mental health difficulties, having been diagnosed with borderline personality disorder, severe depression, bipolar disorder, anxiety disorder and more recently with post-traumatic stress disorder. She had been the victim of physical and verbal abuse, starting when she was only three years old when her mother's boyfriend sexually abused her. In addition, Jennifer

has had a substance abuse problem for almost her entire life. Pet.App.66a-67a.

Jennifer had two abortions, the second of which occurred at the respondents' abortion facility in Fargo, North Dakota. Pet.App.65a.

Jennifer became pregnant from an extramarital affair with her methamphetamine dealer, shortly after obtaining her first abortion (also a pregnancy from that extramarital relationship). Jennifer and her husband were alienated at that time. Jennifer made an appointment for an abortion at the respondent Red River Women's Clinic (RRWC), and her abortion was scheduled for early January, 2004. Jennifer was told when examined at the RRWC that she was a little over 12 weeks pregnant. She told no one of her pregnancy or that she was getting an abortion, and Jennifer went to the respondents' abortion facility alone. Pet.App.70a.

The RRWC required that Jennifer pay the cost of the abortion procedure up-front, even before any paperwork was filled out. Once she gave them the money, Jennifer felt compelled to go through with the abortion even if she had second thoughts. After she paid the required amount, Jennifer filled out paperwork for about 20 minutes and signed releases. Jennifer was asked if she had any prior abortions, and she said "no" because she was so ashamed. Pet.App.70a-71a.

Jennifer does not recall being asked by the RRWC about any medications she was taking, although she

brought her medications along with her. She was taking medication at the time for her mental health problems. When the RRWC employees saw Jennifer's medications they didn't say anything about Jennifer needing to see a counselor before the procedure, or that RRWC would contact Jennifer's doctors or would send her to someone for counseling after the procedure. Pet.App.71a-72a.

After completing the required paperwork, Jennifer went to an exam room where the abortion procedure was explained. It was there that Jennifer was told the abortion doctor's name. Jennifer does not recall having any conversation with the abortion doctor. She only recalls him saying, during the abortion procedure itself, that he could tell Jennifer had a recent abortion, and the nurse responded that that information was not in her chart. They did not stop the procedure, however. Pet.App.72a.

During the entire abortion procedure Jennifer was shaking and crying. Prior to going to the RRWC Jennifer was far enough along in the pregnancy that she felt her baby move inside her. She described it "like butterflies in my stomach – those were wonderful feelings." Pet.App.72a-73a. She was already "showing" as to her pregnancy, and starting to produce milk. While she was sitting in the RRWC waiting for the abortion Jennifer could again feel "those butterfly like movements" of her baby. Pet.App.73a.

When the abortion procedure began, and the doctor went inside of her with a vacuum device, Jennifer

felt her baby kicking. However, it wasn't like before. Rather, the baby was kicking to try and move away from the vacuum device being used for the abortion:

> I just could not take it – I was bawling and shaking because I just knew I was killing my baby but my baby was trying not to die. That was so traumatic to feel my baby trying to stay alive. I was crying so hard because as the procedure was going on, I did not want to do this. The nurse just told me "you're okay you're okay – you are making the right decision for you, for your situation – you're fine." The doctor who performed the abortion said nothing to me.

Pet.App.73a, ¶25.

Jennifer knew that the abortion doctor was pulling her baby out of her, and it was a sickening feeling. When the vacuum stopped, Jennifer knew she had just killed her baby, and felt like the worst person in the world. She hated herself, and knew what she had done was wrong. Then and there Jennifer vowed to "hurt myself." Pet.App.73a.

Following the abortion procedure Jennifer went to the recovery room, where she thinks there was an employee of the RRWC present. She doesn't recall anyone talking to her. She was numb, and pretty much "turned myself off." Pet.App.74a. Jennifer doesn't remember getting dressed, leaving, driving home or anything else that happened over the next few days, until the morning she decided to kill herself, about 5 or 6 days after the abortion. Pet.App.74a-75a.

Jennifer planned her suicide so that her children would be at school, and her husband would find her body first. She waited until everyone left, then took over 300 pills with a bottle of wine in about 30 minutes time, and laid down to die. As providence would have it, Jennifer's son, who was very in tune to everyone's feelings, insisted on coming home from school because he was sick. The school called the house, and Jennifer answered the phone. She was already becoming "fuzzy" and said that she could not come to get her son. She told the school to call her husband. However, the school was not able to get in contact with Jennifer's husband, so they called the next contact person on the list (Jennifer's brother-in-law) who picked up her son from school and brought him home:

> I stumbled to the door and said get him out of here. I told him to go find my husband and I slammed the door. My husband came home and I remember him yelling at me for being stupid and I vaguely remember the paramedics. I woke up 3 days later at Meritcare (now it is Sanford) and then after the 2 week hold, I was transferred to the North Dakota State Hospital.

Pet.App.75a-76a, ¶29.

While Jennifer and her husband were able to work through their difficulties and trauma from her abortions, Jennifer could not forgive herself for what she'd done. Moreover, Jennifer's other children were very angry when they found out. Jennifer's daughter still cries and asks Jennifer why she had an abortion,

wishing she had a little brother or sister. They have a memorial set up in their home for the two babies Jennifer aborted. Pet.App.76a. Jennifer is still seeing a counselor, psychiatrist and addiction sponsor on a regular basis:

> My abortions have been so negative and bad for me. I have had mental health and emotional problems but the abortions really compounded these problems and my trauma. I mean when I felt my baby trying to escape from being killed by the vacuum device at the Red River Women's Clinic, I just could not take it anymore – I wanted to die and tried to kill myself. I have been violated many times in my life and the abortions felt like just another violation. Because of what I have gone through, I have now been officially diagnosed with PTSD along with the other mental health problems I have had in my life.

Pet.App.76a-78a, ¶33.

Jennifer's story is, unfortunately, neither unique nor uncommon. For every affidavit and declaration in the record in this case, and there are many, there are thousands more women and families who've suffered greatly because of abortion. The evidence in this case, both from women who've had abortions and from women's health experts, is overwhelming as to the harm brought about by legalized abortion in this country. As recognized in *Casey*, 505 U.S., at 852:

> Abortion . . . is an act fraught with consequences for others: for the woman who must live with the implications of her decision; for the persons who perform and assist in the procedure; for the spouse, family, and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and, depending on one's beliefs, for the life or potential life that is aborted.

As observed by the Court in *Gonzales*, 550 U.S., at 159: "While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained." *See also*, *H.L., et al. v. Matheson, et al.*, 450 U.S. 398, 411 (1981) ("The medical, emotional, and psychological consequences of an abortion are serious and can be lasting; this is particularly so when the patient is immature [footnote omitted]").

Thankfully, our society has now progressed to the point where tragic stories like that of Jennifer Kraft can be a thing of the past. That is brought about by the advent of Safe Haven (also known as Baby Moses) laws that have been enacted in every state in the country.

### B. North Dakota has one of the most generous Safe Haven laws, relieving the pregnant woman from the burden of caring for an unwanted child.

In *Roe*, 410 U.S., at 153, the Court described the following as the foundation for a woman's right to abortion:

> Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

In *Planned Parenthood v. Casey*, the Court reiterated that the woman's right to an abortion was predicated upon the fact "that the inability to provide for the nurture and care of the infant is a cruelty to the child and an anguish to the parent." *Casey*, 505 U.S., at 853.

With the advent of Safe Haven laws throughout the country, society as a whole has assumed the responsibility and expense of raising unwanted children, no longer placing that burden on pregnant

women. Safe Haven laws provide a mechanism for an unwanted child to be abandoned to the State without any civil or criminal responsibility imposed on the parents of the unwanted child. The central underlying justification given for abortion by the Court in *Roe* and *Casey* is no longer applicable.

Under North Dakota's Safe Haven law, a woman after giving birth can leave her child with the hospital; or she can take up to a year to decide if she cannot handle the burdens of child care and return the child to a hospital and transfer all legal child care responsibility to the State. N.D.C.C. § 50-25.1-15 provides in relevant part:

> 50-25.1-15. Abandoned infant – Hospital procedure – Reporting immunity.
>
> 1. As used in this section:
>
> a. "Abandoned infant" means an abandoned infant as defined in section 27-20-02 and which has been left at a hospital in an unharmed condition.
>
> b. "Hospital" means a facility licensed under chapter 23-16.
>
> 2. A parent of an infant may abandon the infant at any hospital. An agent of the parent may leave an abandoned infant at a hospital with the parent's consent. Neither the parent nor the agent is subject to prosecution under sections 14-07-15 and 14-09-22 for leaving the abandoned infant at a hospital.

N.D.C.C. § 27-20-02(2) defines "abandoned infant" as "a child who has been abandoned before reaching the age of one year." Pet.App.62a-64a.

Every state now has such laws.[19] This remarkable social evolution completely eliminates any need for legal abortion or abortion as a constitutional right.

This new legal reality, transferring child care responsibility from mother to the State, means there is no "undue burden" because there is no longer any need for abortion to relieve pregnant women from unwanted child care obligations. Every child in America is legally "wanted" and abortion of "unwanted" children is no longer necessary. Every woman who feels trapped and alone, desperate for help, can now transfer that burden to the State as a matter of right.

After all, no woman wants an abortion just to experience abortion. North Dakota is not stopping women from participating in something intrinsically valuable; like a job, or school. No one, male or female, liberal or conservative, really wants to have an abortion for its own sake. As the record in this case amply demonstrates, women hurt by abortion know and understand the circumstances where it may seem abortion is the only answer. What women seek is relief from parental obligations; now North Dakota provides that in a more just, compassionate, and safe

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[19] *See* Pet.App.145a-146a for citations to all state Safe Haven laws. *See also* www.nationalsafehavenalliance.org.

way than allowing a pregnant woman to kill her child and suffer the consequences alone for decades.

Abortion may perhaps be remembered in the future as a crude way of removing the burden of child care. The modern view removes the burden of child care from women, and places it on society as a whole, rather than placing it solely on the parent of an unwanted child, while at the same time protecting women from the physical and psychological harm of abortion, and protecting all human life as well.

We acknowledge that in addition to the burden of raising an unwanted child, *Roe* also recognized the risk a woman has in carrying to term and giving birth to the child. However, as already discussed in this petition,[20] medical knowledge about the relative risk of abortion compared to childbirth has changed since the time *Roe* was decided. The relative risk comparison of abortion and childbirth led this Court in *Roe* to identify "the end of the first trimester as the compelling point [for protecting the State's interest in maternal health] because until that time – according to the medical literature available in 1973 – 'mortality in abortion may be less than mortality in normal childbirth.'" *Akron*, 462 U.S., at 429 n.11 (*quoting Roe*, 410 U.S., at 163); *see also id.*, at 460 (O'Connor, J., dissenting) (noting that States have a compelling interest to "ensur[e] maternal safety," "once an abortion may be more dangerous than childbirth").

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[20] *See* declaration of Dr. Thorp, Part IV, Pet.App.113a-128a.

We now know that abortion causes substantial risk of physical and psychological harm to women, without any reference to the antiquated trimester system announced in *Roe*. By legislating that abortions in North Dakota must occur before an unborn child has a detectable heartbeat, North Dakota is not only protecting the life of the unborn child, but ensuring maternal safety as well.

As observed by Justice O'Connor in *Planned Parenthood v. Casey*, 505 U.S., at 864:

> In constitutional adjudication as elsewhere in life, changed circumstances may impose new obligations, and the thoughtful part of the Nation could accept each decision to overrule a prior case as a response to the Court's constitutional duty.

The Court should accept the invitation of the Court of Appeals to reevaluate its abortion jurisprudence in light of extensive evidence in the record of 1) new scientific advances on viability, 2) increasing evidence of the devastating physical and psychological consequences of abortion, and 3) society's willingness to remove from pregnant women all burden of child care for every unwanted child, and uphold the constitutionality of North Dakota's law restricting abortion after there is a detectable human heartbeat.

## CONCLUSION

For all of the foregoing reasons, the petitioners respectfully request that their Petition for Writ of Certiorari be granted.

Respectfully submitted this 10th day of November, 2015.

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# APPENDIX A

## United States Court of Appeals for the Eighth Circuit

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No. 14-2128

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MKB Management Corp., doing business as Red River Women's Clinic; Kathryn L. Eggleston, M.D.

*Plaintiffs-Appellees*

v.

Wayne Stenehjem, in his official capacity as Attorney General for the State of North Dakota; Larry Johnson, M.D.; Robert Tanous, D.O.; Kate Larson, P.A.C.; Norman Byers, M.D.; Cory Miller, M.D.; Kayleen Wardner; Gaylord J. Kavlie, M.D.; Kent Martin, M.D.; Kent Hoerauf; Burt L. Riskedahl; Jonathan Haug, M.D.; Genevieve Goven, M.D.; Robert J. Olson, M.D., in their official capacities as members of the North Dakota Board of Medical Examiners

*Defendants-Appellants*

Birch Burdick, in his official capacity as State Attorney for Cass County

*Defendant*

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Foundation for Moral Law; Lutherans for Life;
Women Injured by Abortion; An Abortion Survivor –
Dawn Milberger and Sandra Cano;
The Former "Mary Doe" of "Doe v. Bolton"

*Amici on Behalf of Appellant(s)*

American Psychological Association;
American Public Health Association;
American College of Obstetricians and Gynecologists;
Physicians for Reproductive Health;
Program for the Study of Reproductive Justice –
Information Society Project at the Yale Law School

*Amici on Behalf of Appellee(s)*

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Appeal from United States District Court
for the District of North Dakota – Bismarck

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Submitted: January 13, 2015
Filed: July 22, 2015

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Before SMITH, BENTON, and SHEPHERD, Circuit Judges.

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SHEPHERD, Circuit Judge.

This case presents the question whether, given the current state of medical science, a state generally may prohibit physicians from aborting unborn children who possess detectable heartbeats. The district

court[1] held that it may not. Because United States Supreme Court precedent does not permit us to reach a contrary result, we affirm.

## I.

North Dakota has, for a number of years, prohibited abortion "[a]fter the point in pregnancy when the unborn child may reasonably be expected to have reached viability," except when necessary to preserve the life or health of the mother. N.D. Cent. Code § 14-02.1-04(3). North Dakota defines "viable" as "the ability of an unborn child to live outside the mother's womb, albeit with artificial aid." *Id.* § 14-02.1-02(19).

In 2013, North Dakota passed House Bill 1456, codified at N.D. Cent. Code § 14-02.1, which extends the general prohibition on abortion to the point in pregnancy when the unborn child possesses a detectable heartbeat. H.B. 1456 contains two operative provisions. The first requires a physician performing an abortion to "determin[e], in accordance with standard medical practice, if the unborn child the pregnant woman is carrying has a detectable heartbeat." H.B. 1456 § 1.1, 63d Leg. Assemb., Reg. Sess. (N.D. 2013). This requirement does not apply "when a medical emergency exists that prevents compliance." *Id.*; *see also* N.D. Cent. Code § 14-02.1-02(12) (defining "medical emergency"). A physician who violates

[1] The Honorable Daniel L. Hovland, United States District Judge for the District of North Dakota.

the heartbeat testing requirement is subject to disciplinary action before the state board of medical examiners. *See* H.B. 1456 § 1.2.

The second operative provision prohibits a physician from performing an abortion on a pregnant woman if the unborn child has a "heartbeat [that] has been detected according to the requirements of section 1." *Id.* § 2.1. There are exceptions for the life or health of the pregnant woman and for the life of another unborn child. *Id.* § 2.2(a). A physician who violates this provision commits a felony. *Id.* § 2.4. The pregnant woman, however, is not subject to liability. *Id.*

Plaintiff MKB Management Corporation, doing business as the Red River Women's Clinic, is the sole abortion provider in North Dakota. Plaintiff Dr. Kathryn Eggelston is a board-certified family medicine physician, licensed to practice in North Dakota, who serves as the Clinic's medical director and provides abortions to the Clinic's patients. The defendants are the State's Attorney for the county in which the Clinic is located, the North Dakota Attorney General, and the members of the North Dakota Board of Medical Examiners, all in their official capacities (collectively, the "State").

Before H.B. 1456 took effect, the plaintiffs brought suit in the district court, challenging the law's constitutionality and seeking injunctive relief. The district court granted a preliminary injunction enjoining the implementation of H.B. 1456. The

plaintiffs then moved for summary judgment, arguing H.B. 1456 violates the Due Process Clause of the United States Constitution. The plaintiffs submitted declarations from Dr. Eggleston and Dr. Christie Iverson, a board-certified obstetrician and gynecologist licensed in North Dakota, both stating that fetal cardiac activity is detectable by about 6 weeks and that a fetus is not viable until about 24 weeks.[2] In response, the State submitted the declaration of Dr. Jerry Obritsch, a board-certified obstetrician and gynecologist licensed in North Dakota, that an unborn child's heartbeat is detectable by about 6 to 8 weeks and that an unborn child is viable from conception because in vitro fertilization ("IVF")[3] "allow[s] an embryonic unborn child to live outside the human uterus (womb) for 2-6 days after conception." Obritsch Dec. at 8.

The district court found that "[a] woman's constitutional right to terminate a pregnancy before viability has consistently been upheld by the United States Supreme Court for more than forty years since *Roe v. Wade*." *MKB Mgmt. Corp. v. Burdick*, 16 F. Supp. 3d

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[2] Dr. Iverson further explained that "[p]regnancy is commonly measured by the number of days that have passed since the first day of a woman's last menstrual period." Iverson Dec. at 2.

[3] Dr. Obritsch described IVF as a common practice in which embryonic unborn children live outside the woman's uterus through artificial means before being transferred into the uterus to continue gestation. He noted a colloquial term for these children is "test tube babies." Obritsch Dec. at 8.

1059, 1070 (D.N.D. 2014). It reasoned that "the affidavit of Dr. Obritsch does not create a genuine issue [as to when viability occurs] primarily because Dr. Obritsch uses a different definition of viability than the one used by either the United States Supreme Court or the medical community generally." *Id.* at 1073. Concluding that "H.B. 1456 clearly prohibits pre-viability abortions in a very significant percentage of cases in North Dakota, thereby imposing an undue burden on women seeking to obtain an abortion," the district court granted summary judgment to the plaintiffs, permanently enjoining H.B. 1456. *Id.* at 1074-75. The State now appeals.

## II.

We review the district court's grant of summary judgment de novo and its permanent injunction for an abuse of discretion. *Roach v. Stouffer*, 560 F.3d 860, 863 (8th Cir. 2009).

The State argues that the Supreme Court has called into question the continuing validity of its abortion jurisprudence, *see Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (merely assuming, rather than reaffirming, the principles established in prior cases), and that changes in the facts underlying *Roe* and *Casey* require us to overturn those cases.

The evolution in the Supreme Court's jurisprudence reflects its increasing recognition of states' profound interest in protecting unborn children. In 1973, the Court announced it would regulate abortion

according to the trimester framework. *Roe v. Wade*, 410 U.S. 113, 164-65 (1973). Although *Roe* acknowledged there were "important state interests in regulation," it prohibited states from issuing regulations designed to promote their interest in "protecting potential life" during the first two trimesters of pregnancy. *Id.* at 154, 164.

By 1992, however, a plurality of the Court had rejected the trimester framework because it failed to "fulfill *Roe*'s own promise that the State has an interest in protecting fetal life or potential life." *Planned Parenthood of Se. Pa v. Casey*, 505 U.S. 833, 876 (1992). *Casey* recognized "there is a substantial state interest in potential life throughout pregnancy." *Id.* (plurality opinion). To give this interest due consideration, *Casey* replaced *Roe*'s trimester framework with the undue burden analysis, under which a state may promote its interest in potential life by regulating abortion before viability so long as the regulation's "purpose or effect is [not] to place a substantial obstacle in the path of a woman seeking an abortion." *Id.* at 878 (plurality opinion).

Most recently, a majority of the Court, when presented with an opportunity to reaffirm *Casey*, chose instead merely to "assume" *Casey*'s principles for the purposes of its opinion. *See Gonzales*, 550 U.S. at 145-46 ("assum[ing] the following principles [from *Casey*] for the purposes of this opinion," but recognizing those principles "did not find support from all those who join the instant opinion"); *see also id.* at 186-87 (Ginsburg, J., dissenting) (observing that

"[t]he Court's hostility to the right *Roe* and *Casey* secured" is evident in the fact that the Court "merely assume[d] for the moment, rather than retained or reaffirmed," *Casey*'s principles (second alteration in original) (citation and internal quotation marks omitted)). This mere assumption may, as the State suggests, signal the Court's willingness to reevaluate its abortion jurisprudence.

Even so, the Court has yet to overrule the *Roe* and *Casey* line of cases. Thus we, as an intermediate court, are bound by those decisions. Neither *Gonzales*'s signal nor the alleged change of underlying facts empowers us to overrule the Supreme Court. *See Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989) (emphasizing that only the Supreme Court may overturn its own precedent).

Accordingly, we have no choice but to follow the majority of the Court in assuming the following principles for the purposes of this opinion:

> Before viability, a State "may not prohibit any woman from making the ultimate decision to terminate her pregnancy." It also may not impose upon this right an undue burden, which exists if a regulation's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." On the other hand, "[r]egulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of

> the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose."

*Gonzales*, 550 U.S. at 146 (alteration in original) (citations omitted) (quoting *Casey*, 505 U.S. at 879, 878, and 877 (plurality opinion)).

Here, because the parties do not dispute that fetal heartbeats are detectable at about 6 weeks, it is clear that H.B. 1456 generally prohibits abortions after that point in a pregnancy. Whether such a prohibition is permissible under the principles we accept as controlling in this case depends on when viability occurs: if viability occurs at about 24 weeks, as the plaintiffs maintain, then H.B. 1456 impermissibly prohibits women from making the ultimate decision to terminate their pregnancies; but if viability occurs at conception, as the State argues, then no impermissible prohibition ensues.

Just as we are bound by the Supreme Court's assumption of *Casey*'s principles, we are also bound by the Court's statement that viability is the time "when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support." *Colautti v. Franklin*, 439 U.S. 379, 388 (1979); *see also Casey*, 505 U.S. at 870 (plurality opinion) ("[T]he concept of viability . . . is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb. . . ."); *Roe*, 410 U.S. at 160, 163

(stating that a fetus becomes viable when it is "potentially able to live outside the mother's womb, albeit with artificial aid" and that viability is the point at which the fetus "presumably has the capability of meaningful life outside the mother's womb").

When we recently reviewed an Arkansas statute similar to H.B. 1456, we noted "the importance of the parties, particularly the state, developing the record in a meaningful way so as to present a real opportunity for the court to examine viability." *Edwards v. Beck*, 786 F.3d 1113, 1119 (8th Cir. 2015) (per curiam). Here, the plaintiffs' declarations, by Drs. Eggleston and Iverson, state viability occurs at about 24 weeks. Dr. Iverson explained she understands viability to mean "the time when a fetus has a reasonable chance for sustained life outside the womb, albeit with lifesaving medical intervention." Iverson Dec. at 2. This definition is in accordance with the one adopted by the Supreme Court.

The State's declaration, by Dr. Obritsch, contends viability occurs at conception because IVF "allow[s] an embryonic unborn child to live outside the human uterus (womb) for 2-6 days after conception." Obritsch Dec. at 8. While this declaration provides some support for the State's argument, we agree with the district court that Dr. Obrtisch's definition of viability differs from the Supreme Court's and thus does not create a genuine dispute as to when viability occurs. *See Churchill Bus. Credit, Inc. v. Pac. Mut. Door Co.*, 49 F.3d 1334, 1336 (8th Cir. 1995) ("A factual dispute is genuine 'if the evidence is such that a reasonable

jury could return a verdict for the nonmoving party.'" (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986))).

Because there is no genuine dispute that H.B. 1456 generally prohibits abortions before viability – as the Supreme Court has defined that concept – and because we are bound by Supreme Court precedent holding that states may not prohibit pre-viability abortions, we must affirm the district court's grant of summary judgment to the plaintiffs. *See* Fed. R. Civ. P. 56(a) ("The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.").[4]

## III.

Although controlling Supreme Court precedent dictates the outcome in this case, good reasons exist for the Court to reevaluate its jurisprudence. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 458 (1983) (O'Connor, J., dissenting) ("Although [the Court] must be mindful of the 'desirability

[4] The State also appeals the district court's affirmance of a magistrate judge's order limiting discovery to the issue of viability. Because viability presents the central issue in this case, the district court did not err in affirming the magistrate judge's order. *See Admiral Theatre Corp. v. Douglas Theatre Co.*, 585 F.2d 877, 889 (8th Cir. 1978) (noting that a district court must be allowed the discretion to limit the scope of discovery "to what the court perceived were the central issues").

of continuity of decision in constitutional questions . . . when convinced of former error, [the] Court has never felt constrained to follow precedent.'" (quoting *Smith v. Allwright*, 321 U.S. 649, 665 (1944))).

A.

To begin, the Court's viability standard has proven unsatisfactory because it gives too little consideration to the "substantial state interest in potential life throughout pregnancy." *Casey*, 505 U.S. at 876 (plurality opinion). By deeming viability "the point at which the balance of interests tips," *id.* at 861, the Court has tied a state's interest in unborn children to developments in obstetrics, not to developments in the unborn. This leads to troubling consequences for states seeking to protect unborn children. For example, although "states in the 1970s lacked the power to ban an abortion of a 24-week-old-fetus because that fetus would not have satisfied the viability standard of that time, [t]oday . . . that same fetus would be considered viable, and states would have the power to restrict [such] abortions." *Edwards*, 786 F.3d at 1118 (final alteration in original) (citation and internal quotation marks omitted). How it is consistent with a state's interest in protecting unborn children that the same fetus would be deserving of state protection in one year but undeserving of state protection in another is not clear. The Supreme Court has posited there are "logical and biological justifications" for choosing viability as the critical point. *Roe*, 410 U.S. at 163. But this choice is better left to the

states, which might find their interest in protecting unborn children better served by a more consistent and certain marker than viability. Here, the North Dakota legislature has determined that the critical point for asserting its interest in potential life is the point at which an unborn child possesses a detectable heartbeat. "To substitute its own preference to that of the legislature in this area is *not* the proper role of a court." *Edwards*, 786 F.3d at 1119.

By taking this decision away from the states, the Court has also removed the states' ability to account for "advances in medical and scientific technology [that] have greatly expanded our knowledge of prenatal life," *Hamilton v. Scott*, 97 So. 3d 728, 742 (Ala. 2012) (Parker, J., concurring specially), including that "a baby develops sensitivity to external stimuli and to pain much earlier than was . . . believed [when *Roe* was decided]." *McCorvey v. Hill*, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring). "[B]ecause the Court's rulings have rendered basic abortion policy beyond the power of our legislative bodies, the arms of representative government may not meaningfully debate" medical and scientific advances. *Id.* (Jones, J., concurring). Thus the Court's viability standard fails to fulfill *Roe*'s "promise that the State has an interest in protecting fetal life or potential life." *Casey*, 505 U.S. at 876 (plurality opinion).

Medical and scientific advances further show that the concept of viability is itself subject to change. The Court has already acknowledged that viability continues to occur earlier in pregnancy. *See Casey*,

505 U.S. at 860. When the Court decided *Roe* in 1973, viability generally occurred at 28 weeks. *Roe*, 410 U.S. at 160. In 1992, viability "sometimes" occurred at 23 to 24 weeks. *Casey*, 505 U.S. at 860. Today, viability generally occurs at 24 weeks, but it may occur weeks earlier. *See* Matthew A. Rysavy, B.S., et al., *Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants*, 372 New England Journal of Medicine 1801 (2015) (documenting survival rates of infants born at 22 weeks); *see also Edwards*, 786 F.3d at 1119 (discussing the case of Amillia Taylor, who survived after being born at 21 weeks). Dr. Obritsch's declaration, although insufficient to create a genuine dispute of fact in the face of the Supreme Court's current definition of viability, shows the concept of viability may be attacked from the point of conception forward, as well. As IVF and similar technologies improve, we can reasonably expect the amount of time an "embryonic unborn child" may survive outside the womb will only increase. The viability standard will prove even less workable in the future.

B.

Another reason for the Court to reevaluate its jurisprudence is that the facts underlying *Roe* and *Casey* may have changed. The State has presented evidence to that effect and the plaintiffs did not contest this evidence at the summary judgment stage. The State's evidence "goes to the heart of the balance *Roe* struck between the choice of a mother and the life

of her unborn child." *McCorvey*, 385 F.3d at 850 (Jones, J., concurring). First, "*Roe*'s assumption that the decision to abort a baby will be made in close consultation with a woman's private physician is called into question by" declarations from women who have had abortions. *Id.* at 851 (Jones, J., concurring). These declarations state women may receive abortions without consulting the physician beforehand and without receiving follow-up care after, *see, e.g.*, J.A. 1550, that women may not be given information about the abortion procedure or its possible complications, *see, e.g.*, J.A. 1541, and that the abortion clinic may function "like a mill." J.A. 1556. The declaration by Dr. John Thorp, a board-certified obstetrician and gynecologist, further states that "coercion or pressure prior to the termination of pregnancy occurs with frequency." J.A. 973. One woman declared her husband threatened to kick her out of the house and take her children away forever if she did not abort a pregnancy that was the product of an affair. J.A. 1555.

The declarations from women who have had abortions also show abortions may cause adverse consequences for the woman's health and well-being. One woman reported that "[t]he negative effects of my abortion resulted in ten years of mental and emotional torment." J.A. 1533. Another reported she "suffered for years from depression, anxiety, panic attacks, low self esteem" and "suicidal ideation." J.A. 1519. Yet another reported her abortion caused "numerous female health issues, including an ectopic

pregnancy, chronic bladder infections, debilitating menstrual cycles, cervical cancer and early hysterectomy." J.A. 1525. Dr. Obritsch also explained some studies support a connection between abortion and breast cancer. J.A. 340.

We further observe that the pseudonymously named plaintiffs in two of the Supreme Court's foundational abortion cases later advocated against those very decisions. Norma McCorvey, the "Jane Roe" of *Roe v. Wade*, sought relief from the judgment in her case on the ground that changed factual and legal circumstances rendered *Roe* unjust. *See McCorvey*, 385 F.3d at 850 (affirming denial of McCorvey's Federal Rule of Civil Procedure 60(b) motion). Sandra Cano, the "Mary Doe" of *Doe v. Bolton*, 410 U.S. 179 (1973), *Roe*'s companion case, similarly sought relief from the judgment in her case. *See Cano v. Baker*, 435 F.3d 1337, 1342 (11th Cir. 2006) (per curiam) (affirming denial of Cano's Rule 60(b) motion). Cano also filed an amicus brief in this case arguing "that abortion is psychologically damaging to the mental and social health of significant numbers of women." Women Injured By Abortion, et al., Br. of *Amici Curiae*, at 5; *see also Gonzales*, 550 U.S. at 159 (citing Cano's amicus brief in that case). McCorvey's and Cano's renunciations call into question the soundness of the factual assumptions of the cases purportedly decided in their favor.

Finally, the State argues that, by enacting a law that permits parents to abandon unwanted infants at hospitals without consequence, it has reduced the burden of child care that the Court identified in *Roe*. *See* N.D. Cent. Code § 50-24.1-15; *Roe*, 410 U.S. at 153 ("Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.").

In short, the continued application of the Supreme Court's viability standard discounts the legislative branch's recognized interest in protecting unborn children.

## IV.

For the foregoing reasons, we affirm the district court's grant of summary judgment to the plaintiffs[5] and the permanent injunction of H.B. 1456.[6]

[5] Because we affirm the grant of summary judgment to the plaintiffs, we decline to address the parties' arguments about whether H.B. 1456 violates the Equal Protection Clause.

[6] Although the North Dakota Century Code contains a presumptive severability clause, *see* N.D. Cent. Code § 1-02-20, we decline to consider whether H.B. 1456's heartbeat testing requirement is severable from its abortion restriction because the State has not argued for severability. *See Mont.-Dakotas Utils. Co. v. Johaneson*, 153 N.W.2d 414, 424 (N.D. 1967) (discussing severability under North Dakota law). We note that H.B. 1456 does not require the physician to inform the pregnant woman whether her unborn child possesses a detectable heartbeat. *See Edwards v. Beck*, 8 F. Supp. 3d 1091, 1098 (E.D. Ark. 2014) (finding that Arkansas's heartbeat testing requirement was severable from its abortion restriction where the law in question required the physician to inform the pregnant woman that her unborn child possessed a detectable heartbeat and of the statistical probability of bringing the unborn child to term).

## APPENDIX B

## IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTH DAKOTA SOUTHWESTERN DIVISION

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|---|---|
| MKB Management Corp., d/b/a Red River Women's Clinic; and Kathryn L. Eggleston, M.D.,<br><br>Plaintiffs,<br><br>v.<br><br>Birch Burdick, in his official capacity as State's Attorney for Cass County, et al.,<br><br>Defendants. | **ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**<br><br>Case No. 1:13-cv-071 |

Before the Court is the "Plaintiffs' Motion for Summary Judgment" filed on October 15, 2013. *See* Docket No. 40. The Defendants filed a response on January 17, 2014. *See* Docket No. 69. The Plaintiffs filed a reply brief on February 24, 2014. *See* Docket No. 96. A hearing on the motion was held on April 4, 2014, in Bismarck, North Dakota. The threshold question is whether the Legislative Assembly of North Dakota can prohibit abortions beginning at six weeks gestation and before the fetus is viable. The United States Supreme Court has clearly spoken and held it is not constitutionally permissible to do so. For the reasons set forth below, the Plaintiffs' motion for summary judgment is **GRANTED**.

## I. BACKGROUND

The Plaintiff, MKB Management Corp., doing business as Red River Women's Clinic ("the Clinic"), is the only clinic providing abortions in North Dakota. The Plaintiff, Kathryn Eggleston, is a board-certified family medicine physician licensed in North Dakota. Dr. Eggleston is the Clinic's medical director and has been providing reproductive health care for women, including abortions, colposcopy services, and family planning services, for over a decade. The Defendants include various North Dakota officials, including: Birch Burdick, the Cass County State's Attorney; Wayne Stenehjem, the Attorney General for the State of North Dakota; and the thirteen members of the North Dakota Board of Medical Examiners. All Defendants are sued in their official capacity.

The Plaintiffs challenge the constitutionality of House Bill 1456 ("H.B. 1456"), codified at North Dakota Century Code Chapter 14-02.1, which provides as follows:

> **Determination of detectable heartbeat in unborn child before abortion-Exception.** Except when a medical emergency exists that prevents compliance with this subsection, an individual may not perform an abortion on a pregnant woman before determining, in accordance with standard medical practice, if the unborn child the pregnant woman is carrying has a detectable heartbeat. Any individual who performs an abortion on a pregnant woman

> based on the exception in this subsection shall note in the pregnant woman's medical records that a medical emergency necessitating the abortion existed.
>
> * * *
>
> **Abortion after detectable heartbeat in unborn child prohibited-Exception-Penalty.** Notwithstanding any other provision of law, an individual may not knowingly perform an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn child the pregnant woman is carrying and whose heartbeat has been detected according to the requirements of [the above section] of this Act.

H.B. 1456, 63d Leg. Assemb., Reg. Sess. (N.D. 2013). H.B. 1456, passed during the 2013 legislative session, makes it a criminal offense to perform an abortion if a "heartbeat" has been detected, thereby banning abortions beginning at approximately six weeks of pregnancy, with limited exceptions. The amendments contained in H.B. 1456 were scheduled to take effect on August 1, 2013. However, on July 22, 2013, this Court issued a preliminary injunction enjoining the implementation of the law. *See* Docket No. 25.

At the present time, North Dakota law prohibits abortions "[a]fter the point in pregnancy when the unborn child may reasonably be expected to have reached viability," unless "in the medical judgment of the physician the abortion is necessary to preserve

the life of the woman or if in the physician's medical judgment the continuation of her pregnancy will impose on her a substantial risk of grave impairment of her physical or mental health." N.D.C.C. § 14-02.1-04(3). Viability is defined as "the ability of an unborn child to live outside the mother's womb, albeit with artificial aid." N.D.C.C. § 14-02.1-02(14) (to be recodified by H.B. 1305 as N.D.C.C. § 14-02.1-02(16)). H.B. 1456 would prohibit abortions after a heartbeat is detected, which all agree can occur as early as six weeks after a woman's last menstrual period.

The Plaintiffs initially requested preliminary injunctive relief to restrain the Defendants from enforcing H.B. 1456, which would essentially ban all abortions in the State of North Dakota. The Plaintiffs contend the North Dakota statute is an unconstitutional abridgment of the right to abortion protected under the Fourteenth Amendment of the United States Constitution. H.B. 1456 also puts restraints on physicians in performing abortions by providing criminal punishment. A physician who knowingly violates the ban by performing an abortion when a heartbeat has been detected may face Class C felony charges, punishable by up to five years in prison. H.B. 1456 § 2(4) (referencing N.D.C.C. § 12.1-32-01(4)). Failure to determine whether a heartbeat is detectible is punishable through a disciplinary action against a physician by the North Dakota Board of Medical Examiners, which can include suspension or revocation of the physician's license. H.B. 1456 §§ 1(2), 3 (creating a new subsection to N.D.C.C.

§ 43-17-31); N.D.C.C. § 43-17-31 (referencing N.D.C.C. § 43-17-30.1).

Since the issuance of a preliminary injunction on July 22, 2013, the parties have engaged in limited discovery and conducted depositions of several key witnesses.

## II. LEGAL DISCUSSION

### A. STANDARD OF REVIEW

Summary judgment is appropriate when the evidence, viewed in a light most favorable to the non-moving party, indicates no genuine issues of material fact exist and, therefore, the moving party is entitled to judgment as a matter of law. *Davison v. City of Minneapolis, Minn.*, 490 F.3d 648, 654 (8th Cir. 2007); *see* Fed. R. Civ. P. 56(a). Summary judgment is not appropriate if there are factual disputes that may affect the outcome of the case under the applicable substantive law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). An issue of material fact is genuine if the evidence would allow a reasonable jury to return a verdict for the non-moving party. *Id.*

The Court must inquire whether the evidence presents sufficient disagreement to require the submission of the case to a jury or if it is so one-sided that one party must prevail as a matter of law. *Diesel Mach., Inc. v. B.R. Lee Indus., Inc.*, 418 F.3d 820, 832 (8th Cir. 2005). The moving party bears the burden of demonstrating an absence of a genuine issue of

material fact. *Simpson v. Des Moines Water Works*, 425 F.3d 538, 541 (8th Cir. 2005), *abrogated on other grounds by Torgerson v. City of Rochester*, 643 F.3d 1031 (8th Cir. 2011). The non-moving party may not rely merely on allegations or denials in its own pleading; rather, its response must set out specific facts showing a genuine issue for trial. Fed. R. Civ. P. 56(c)(1). The court must consider the substantive standard of proof when ruling on a motion for summary judgment. *Anderson*, 477 U.S. at 252.

### B. DECLARATIONS OF OB/GYN SPECIALISTS

The Plaintiffs contend H.B. 1456 is unconstitutional on its face because it bans abortions prior to viability. Given controlling United States Supreme Court precedent, the Plaintiffs contend that H.B. 1456 violates the substantive due process rights of their patients. If H.B. 1456 is allowed to take effect, nearly 100% of the abortions currently performed at the Red River Women's Clinic, the sole clinic providing abortions in North Dakota, will be prohibited. The Defendants have recently taken the position that viability of a fetus occurs at the moment of conception, which would result in a prohibition of all abortions in North Dakota.

Despite the newly-adopted position that viability occurs at the point of conception, the Defendants argue H.B. 1456 does not ban all abortions prior to viability because abortions can be performed up until

the point at which a fetal heartbeat is detected and, therefore, is constitutional. The Defendants opine H.B. 1456 limits pre-viability abortions after detection of the fetal heartbeat pursuant to the State's interest "in protecting the life of the fetus that may become a child. . . ." *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007).

The Defendants also argue a woman's right to abortion before viability is not absolute and must be weighed against the state's interest in protecting the fetus and the mother. According to the Defendants' [sic], the fact that H.B. 1456 serves a valid purpose – to further the state's interest in protecting the life of the unborn, protecting the physical and mental health of women who may seek to procure an abortion, preserving the integrity of the medical profession, preventing the coarsening of society's moral sense and promoting respect for human life – "not designed to strike at the right itself, [but which] has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id.* at 157-58 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992)). While the Defendants are correct that a state's interests must also be examined in the abortion debate, the state's interest cannot unduly burden a woman's right to choose.

In support of the motion for summary judgment, the Plaintiffs submitted declarations of two physicians practicing medicine in North Dakota in the fields of obstetrics and gynecology. Kathryn Eggleston, M.D. has been the medical director of the

Red River Women's Clinic since 2008. Dr. Eggleston's opinions are set forth in her affidavit as follows:

> 2. I am a board-certified family medicine physician and have been providing reproductive health care for women, including abortion and family planning services, for over a decade. In addition, I have provided full-spectrum family medicine care, including obstetric and prenatal care and gynecologic services, to numerous patients. I graduated from the Medical College of Wisconsin with an M.D. in 1996 and from Colorado State University with a B.S. in Biological Science in 1991. I completed my residency at the University of Wisconsin's Eau Claire Family Medicine Residency Program in 1999. I have trained residents and medical students in reproductive health care methods, including medication and surgical abortion.
>
> 3. The opinions provided herein, which are held to a reasonable degree of medical certainty, are based upon my fourteen years of experience as a family medicine physician and reproductive health care provider, and the knowledge I have obtained through my education, training, teaching experience, discussions with colleagues, attendance at conferences, and ongoing review of the relevant professional literature. A copy of my curriculum vitae, which summarizes my

background, experience, and professional activities, is attached as Exhibit A.

4. I submit this affidavit in support of Plaintiffs' Motion for Summary Judgment.

**Red River Women's Clinic**

5. Since 2008, I have been the medical director of Red River Women's Clinic in Fargo, North Dakota.

6. Pregnancy is commonly measured by the number of days that have passed since the first day of a woman's last menstrual period ("lmp"). The Clinic provides abortions to women from about five weeks lmp through about sixteen weeks lmp.

7. I provide abortions at the Clinic one day a week, about forty-five to fifty weeks each year.

8. Red River Women's Clinic's protocols include an ultrasound for all abortion patients, which is important for dating the pregnancy and determining where the pregnancy is located within the uterus. A physician needs to confirm an intrauterine pregnancy and gestational age in order to safely provide an abortion.

9. The ultrasound is also used to detect fetal cardiac activity, which is detectible by about 6 weeks lmp on average, and sometimes a few days earlier.

10. The Clinic does not typically perform abortions before five weeks lmp because, due to the pregnancy's extremely small size, it may not be possible to confirm the location of the pregnancy in the uterus, even using vaginal ultrasound. If the location of the pregnancy is not confirmed, it can be dangerous to perform an abortion. Also – most patients do not present to the clinic at this gestational age due to the fact [they] are not aware they are pregnant.

11. North Dakota law defines viability as "the ability . . . to live outside the mother's womb, albeit with artificial aid." N.D. Cent.Code § 14-02.1-02(14). A fetus does not become viable until approximately twenty-four weeks lmp.

12. Many women do not know they are pregnant until after 6 weeks lmp. Typically, only women who have regular menstrual periods, keep close track of them, and take a pregnancy test promptly after missing a period at four weeks lmp will know they are pregnant by 6 weeks.

13. Since the Clinic only performs abortions one day per week, and cannot safely perform abortions before five weeks lmp, the bill will effectively limit women's ability to obtain an abortion to a single day during their pregnancy's fifth week.

14. Most of the women who currently receive abortions from the Clinic at or after 6 weeks lmp would probably be unable to schedule their abortions early enough to avoid the ban, due to a combination of some or all of the following reasons: they will not yet have realized that they are pregnant; they will be unable to gather the necessary funds or obtain transportation in sufficient time to reach the Clinic; they will be unable to take the necessary time off work with such short notice; they will be waiting through the delays imposed by the laws of the State of North Dakota; or they will need more time than the few days allotted to them to make the important decision of whether or not to have an abortion.

15. In my experience, women often consider many factors in deciding whether or not to have an abortion. These can include, among other things, their ability to care for [existing] children, the impact of parenthood on their educational goals, and the impact of parenthood on their ability to work and pursue a career. For most women, the risks associated with abortion and the relative risks of abortion compared to carrying a pregnancy to term, are only one factor among many that they consider.

*See* Docket No. 42-1.

Christie Iverson, M.D. also submitted an affidavit in support of the motion for summary judgment. *See* Docket No. 42-2. Dr. Iverson is a board-certified obstetrician and gynecologist licensed to practice in North Dakota. Dr. Iverson also opines that viability, or the time when a fetus has a reasonable chance for sustained life outside the womb, albeit with lifesaving medical intervention, does not occur until approximately twenty-four weeks LMP. She further states "no pregnancy is viable at 6 weeks LMP, nor for several months thereafter." *See* Docket No. 42-2, p. 4. Dr. Iverson's opinions are set forth in her affidavit as follows:

> 1. I provide the following opinions as an expert in pregnancy, embryonic and fetal development, and the practice of obstetrics in the State of North Dakota. I am a board-certified obstetrician and gynecologist licensed to practice in this state. I have practiced medicine continuously for over fifteen years. I received my bachelors of science in zoology from North Dakota State University in Fargo in 1985, and my medical doctorate from the University of North Dakota School of Medicine in Grand Forks in 1991. I undertook a family practice residency in Fargo from 1991 to 1992, and a residency in obstetrics and gynecology at the University of Minnesota in Minneapolis from 1992 to 1996. I practiced at the Medical Arts Clinic in Minot from 1996 to 2001, and since then I have worked at Sanford

Health (formerly Medcenter One Health Systems) here in Bismarck. I am a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading association of medical professionals specializing in obstetrics and gynecology, and a member of the North Dakota Society of Obstetricians/ Gynecologists. A copy of my curriculum vitae, which summarizes my background and experience, is attached hereto as Exhibit A.

2. I have reviewed House Bill 1456 ("the bill"). I submit this declaration in support of Plaintiffs' Motion for Summary Judgment. The opinions I express are held to a reasonable degree of medical certainty, based on my medical education and training, my years of clinical experience in the field of obstetrics, and my review of the medical literature.

**Pregnancy and embryonic and fetal development**

3. Pregnancy is commonly measured by the number of days that have passed since the first day of a woman's last menstrual period ("lmp"). In a typical pregnancy, an egg is fertilized around fourteen days lmp, and the pregnancy itself begins a week later, when the fertilized egg implants in the uterine lining. If the

pregnancy reaches full term, birth usually occurs around forty weeks lmp.

4. In a normally developing embryo, cardiogenesis, or heart development, begins at thirty-five days, or five weeks, lmp, when the tissues that will become the heart form a pair of tubes, called heart tubes. Within two to three days, these tubes fuse together to form the embryonic heart, which begins coordinated motion to circulate blood throughout the embryo. At this point, the embryo is about one millimeter in diameter.

5. In early pregnancy, standard medical practice for detecting cardiac activity requires the use of vaginal ultrasound. Using vaginal ultrasound, cardiac activity is usually detectible by forty-two days, or 6 weeks, lmp. In some cases, this may occur up to a few days earlier.

6. Viability, the time when a fetus has a reasonable chance for sustained life outside the womb, albeit with lifesaving medical intervention, does not occur until approximately twenty-four weeks lmp. No pregnancy is viable at 6 weeks lmp, nor for several months thereafter.

7. It is my understanding that Red River Women's Clinic performs abortions through approximately 17 weeks lmp. No fetus is viable at this point in pregnancy.

8. Missing a period is the hallmark of pregnancy. A woman with a regular menstrual cycle will have a menstrual period every four weeks. This means that, if a woman with a regular menstrual cycle becomes pregnant, she will first miss a period at approximately four weeks lmp.

9. However, many women, including most adolescents, have irregular menstrual cycles. In addition to youth, other factors that can lead to irregular menstrual cycles include athletic activity, breastfeeding, stress, the use of birth control, the approach of menopause, and various illnesses. By 6 weeks lmp, women with irregular menstrual cycles may not realize that they have missed a period, and therefore not realize that they are pregnant.

10. Also, the implantation of an embryo in the uterine lining, at around three weeks lmp, can sometimes cause light vaginal bleeding or spotting. Some women mistake this bleeding for an early menstrual period. These women, too, many not realize they are pregnant by 6 weeks lmp.

11. Even for women with highly regular periods, 6 weeks lmp will be two weeks after they have their first missed period.

12. For those women who do know they are pregnant by 6 weeks lmp, HB 1456

> would create a narrow window of, at most, two weeks from their first missed period to decide whether they wish to choose to have an abortion and then to obtain one.

*See* Docket No. 42-2.

The record reveals that many women must travel long distances to the closest abortion provider, where in North Dakota only one clinic provides these services. Tammi Kromenaker indicates in her declaration that the Clinic's patients travel from throughout the state, and from neighboring states, resulting in hundreds of miles of travel for this care. *See* Docket No. 42-3, p. 3. Due to the small population of North Dakota and surrounding areas, the Clinic typically performs abortions only one day per week. *Id.* North Dakota law also requires a delay of at least twenty-four hours between the time a patient receives mandated information and when the abortion is performed. *See* N.D.C.C. § 14-02.1-03. If a patient is a minor, parental consent or judicial authorization is required, sometimes extending the twenty-four hour waiting period. *See* N.D.C.C. § 14-02.1-03.1 (requiring parental consent or judicial authorization for an abortion of an unmarried minor).

Dr. Eggleston and Dr. Iverson state many women do not know they are pregnant until after six weeks LMP, or after a heartbeat is detected. *See* Docket Nos. 42-1, p. 4 and 42-2, p. 4. Typically only women who have regular menstrual periods, keep close track of them, and take a pregnancy test promptly after a

missed period at four weeks LMP, will know they are pregnant by six weeks. *See* Docket Nos. 42-1, p. 4 and 42-2, p. 4. Because the Clinic only performs abortions one day per week, and cannot safely perform abortions before five weeks LMP, H.B. 1456 will effectively limit a woman's ability to obtain an abortion to a single day during the pregnancy's fifth week. *See* Docket No. 42-1, p. 4. According to the three most recent years of Induced Termination of Pregnancy Reports made available by the North Dakota Department of Health,[1] 91% of abortions performed at the Clinic occur at and after six weeks LMP. *See* Docket No. 42-3.

To refute the issue of viability, the Defendants submitted the affidavit of Jerry M. Obritsch, M.D. *See* Docket No. 70. Dr. Obritsch has opined that viability occurs at the point of conception. In other words, Dr. Obritsch equates viability with conception and states that because newly-created embryos can survive in a

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[1] N.D. DEP'T OF HEALTH, VITAL RECORDS, *available at* http://ndhealth.gov/vital/pubs.htm (follow Induced Termination of Pregnancy Report; then follow 2010 Report (pdf), 2011 Report (pdf), and 2012 Report (pdf)). Every abortion performed in North Dakota must be reported using a form provided by the Department of Health. N.D.C.C. §§14-02.1-02.2 and 14-02.1-07. The completed form includes the gestational age at which the abortion was performed. The State compiles this information and reports it on an annual basis. Because it appears that the Clinic is the only provider reporting abortions in North Dakota, these statistics reflect the percentage of women currently obtaining abortions at and after 6 weeks LMP at the Clinic. *See* Docket No. 42-3, p. 3.

test tube for 2-6 days as part of in vitro fertilization ("IVF"), viability occurs at the point of conception. *Id.* at ¶¶ 26-30. The gist of Dr. Obritsch's opinions are set forth in his affidavit:

> 26. In addition, Dr. Iverson's opinion that viability requires a percent chance the unborn child will survive to adulthood is medically erroneous. Viability in Obstetrics and Human Reproduction has vastly changed over the past decades. Viability was once thought to mean or be defined as only the ability of the unborn child to survive outside the uterus, albeit under the sophisticated care of the Neonatologist in the highly complex medical environment of the Neonatal Intensive Care unit (NICU). In modern and current medical and clinical practice, the embryo is able to survive as a human being independently at conception. This occurred for the first time in 1978 with the successful birth of Louise Brown and was known as the "test tube baby". Dr. Robert G. Edwards, the physiologist who developed the technology to successfully achieve this goal, was awarded the Nobel Prize in Medicine in 2010. Today in vitro fertilization (IVF) is commonly practiced and actually, Reproductive Endocrinology and Infertility (REI) has evolved into a well recognized subspecialty of the field of Obstetrics and Gynecology. It is my medical opinion that the development of Reproductive Technology

has caused and allowed an embryonic unborn child to live outside the human uterus (womb) for 2-6 days after conception – which is viability as defined by the United States Supreme Court and in the North Dakota statutes because this embryonic unborn child is not just potentially but is in fact living outside the woman's womb, albeit through artificial means. This viable unborn child is then transferred into the human uterus (womb) to continue its gestation. Once a heartbeat is detected in this implanted or any other unborn child within the womb, there exists a medically recognized 98% rate of survival and live birth for the unborn child and this medically recognized rate of survival and live birth drops only slightly to 82% when the woman has a history of recurrent pregnancy loss (being three or more consecutive spontaneous losses of the unborn child). *See Predictive value of the presence of an embryonic heartbeat for live birth: comparison of women with and without recurrent pregnancy loss. Hyer, et al., Sterility and Fertility, vol. 82, no. 5, November, 2004.* Since in vitro fertilization (IVF) or "test tube baby" – a colloquial term for babies conceived as the result of IVF, first occurred in 1978, 5 years after the decision of *Roe vs. Wade*, this information was unavailable to the United States Supreme Court for deliberation. However, since 1973, tremendous

medical advancements have occurred throughout all areas of Medicine, including the development of completely new areas such as the field of Reproductive Medicine.

27. Therefore based on the foregoing, it is my opinion, to a reasonable degree of medical certainty, an unborn child is viable or viability occurs, as medically defined as well as legally defined, from the time of conception.

> *(d) Viability at a time other than at conception is not a medically valid basis to determine whether state's interests to preserve life of unborn child are sufficiently strong to preclude an abortion.*

28. It behooves the legal profession to acknowledge the medical developments and advancements, and in turn appropriately act upon the current medical standards to change existing law, which is based on either old, outdated medical science, or previously unknown medical science and fact, or both. Viability now determined to occur at conception (see Paragraphs 19-27 above) provides a solid basis that will stand the test of time because it is not based on the ever shifting and changing neonatal definition, which currently plagues the legal and medical profession. For example, some like Dr. Iverson now conclude viability only can

occur at 22-24 weeks last menstrual period (LMP) when only a few years ago, these same parties concluded viability could only occur at 28-30 weeks last menstrual period (LMP). This standard of viability occurring at any time other than conception, being not only medically unsound, plagues the medical profession because of the uncertainty and vagueness when rendering a medical judgment as to whether viability is present for ongoing clinical decision making. Viability at conception is based on medical science and fact and is in alignment with natural law. It is clearly and succinctly defined.

29. Furthermore, the following sets forth the medically recognized attributes that exist in an unborn child demonstrate the framework of viability, at a time other than at conception, is no longer a medically valid basis:

(i) At the moment of conception, an unborn child has a unique set of DNA that never previously existed in the history of the world. Also, the hair and eye color, along with facial features are established at conception.

(ii) By 22 days after conception, the unborn child's heart was already beating and for some, with a different blood type than the unborn child's mother.

(iii) At 6 weeks after conception, an unborn child has brain function because the unborn child has detectable brain waves. Neurological development of the unborn child begins as early as the fourth week of development. The processes involved in the formation of the neural plate and neural folds and closure of the folds to form the neural tube constitute neurulation. Neurulation is completed by the end of the fourth week. *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 4, Third Week Of Human Development*, page 61. Neurological development not only involves the development of the central nervous system (brain and spinal cord), but the peripheral nervous system as well (sensory and motor (muscle)).

(iv) By the 8th week of development, the unborn child experiences pain in any capacity. (Testimony of Maureen L. Condic, PhD, University of Utah, School of Medicine, Department of Neurobiology and Anatomy, before the Subcommittee on the Constitution and Civil Justice, Committee on the Judiciary, U.S. House of Representatives, May 23, 2013 (judiciary.house.gov/hearings/113th/05232013/Condic%2005232013.pdf)). Therefore, by the 8th week of development, at the latest, the unborn child has brain function.

(v) Further, by 8 weeks after conception, every major organ of the unborn child is in place.

30. Therefore, in my opinion, to a reasonable degree of medical certainty, establishing viability of an unborn child at a time other than at conception is not a medically valid basis to determine whether the state's interests to preserve the life of an unborn child are sufficiently strong to preclude an abortion. Rather, viability being established at conception, and precluding the ending of the life of the unborn intentionally thereafter, is consistent with the state's and the medical profession's obligation to protect the health of the woman and the life of the unborn child and avoids the uncertainty and vagueness that exists with the current standard that will be ever evolving and changing.

*See* Docket No. 70, ¶¶ 26-30.[2]

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[2] Defense counsel was asked at the hearing whether the Defendants had actually adopted the position that viability occurs at the moment of conception and he said "I can't – I don't think it's been. I don't know if it's been adopted within the Attorney General's Office. I don't know if it's been adopted by the Board of Medical Examiners." Therefore, it appears this new position on abortion is a litigation strategy developed by defense counsel and designed to overturn *Roe v. Wade*, rather than a position adopted by the Defendants.

### C. H.B. 1456 VIOLATES A WOMAN'S RIGHT TO DUE PROCESS

The Plaintiffs' challenge to the abortion statute in question focuses on the purported infringement on the constitutional right to choose an abortion first enunciated in *Roe v. Wade*, 410 U.S. 113 (1973), and refined in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). In *Roe*, the United States Supreme Court held a pregnant woman has a constitutional right, under the Due Process Clause of the Fourteenth Amendment, to choose to terminate her pregnancy before viability. 410 U.S. at 152-66. "[T]he concept of viability . . . is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." *Casey*, 505 U.S. at 870 (citing *Roe v. Wade*, 410 U.S. at 163).

In *Casey*, the Supreme Court upheld *Roe's* essential holding by reaffirming "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State." 505 U.S. at 846. Thus, a woman has a constitutional right to choose to terminate her pregnancy before the fetus is viable without undue interference by the state. *Id.* This right is encompassed within a woman's right to personal privacy. The constitutional right to choose recognized in *Roe* and reaffirmed in *Casey* is "the woman's right to make the ultimate decision." *Id.* at 877.

The Supreme Court in *Casey* also clarified that the right to obtain an abortion is not absolute and that state interests in maternal health and protecting fetal life can, in some circumstances, justify regulations of abortion. *Id.* at 846. The Supreme Court in *Casey* abandoned *Roe's* trimester framework of analysis for determining the validity of an abortion regulation, and replaced it with an undue burden standard. Under the undue burden standard, an abortion law is unconstitutional on its face if "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Id.* at 845-46; *see also Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1456-58 (8th Cir. 1995).

The United States Supreme Court in *Casey* then asked whether a law designed to further the State's interest in fetal life, but which imposed an undue burden on a woman's decision before fetal viability, could be constitutional. *Id.* at 877. The Supreme Court clearly answered this question "no." *Id.* The plurality opinion in *Casey* contained a summary of the salient points which are useful for the issues presented by the constitutionality of H.B. 1456.

- An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus obtains viability.
- To promote the state's profound interest in potential life, throughout pregnancy

> the state may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. However, these measures must not be an undue burden on the right to have an abortion.
>
> - As with any medical procedure, the state may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion impose an undue burden on the constitutionally protected right to choose.
> - Regardless of whether exceptions are made for particular circumstances, a state may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.
> - Subsequent to viability, and in promoting its interest in the potentiality of human life, the state may regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

*McCormack v. Hiedeman*, 900 F. Supp. 2d 1128, 1143-44 (D. Idaho 2013) (citing *Casey*, 505 U.S. at 878-79).

The plurality in *Casey* explained "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877.

A woman's constitutional right to terminate a pregnancy before viability has consistently been upheld by the United States Supreme Court for more than forty years since *Roe v. Wade. See e.g.*, *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 420 (1983) (a woman has a constitutional right to terminate her pregnancy) (overruled on other grounds); *Casey*, 505 U.S. at 846 (a woman has a right to an abortion before viability without undue interference from the state); *Stenberg*, 530 U.S. at 921 (a woman has the right to choose an abortion before viability); *Gonzales*, 550 U.S. 124 (the state may not prevent "any woman from making the ultimate decision to terminate her pregnancy").

The right to terminate a pregnancy is not absolute, and must be balanced with the state's interest in protecting the woman's health and the potential life of the fetus. *Roe*, 410 U.S. at 162. After the fetus becomes viable, a state's interest in protecting its potential life becomes compelling enough in certain circumstances to outweigh the woman's right to seek an abortion. *See Casey*, 505 U.S. at 845-46. However, it is clear that before viability, "the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to

the woman's effective right to elect the procedure." *Id.* The state can impose *regulations* aimed at ensuring a thoughtful and informed choice, but only if such regulations do not unduly burden the right to choose. *Id.* at 872. The Supreme Court's central holding in *Roe* and *Casey* is that *viability* marks the earliest point at which a state's interest in fetal life may be adequate to justify a ban on non-therapeutic abortions. Thus, it is well-established in United States Supreme Court precedent that before viability a woman has a right to choose to terminate her pregnancy.

Recently, other federal courts have been faced with similar state statutes that would effectively eliminate a substantial portion of abortions in various states. These courts have found such statutes to constitute a substantial obstacle to a woman's right to seek an abortion. *See, e.g.*, *Okpalobi v. Foster*, 190 F.3d 337, 357 (5th Cir. 1999) (affirming a district court's finding that the regulation's effect of closing clinics which provided approximately 80% of all abortions in the state constituted an undue burden); *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280 (M.D. Ala. 2013) (granting temporary restraining order where admitting privileges requirement would close three of five clinics in the State of Alabama); *Jackson Womens' Health Org. v. Currier*, 940 F. Supp. 2d 416 (S.D. Miss. 2013) (granting preliminary injunction after finding an undue burden where state admitting privileges requirement would close the only known abortion provider in Mississippi).

A federal district court in Arkansas recently addressed a very similar constitutional challenge to a state statute seeking to ban abortions where a fetal heartbeat is detected and the fetus has reached twelve weeks gestational age. *See Edwards v. Beck*, 946 F. Supp. 2d 843 (E.D. Ark. 2013). The United States District Court for the Eastern District of Arkansas found the Plaintiffs met the burden of showing sufficient evidence of each *Dataphase* factor, warranting a preliminary injunction enjoining the act passed by the Arkansas Legislature seeking to prohibit abortions where a fetal heartbeat is detected after twelve weeks LMP. *Id.* at 846-51. More important, the federal district court in Arkansas found that an abortion law is unconstitutional on its face if, in a large fraction of the cases in which the law is relevant, the law will operate as a substantial obstacle to a woman's choice to undergo an abortion. *Id.* at 848. The federal case in Arkansas involved a law prohibiting abortions after twelve weeks LMP, which is six weeks later than the North Dakota law (H.B. 1456).

On March 14, 2014, the Arkansas court ultimately determined the portion of the law prohibiting abortions after twelve weeks gestation, and after a heartbeat has been detected, to be unconstitutional. *See Edwards v. Beck*, No. 4:13-CV00224 SWW, 2014 WL 1245267 (E.D. Ark. Mar. 14, 2014). The Arkansas court found "as a matter of law that the twelve-week abortion ban included in [the Arkansas Legislation] prohibits pre-viability abortions and thus impermissibly

infringes a woman's Fourteenth Amendment right to elect to terminate a pregnancy before viability." *Id.* at *4. The federal district court in Arkansas permanently enjoined the enforcement of the portions of the Arkansas law which prohibited abortions "where a fetal heartbeat is detected and the fetus has attained twelve weeks' gestation." *Id.* at *8.

On May 21, 2013, and prior to the Arkansas ruling, the Ninth Circuit Court of Appeals held that an Arizona law passed prohibiting abortions beginning at 20-weeks gestation was unconstitutional. *See Isaacson v. Horne*, 716 F.3d 1213 (9th Cir. 2013). In the court's words,

> [u]nder controlling Supreme Court precedent, Arizona may not deprive a woman of the choice to terminate her pregnancy at any point prior to viability. Section 7 effects such a deprivation, by prohibiting abortion from twenty weeks gestational age through fetal viability. The twenty-week law is therefore unconstitutional under an unbroken stream of Supreme Court authority, beginning with *Roe* and ending with *Gonzales*. Arizona simply cannot proscribe a woman from choosing to obtain an abortion before the fetus is viable.

*Id.* at 1231. The Supreme Court of the United States recently declined to hear the appeal, leaving in place the Ninth Circuit decision and effectively striking down the ban on abortions in Arizona. *See Horne v. Isaacson*, 134 S. Ct. 905 (2014). The decision of the

Ninth Circuit was consistent with legal precedent established by the United States Supreme Court for more than forty years.

It is clear from United States Supreme Court precedent that *viability*, although not a fixed point, is *the* critical point. The Supreme Court in *Casey* noted that although the line of viability may come earlier with advances in neonatal care, the attainment of viability continues to serve as the critical factor. 505 U.S. at 860. The Supreme Court in *Casey* could not have been more clear in stating:

> We have seen how time has overtaken some of *Roe*'s factual assumptions: advances in maternal health care allow for abortions safe to the mother later in pregnancy than was true in 1973, . . . and advances in neonatal care have advanced viability to a point somewhat earlier. . . . But these facts go only to the scheme of time limits on the realization of competing interests, and the divergences from the factual premises of 1973 have no bearing on the validity of *Roe*'s central holding, that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. The soundness or unsoundness of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity

> can somehow be enhanced in the future. Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since *Roe* was decided; which is to say that no change in *Roe*'s factual underpinning has left its central holding obsolete, and none supports an argument for overruling it.

*Id.*

Although viability may be a flexible point, it is clearly one that is medically determinable. The United States Supreme Court has repeatedly held that "'the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.'" *Colautti v. Franklin*, 439 U.S. 379, 396 (1979) (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64-65 (1976)). The Supreme Court further said that is precisely why a state may not fix viability at a specific point in the pregnancy. *Id.* at 388-89.

This Court fully recognizes the attainment of viability may continue to come earlier in a pregnancy with significant advances in medicine. The practical effect of H.B. 1456 is to prohibit any abortion after a heartbeat is detected, which can occur as early as six weeks LMP. Coupled with the standard set forth in current North Dakota law that an abortion is allowed until viability, the new law suggests a fetus is viable at six weeks which is the point a heartbeat is generally detected.

For purposes of this lawsuit, the Defendants have now taken it one step further and assert that viability occurs at the moment of conception. Counsel for the Defendants acknowledged that he was unaware of any other state in the country, or any other case in the country, where an expert witness has opined that viability occurs at the moment of conception. Although the Defendants have strained to create a material issue of fact through the affidavit of Dr. Obritsch, the position that viability occurs at the moment of conception is one this Court is obligated to reject under binding precedent of the United States Supreme Court.

The Plaintiffs submitted affidavits of two experienced medical professionals whom have opined that viability does not occur until twenty-four weeks LMP. That time frame appears to be consistent with modern day medicine. It is also consistent with the litany of United States Supreme Court case law this Court is bound to uphold. The evidence presented under the applicable substantive law is so one-sided that summary judgment is appropriate and warranted based on the lack of any genuine issue of material fact.

The Court finds that the affidavit of Dr. Obritsch does not create a genuine issue of material fact primarily because Dr. Obritsch uses a different definition of viability than the one used by either the United States Supreme Court or the medical community generally. It is clear from *Roe* and *Casey*, and the medical authority cited therein, that viability "is the

time at which there is a realistic possibility of maintaining and nourishing a life outside the womb," albeit with artificial aid. *Casey*, 505 U.S. at 870; *Roe*, 410 U.S. at 163. That is, viability is the time that life can be sustained on a continuous basis outside the womb without having to be returned to the womb for proper development.

The definition of viability announced by the Supreme Court in *Roe* and *Casey* is contrary to Dr. Obritsch's definition. The affidavit of Dr. Obritsch asserts that viability occurs at conception because of the ability of the embryo to be sustained by artificial means outside the womb for a short period of time before being returned to the uterus "to continue its gestation." *See* Docket No. 70, ¶ 26. The State does not contend that an embryo can be sustained on a continuous basis, and properly nourished from the time of conception, without the need for further development in the uterus. Nor has the State cited to any medical literature to support this theory of viability. There may indeed be medical developments that will one day significantly affect the precise point of viability. But the Supreme Court has announced the rule of law which this Court has no authority to renounce. The affidavit submitted by the State to support the position that viability occurs at the moment of conception is contrary to the rule of law established in *Roe* and *Casey*. The Defendants have failed to provide reliable evidence that a fetus, at the time a heartbeat is first detected around six weeks,

could live outside of the mother's womb and thus be *viable*.

The Defendants have admittedly undertaken an effort to overturn *Roe v. Wade* and United States Supreme Court precedent that has existed for decades. The State has recently taken the position in this lawsuit that a fetus is *viable* at the point of conception. Neither this Court nor any other federal district court in the country has the discretion to take that giant leap based on a definition of viability that is contrary to that announced by the Supreme Court. To take the position that viability occurs at the moment of conception results in a complete ban of all abortions which is in clear defiance of United States Supreme Court precedent.

Suffice it to say the Defendants' arguments rest on the premise that every federal district court and appellate court in this country which has upheld the law as announced by the United States Supreme Court for the past forty years has misread Supreme Court precedent. The bright-line viability rule the United States Supreme Court established in *Roe* and affirmed in *Casey* cannot be overturned by this Court based on a single affidavit of a physician who has opined that viability occurs at the point of conception.

H.B. 1456 clearly prohibits pre-viability abortions in a very significant percentage of cases in North Dakota, thereby imposing an undue burden on women seeking to obtain an abortion. H.B. 1456 equates fetal viability with a 6-week gestational age

and a fetal heartbeat, and it bans abortions according to that definition. On December 19, 2013, the State submitted an affidavit and has now essentially taken the position that *all* abortions after the point of conception are prohibited. Even counsel for the State of North Dakota acknowledged this position is unprecedented in this country. This position is clearly contrary to the law of the land as announced by the United States Supreme Court, and which this Court is obligated to apply. It is well-established that controlling United States Supreme Court precedent provides that viability is "the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection. . . ." *Casey*, 505 U.S. at 870 (citing *Roe*, 410 U.S. at 163).

It is clear and undisputed that until *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* are overturned by the United States Supreme Court, all lower courts are bound to follow that precedent under the rule of *stare decisis. See Casey*, 505 U.S. at 870 (stating that the doctrine of *stare decisis* requires reaffirmance of *Roe v. Wade*'s essential holding recognizing a woman's right to choose an abortion before fetal viability). In considering the fundamental constitutional question resolved by *Roe v. Wade* and *Casey*, principles of institutional integrity, and the rule of *stare decisis*, this Court is led to conclude that H.B. 1456 is unconstitutional.

## III. CONCLUSION

After a careful review of the entire record, there is no question that North Dakota House Bill 1456 is in direct contradiction of United States Supreme Court case law addressing restraints on abortion. H.B. 1456 is an invalid and unconstitutional law based on the United States Supreme Court precedent in *Roe v. Wade* from 1973, *Planned Parenthood of Southeastern Pennsylvania v. Casey* from 1992, and the litany of cases that have followed. As a practical matter, H.B. 1456 would ban nearly all abortions performed at the only clinic in North Dakota which provides such services. If this Court adopts the Defendants' newly-stated position that viability occurs at the point of conception, H.B. 1456 would ban all abortions performed in North Dakota. The North Dakota strict ban on abortions at the time when a "heartbeat" has been detected – essentially banning all abortions as early as six weeks of pregnancy – cannot withstand a constitutional challenge.

A woman's constitutional right to terminate a pregnancy before viability has been recognized by the United States Supreme Court for more than forty years. The United States Supreme Court has clearly determined the dispositive issue presented in this lawsuit. This Court is not free to impose its own view of the law.

The State of North Dakota has presented no reliable medical evidence to justify the passage of this troubling law. No genuine issue of material fact is

created by a single affidavit that contravenes existing Supreme Court case law, and was offered for the purpose of attempting to overturn long-standing United States Supreme Court precedent. As the Court noted back in July of 2013, the State has extended an invitation to an expensive court battle over a law restricting all abortions that is a blatant violation of the constitutional guarantees afforded to all women.

The United States Supreme Court has spoken and has unequivocally said no state may deprive a woman of the choice to terminate her pregnancy at a point prior to viability. The Supreme Court recently declined to hear an appeal from the Ninth Circuit Court of Appeals which struck down an Arizona law prohibiting abortions beginning at 20-weeks gestation. Further, the Supreme Court has never held that viability occurs at the point of conception, which is the new position advocated by the State of North Dakota in its responsive pleadings, in an effort to overturn *Roe v. Wade*. The controversy over a woman's right to choose to have an abortion will never end. The issue is undoubtedly one of the most divisive of social issues. The United States Supreme Court will eventually weigh in on this emotionally-fraught issue but, until that occurs, this Court is obligated to uphold existing Supreme Court precedent.

Accordingly, the Court **GRANTS** the Plaintiffs' motion for summary judgment (Docket No. 40) and permanently enjoins the implementation of House Bill 1456. With no further issues to be decided, the

Court **FINDS AS MOOT** the Defendants' motion for discovery (Docket No. 66).

**IT IS SO ORDERED.**

Dated this 16th day of April, 2014.

*/s/ Daniel L. Hovland*
Daniel L. Hovland, District Judge
United States District Court

## APPENDIX C

### United States Constitution

**Amendment XIV, Section 1**

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

## APPENDIX D

### North Dakota Abortion Control Act

**14-02.1-05.1. Determination of detectable heartbeat in unborn child before abortion – Exception.**

1. Except when a medical emergency exists that prevents compliance with this subsection, an individual may not perform an abortion on a pregnant woman before determining, in accordance with standard medical practice, if the unborn child the pregnant woman is carrying has a detectable heartbeat. Any individual who performs an abortion on a pregnant woman based on the exception in this subsection shall note in the pregnant woman's medical records that a medical emergency necessitating the abortion existed.

2. If a physician performs an abortion on a pregnant woman before determining if the unborn child the pregnant woman is carrying has a detectable heartbeat, that physician is subject to disciplinary action under section 43-17-31.

**14-02.1-05.2. Abortion after detectable heartbeat in unborn child prohibited – Exception – Penalty.**

1. Notwithstanding any other provision of law, an individual may not knowingly perform an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn child the

pregnant woman is carrying and whose heartbeat has been detected according to the requirements of section 14-02.1-05.1.

2. a. An individual is not in violation of subsection 1 if that individual performs a medical procedure designed to or intended, in that individual's reasonable medical judgment, to prevent the death of a pregnant woman, to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, or to save the life of an unborn child.

   b. Any individual who performs a medical procedure as described in subsection 1 shall declare in writing, under penalty of perjury, that the medical procedure is necessary, to the best of that individual's reasonable medical judgment, to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman. That individual also shall provide in that written document, under penalty of perjury, the medical condition of that pregnant woman that the medical procedure performed as described in subdivision a assertedly will address, and the medical rationale for the conclusion that the medical procedure is necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment

of a major bodily function of the pregnant woman.

c. The individual who performs a medical procedure as described in subdivision a shall place the written documentation required under subdivision b in the pregnant woman's medical records and shall maintain a copy of the written documentation in the individual's own records for at least seven years.

3. An individual is not in violation of subsection 1 if that individual has performed an examination for the presence of a heartbeat in the unborn child utilizing standard medical practice and that examination does not reveal a heartbeat in the unborn child or the individual has been informed by a physician who has performed the examination for the unborn child's heartbeat that the examination did not reveal a heartbeat in the unborn child.

4. It is a class C felony for an individual to willingly perform an abortion in violation of subsection 1. The pregnant woman upon whom the abortion is performed in violation of subsection 1 may not be prosecuted for a violation of subsection 1 or for conspiracy to violate subsection 1.

5. This section does not prohibit the sale, use, prescription, or administration of a measure, drug, or chemical designed for contraceptive purposes.

## APPENDIX E

### N.D. Cent. Code §§ 27-20-02, 50-25.1-15

**27-20-02. Definitions.**

As used in this chapter:

* * *

2. "Abandoned infant" means a child who has been abandoned before reaching the age of one year.

* * *

**50-25.1-15. Abandoned infant – Hospital procedure – Reporting immunity.**

1. As used in this section:

   a. "Abandoned infant" means an abandoned infant as defined in section 27-20-02 and which has been left at a hospital in an unharmed condition.

   b. "Hospital" means a facility licensed under chapter 23-16.

2. A parent of an infant may abandon the infant at any hospital. An agent of the parent may leave an abandoned infant at a hospital with the parent's consent. Neither the parent nor the agent is subject to prosecution under sections 14-07-15 and 14-09-22 for leaving the abandoned infant at a hospital.

3. A hospital shall accept an infant abandoned or left under this section. The hospital may request information regarding the parents and shall provide the parent or the agent with a medical history form and an envelope with the hospital's return address.

Neither the parent nor the agent is required to provide any information.

4. The hospital shall provide the parent or the agent with a numbered identification bracelet to link the parent or the agent to the abandoned infant. Possession of an identification bracelet does not entitle the bracelet holder to take custody of the abandoned infant on demand. If an individual possesses a bracelet linking the individual to an abandoned infant left at a hospital under this section and parental rights have not been terminated, possession of the bracelet creates a presumption that the individual has standing to participate in a protection services action brought under this chapter or chapter 27-20. Possession of the bracelet does not create a presumption of maternity, paternity, or custody.

5. The hospital may provide the parent or the agent with any relevant information, including:

a. Information about the safe place for abandoned infant programs;

b. Information about adoption and counseling services; and

c. Information about whom to contact if reunification is sought.

6. Within twenty-four hours of receiving an abandoned infant under this section, the hospital shall report to the department, as required by section 50-25.1-03, that an abandoned infant has been left at the

hospital. The report may not be made before the parent or the agent leaves the hospital.

7. The hospital and its employees and agents are immune from any criminal or civil liability for accepting an abandoned infant under this section.

8. Upon receiving a report of an abandoned infant left at a hospital under this section, the department shall proceed as required under this chapter if it appears that the abandoned infant was not harmed, except the department may not attempt to identify or contact the parent or the agent. If it appears the abandoned infant was harmed, the department shall initiate an assessment of the matter as required by law.

9. If an individual claiming to be the parent or the agent contacts the department and requests to be reunited with the abandoned infant, the department may identify or contact the individual as required under this chapter and all other applicable laws. If an individual contacts the department seeking information only, the department may attempt to obtain information regarding the identity and medical history of the parents and may provide information regarding the procedures in an abandoned infant case. The individual is under no obligation to respond to the request for information, and the department may not attempt to compel response to investigate the identity or background of the individual

## APPENDIX F

## IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTH DAKOTA SOUTHWESTERN DIVISION

| | | |
|---|---|---|
| MKB Management Corp., d/b/a Red River Women's Clinic, et al., | ) | |
| Plaintiffs, | ) | |
| vs. | ) | Case No. 1:13-cv-071 |
| Birch Burdick, in his official capacity as State Attorney for Cass County, et al.; | ) | |
| Defendants. | ) | |

## DECLARATION

STATE OF NORTH DAKOTA )
) SS.
COUNTY OF CASS )

My name is Jennifer Kraft. I am over the age of eighteen years, and I am of sound mind and competent to make this declaration. I have personal knowledge of the facts stated in this declaration, and I declare under penalty of perjury the following:

1. I have had two abortions. One in August, 2003 at a facility in Minneapolis and the other in January, 2004 at the Red River Women's Clinic in Fargo, North Dakota.

2. I am married and have three children with my husband. My children are ages 18, 15, 12 year old.

3. I graduated from Key West High School in Key West, Florida. I did go to UND-Lake Region and NDSU. I have not gotten my Bachelors yet. I was studying vocal education but dropped out of school right before things happened.

4. Throughout my life, I have had a history of mental health problems starting when I was just a child. I have been diagnosed with borderline personality disorder, severe depression, possibly bipolar disorder, anxiety disorder and more recently was diagnosed with PTSD. I am currently seeing a counselor, psychiatrist and psychologist and have been doing so for a long time.

5. I have had numerous traumatic events during my lifetime. As a child, I was witness of physical and verbal abuse by my parents and step-parents, and witnessed substance abuse. The physical and verbal abuse I witnessed, carried over to me as I was subject to physical and verbal abuse by my mother and step-mother. I was also sexually abused by a boyfriend of my mother when I was only 3 years old. At age 17, I lost a baby and had a D&C procedure. At age 12, I was in a mental health institution and while there was sexually abused. I ran away from this institution and that night, I was physically attacked at knife point, and was raped by the attacker.

6. I also have had a substance abuse problem for nearly my entire life. I am currently in treatment

and have been for 7 months. When I was in college at UND-Lake Region, I was an older than average student, with three children, but I would go out and party with girls that I should not have and got introduced to and hooked on meth. My meth use started after the birth of my third child.

7. My first abortion occurred because I had an extra-marital affair with my meth dealer and became pregnant. This affair occurred after the birth of my third child.

8. At that time, my husband and I were having marital problems and we had a lot of resentment toward each other. When I told him that I was pregnant and the father was my meth dealer, he said that we would no longer be together if I had another man's child. He told me he would kick me out of the house and that I would never see my children again. My husband hated me at this time. I was scared and I did not know what to do, so I went along with his plan to get an abortion.

9. We drove to Minneapolis to have the abortion. I think we decided to go there because it was an insurance thing and it was cheaper. Also, my husband and I are Catholic. Our kids go to Catholic school. We were afraid to go to the Red River Clinic because we thought we would see people who know us, like those that were praying out front or those that work in the businesses in downtown Fargo. We did not want anyone to see me going in there that knew us. We were ashamed and knew it was wrong but I didn't

know any other way or what to do, especially since I was being told I would be kicked out of the house and would not see my kids if I did not have the abortion.

10. My husband just dropped me off at the Minneapolis abortion clinic – he did not come in with me. When the procedure was over, I called my husband to come pick me up. I was outside the clinic for a long time and was not sure if my husband would even come and get me. He did and we drove back to Fargo right afterwards – we said nothing to each other and it was a horrible day.

11. This first abortion in Minneapolis was very early in my pregnancy – maybe around 6 or 7 weeks. The abortion happened on the wedding anniversary for my husband and me.

12. My husband and I did not ever meet the people from the Minneapolis abortion clinic or even talk to them before I went into the clinic – I just went in. I went in and did some paperwork. I'm pretty sure they asked about the number of children I had and whether I had any abortions before. I do not think the people at the abortion clinic ever asked me if I needed any type of counseling or even asked if I had any mental health problems. They should have known because I would have showed them the medications that were in my purse. There was no counseling at all. All they said was I could talk to somebody before the abortion but it was not like they were saying I should talk to someone. I did not do so because I was scared I would change my mind and if I did so, then I

knew my husband would kick me out of the house and I would not see my kids. This clinic never followed up with me or gave me anything, not even a contact phone number to call after my abortion if I needed any further help.

13. The time when I entered the clinic until I was outside on the steps waiting for my husband was about 90 minutes. There were a lot of women at this clinic. Women were parading in and you basically took a number – it was like a mill.

14. The nurses at the Minneapolis abortion clinic got me ready and brought me to the exam room. It was a dark room. It was really odd how dark it was in the room as I was thinking it should be brighter in the room – like an operating room that has bright lights – but it was not. I was put on the examination table, with my gown on and my legs were put into stirrups. At that point, I was then left all alone to wait for the procedure to happen. It seemed like forever that I was in the exam room by myself – it was horrible and freaky.

15. The doctor then came in the room along with the nurses – I think there was one or two nurses in the room during the procedure. I never spoke to the doctor before the procedure. I don't think the doctor said one thing to me while he was in the examination room. I never even saw the doctor's face because he had a nose & mouth mask on the entire time. The doctor turned on the machine. I didn't say anything during the procedure. I just cried. The nurse

said it's okay, it's okay. I was crying because I didn't want to do it – it felt so wrong and I had so much trauma in my life, and I was all alone and never got to see any faces and it was so impersonal.

16. I got pregnant shortly after this first abortion. I ended up seeing my meth dealer again and I again had an extra marital affair with him that resulted in me getting pregnant. My husband and I were alienated at that time. Within weeks after my affair with my meth dealer, I realized I was pregnant again. I didn't do a test – I just knew I was pregnant. I kept trying to ignore the fact I was pregnant again.

17. This time I called and made an appointment at the Red River Women's Clinic in Fargo. I was scheduled to come in a day or two later. I think my abortion was scheduled for January 4-6, 2004. I was told by the Red River Women's Clinic person that I was a little over 12 weeks pregnant when I went in for the abortion.

18. I went to the appointment by myself. I did not tell anyone that I was pregnant or that I was getting an abortion. I parked the car around the corner from the Red River Women's Clinic in downtown Fargo and walked a block or two there. I did not want anyone to see me going in. I had to check to see if anybody was outside praying – and there wasn't and I thanked God there was nobody out there today.

19. The one thing I remember was the Red River Women's Clinic required that I pay for the procedure first before they would go any further –

even to fill out paper work was not to be done until I gave them the money for the procedure. They made it pretty clear if you didn't have money on you, you weren't going any further. Once I gave them the money, I felt committed to going forward with the abortion no matter what would have happened later or if I changed my mind. Once I handed over the cash, when I started second guessing, I would think that I already paid for it I'm not backing out and that I would not get my money back. I feel like they take payment first for that reason.

20. After I gave them the money, the first 20 minutes I was in the Red River Women's Clinic was to fill out some paperwork – asking about medications and signing releases. They did say that they do have some counseling before and after the procedure but it was the same as it was at the Minneapolis abortion clinic – that I can talk to someone if I liked but it was not necessary for me to do that. I again declined.

21. At Red River Clinic they talked to me a little bit, but still really nothing about my mental health history. They asked if I had an abortion previously and I said no even though I had one just a short time before in Minneapolis. I lied to them because I was so ashamed, and it sounded so bad that I had an abortion before, and I also thought I might not be able to have another abortion. I just couldn't tell them I had an abortion.

22. I do not remember the Red River Women's Clinic asking me about any medications I was taking.

I brought them in my purse and showed them the medications I was taking for my mental health problems. When they saw my medications they didn't say anything about that they thought I needed to see a counselor – before the procedure or that they would contact my doctors or would send me to someone for counseling after the procedure.

23. After the paperwork was done, I went to an exam room for about 15 to 20 minutes, where I changed. Once I was in the exam room, they then explained the procedure to me, and told me the doctor's name. I do not remember the name of the doctor but he was an older gentleman. I do remember the doctor saying only one thing – but it was not to me – because when he started the abortion procedure, he said something to effect that he knew I had a recent abortion and the nurse responded that this was not in my chart. They did not stop the procedure because of this.

24. The abortion procedure took only a couple of minutes. When it was done, the doctor just left and he never said a thing to me – in fact he said nothing to me other than to introduce himself. I then went to a recovery room for 30-45 minutes, I spoke to no one because I was such shock and horror as to what I had just done in killing my baby and I left. I think I was in the clinic a total of about 90 minutes.

25. I was shaking and bawling during the entire abortion procedure. This was because before I went to the clinic I could feel my baby move around – it felt

like butterflies in my stomach – those were wonderful feelings. I was also showing as to my pregnancy and I was even starting to produce milk. As I was sitting in the clinic waiting for the abortion doctor to show up I could feel those butterfly like movements of my baby again. Then, when the doctor went inside of me with that vacuum device he used, I could then feel my baby kicking me – it wasn't the butterfly feeling any more but was a kick because I could feel that my baby was trying to move away from the vacuum device that was used by the abortion doctor to kill my baby. I just could not take it – I was bawling and shaking because I just knew I was killing my baby but my baby was trying not to die. That was so traumatic to feel my baby trying to stay alive. I was crying so hard because as the procedure was going on, I did not want to do this. The nurse just told me "you're okay you're okay – you are making the right decision for you, for your situation – you're fine." The doctor who performed the abortion said nothing to me.

26. The sound of the vacuum really freaked me out too – it was so gross, like it was sucking out my uterine lining. I knew the abortion doctor was pulling my baby out of me – it was a sickening feeling. When the vacuum machine stopped, I knew I had just killed my baby and at that moment I felt like I was the worst person in the world, I hated myself – I knew it was wrong – I knew I was being selfish. I knew right then and there I was going to hurt myself. It was so traumatic to physically feel what I had felt during that procedure. When I heard that suction stop on

that machine and I felt them pulling the baby's body out of me, I just totally shut down – I thought I had just killed my baby.

27. I also remember thinking to myself that I had just killed somebody else's baby not just my own – I had just killed the father's child. I felt really guilty I was killing someone's baby because I did not tell him about this one. I did tell him about the first abortion and he was really upset about it, so I didn't tell him about this one. He does know now. In fact, I was approached a couple years ago – I saw his teenage daughter in public she was 18 or 19 years old, and she said I know who you are and she knew my name and was telling me all the pain I had caused her father because of the abortion. She was so upset she was yelling at me at first and I explained to her what I was feeling and then we cried together and I hugged her and then her mother came around the corner and started screaming at me who are you and why did you make my daughter cry. I ran. We were in a grocery store in Fargo, I left my cart and everything. I sat in my car and hyperventilated. It was awful.

28. After the abortion was done at the Red River Women's Clinic, I went into a recovery room and there was a lady there who I think was from the Red River Women's Clinic, and some other women that had just had an abortion. I don't remember if anyone talked to me at all. I was numb – I had turned myself off. I vaguely remember someone being there and patting my arm, but I don't remember getting

dressed, I don't remember leaving, driving home or anything that happened the next several days. I really don't remember anything until the morning I decided to kill myself. I remember that day vividly – that was the 11th – so about 5 days or 6 days after the abortion at the Red River Women's Clinic.

29. I hated myself so much for what I had done in aborting my child at the Red River Women's Clinic, that I decided to kill myself. I had planned my suicide so that my children wouldn't find me but my husband would. I planned to kill myself on a Thursday because my husband only worked half a day so he would be the first person to find me – before my kids got home from school. I waited until they all left for the day and then I took every pill in the house – I was on a lot of stuff. I had barbiturates and narcotics – I'd gone through viral meningitis so had a bunch of those. I took over 300 pills with a bottle of wine in 30 minutes and just laid down to die. My son was very in tune to everyone else's feelings – he insisted coming home and said he was sick, so I was called by the school right after taking the pills. I was already getting fuzzy. I said I can't come get him, call his dad and I hung up. My husband was not available because he was out trying to file for divorce. So the next person to contact by the school was my brother-in-law and he picked up my son. I stumbled to the door and said get him out of here. I told him to go find my husband and I slammed the door. My husband came home and I remember him yelling at me for being stupid and I vaguely remember the paramedics. I woke up 3 days

later at Meritcare (now it is Sanford) and then after the 2 week hold, I was transferred to the North Dakota State Hospital. While I was being transmitted by the ambulance to Meritcare, the emergency responders revived me twice. While I was at Meritcare, I was revived 3 times. I had been restrained for several days while at Meritcare. I had paddle marks on my chest and restraint marks on my arms and I had been trying to pull the iv's out and the tubes out of my throat. I didn't remember any of it. I was very angry when I woke up that I wasn't dead.

30. My husband and I went through Rachel's Vineyard. The decision that my husband made that day tore him up too – for putting me in the position to make the decision to kill another man's baby. He hated himself for not having the courage to deal with it, to allow the baby to live. We both hated ourselves for a long time. He went to confession and did his penance and was okay, but when I went to confession I couldn't forgive myself. I think he had a hard time forgiving himself for the pain he had put me through too, once he'd forgiven me through confession. My children were so angry when they found out. My daughter still cries sometimes – she tells me that she wishes she had a little brother or sister and asks me why? How could I do that? We have a memorial set up in our house for each of the babies that I aborted.

31. I am now in after care one hour a week, and see a counselor, psychiatrist and my addiction sponsor on a regular basis. I'm at the point where I'm ready. I realize now that every experience I go

through is to lead me to something. This feels right. I truly feel that my experiences are meant to help others in the same situation. If I can help them through it or not to do the same thing I did – that can be the only point of it.

32. I do not remember if the Red River Women's Clinic gave me any information or contacts if I needed any help after my abortion. But I now think why didn't they have more help or counseling for me, especially since I had a long history of mental health problems. I mean if you go in for a routine procedure or some surgery, there is counseling to make sure you can handle the procedure. When I have a gynecology appointment they ask if there's been any sexual trauma so they approach you different when they do the exam. I am blown away now that I've thought about it that none of that was given or even offered to me, even though I had all of those mental health and emotional problems. I just can't imagine anyone having an abortion and not freaking out.

33. My abortions have been so negative and bad for me. I have had mental health and emotional problems but the abortions really compounded these problems and my trauma. I mean when I felt my baby trying to escape from being killed by the vacuum device at the Red River Women's Clinic, I just could not take it anymore – I wanted to die and tried to kill myself. I have been violated many times in my life and the abortions felt like just another violation. Because of what I have gone through, I have now

been officially diagnosed with PTSD along with the other mental health problems I have had in my life.

34. Also, since my abortions, I have unable to hold a job for any length of time. Before my abortions, I was able to work. Now, I am on social security disability benefits because I am not capable of holding a job and functioning because of my mental health problems.

35. Over the years and through my counseling, I have been able to cope with my physical, mental and sexual abuse and I am at ease in talking about this. But with my abortions, that is something that I will never forget that traumatic event and I always become very emotional whenever it is brought up or when I speak about it.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 8th day of January, 2014.

Signature: Jennifer L. Kraft
Jennifer Kraft

Subscribed and sworn before me by Jennifer Kraft this 8th day of January, 2014.

DANIEL L. GAUSTAD
NOTARY PUBLIC
STATE OF NORTH DAKOTA
My Commission
Expires: Dec. 4, 2014

/s/ Daniel L. Gaustad
Notary Public
State of ND
My Commission Expires:
12/4/2014

**APPENDIX G**

**IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTH DAKOTA SOUTHWESTERN DIVISION**

| | |
|---|---|
| **MKB MANAGEMENT CORP., et al., Plaintiffs,** | **Declaration and Expert Report of Jerry M. Obritsch, MD, FACOG** |
| **vs.** | |
| **BIRCH BURDICK, et al. Defendants.** | **Case No. 1:13-cv-071** |

Jerry M. Obritsch, MD, FACOG declares and states the following:

## I. Professional Background and Credentials

1. I provide the following opinions as an expert in embryonic and fetal development and a practicing Obstetrician in the State of North Dakota.

2. I am certified by the American Board in Obstetrics and Gynecology and a certified sonographer in Obstetrics and Gynecology by the American Registry of Diagnostic Medical Sonographers.

3. I am licensed to practice Medicine in North Dakota, South Dakota, and Missouri. I have practiced Obstetrics and Gynecology in the State of North Dakota continuously for the past 22 years (since 1991).

4. I earned a Bachelor's degree in Biology and a Bachelor's degree in Chemistry from Dickinson State University, Dickinson, ND, in 1979. I earned a Master of Science degree in Microbiology from the University of Nebraska, Lincoln, NE, in 1980. I completed my Medical Doctor (MD) degree at the University of North Dakota School of Medicine and Health Sciences, Grand Forks, ND, in 1987. I completed my Graduate Medical Education (Resident Physician) in 1991 in the School of Medicine, University of Missouri, Columbia, MO.

5. I began private practice as an Attending Obstetrician and Gynecologist in 1991 at the Center For Women, Mid Dakota Clinic, Bismarck, ND, and continue to practice as such to the present time. I am Vice Chairman and Clinical Professor in the School of Medicine, University of North Dakota School of Medicine and Health Sciences.

6. I am a Fellow in the American Congress of Obstetrician and Gynecologists (ACOG), the Nation's leading organization in Women's Health Care, and a member of the North Dakota Society of Obstetricians and Gynecologists

7. I am a member of Alpha Omega Alpha Honor Medical Society, founded by William W. Root, MD, 1902. This is the elite honor society of medical students, residents, and physicians.

8. A copy of my curriculum vitae which summarizes my background and professional experience is attached hereto as Exhibit A.

## II. Introduction

9. I was retained by the Office of the Attorney General, Civil Litigation Division, as an expert witness on behalf of the State of North Dakota in defense of House Bill 1456.

10. I have reviewed House Bill 1456. As I understand, North Dakota's HB 1456 prohibits an abortion[1] if the unborn child[2] the pregnant woman is carrying has a detectable heartbeat, absent certain exceptions such as to prevent the death of a pregnant woman, to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, or to save the life of an unborn child.

11. I provide these opinions in opposition to Plaintiffs' Motion for Summary Judgment against enforcement of North Dakota House Bill 1456, now codified at North Dakota Century Code Sections 14-02.1-05.1, 14-02.1-05.2 and 43-17-31.

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[1] In referring to an "abortion," I am employing the definition found in N.D.C.C. § 14-02.1-02(1), an induced termination of a clinically diagnosed intrauterine pregnancy of a woman with knowledge that the termination will with reasonable likelihood cause the death of the unborn child.

[2] I may sometimes refer to the term "unborn child," which shall have the same meaning as that term is defined in N.D.C.C. § 14-02.1-02(18), the offspring of human beings from conception until birth.

12. The opinions I express are held to a reasonable degree of medical certainty, based on my medical education, training, 22 years of clinical practice, including completing a little over 5000 deliveries, providing Obstetrical care for those deliveries, ongoing Director of Ultrasound in Obstetrics and Gynecology in my Department of Obstetrics and Gynecology for 19 years, ongoing preceptor and medical educator as Clinical Professor and Vice Chairman, Department of Obstetrics and Gynecology, University of North Dakota School of Medicine and Health Sciences, and my ongoing review of the medical literature. Citations used in this document are from *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013*, which is the medical textbook used in the University of North Dakota School of Medicine and Health Sciences to teach the course Medical Embryology.

## III. Statement of Opinions and the Basis Therefore

### *(a) Pregnancy, Embryonic and Fetal Development in the Human Being*

13. Human development is a continuous process that begins (being conception) when an **oocyte** (ovum) from a female is fertilized by a **sperm** (spermatozoon) from a male. *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 1, Introduction to the Developing Human*, page 1. Conception occurs and pregnancy thus commences and occurs in the menstrual cycle

around cycle day 14 when ovulation occurs. Following fertilization, the zygote (egg and sperm) undergoes division into the blastocyst which implants in the endometrium, usually on day 6 of the luteal phase (6 days after ovulation) or day 20 of the menstrual cycle in a classical 28 day menstrual cycle.

14. Calculation of the due date or Estimated date of Confinement (EDC) is based on Naegle's rule, which is a rule used as a means of estimating date of confinement (delivery) by counting back three months from the first day of the last menstrual period and adding seven days. Human gestation is completed in 266 days (38 weeks) following ovulation or 280 days (40 weeks) when using the first day of the last menstrual period (LMP). Most women know the first day of their last menstrual period (LMP) as opposed to their day of ovulation which is why Naegle's rule is utilized clinically. Human gestation is divided clinically in trimesters.

*(b) Detection of Heartbeat – Standard Medical Practice*

15. In embryological development, cardiogenesis involves the development of the heart and circulatory system. "The heart begins to beat at 22 to 23 days". *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 13, Cardiovascular System*, page 290. This represents 3 weeks, 2 or 3 days true gestational age or 5 weeks 2 or 3 days menstrual age.

16. Blood flow begins during the fourth week and can be visualized by Doppler ultrasonography. *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 13, Cardiovascular System*, page 290.

17. Detection of the unborn child's heart beat is accomplished clinically through ultrasound which is utilizing high frequency sound waves emitted by a transducer which is placed on the patient's abdomen or intravaginally. Abdominal ultrasound imaging will detect an unborn child's heart beat at approximately 6-8 weeks depending upon the body habitus of the patient or as early as 5 ½ weeks with an intravaginal transducer. Intravaginal ultrasound imaging allows for earlier cardiac detection secondary to a higher frequency transducer and being placed anatomically closer to the developing embryo.

18. It is only natural that heart rate is used in society as the presence or absence of life. Indeed, for thousands of years man has declared another human being as alive or dead based on whether or not a heartbeat or pulse is present or absent. It is only in relatively recent modern times with the evolution of modern medical research that additional means, such as functional brain waves, have assisted in this determination.

*(c)* *Viability*

19. Viability is generally defined by Webster as "the quality or state of being viable: the ability to live,

grow, and develop." Dictionary.com defines viability as 1. "ability to live, especially under certain conditions. 2. the capacity to operate or be sustained." The complexity of human development from its earliest stage of conception (the formation of a zygote from two gametes, ovum and sperm) is now well studied and furthermore, documented by media and research unknown 40 years ago. Please review "Conception to Birth – visualized", by Dr. Alexander Tsiaras, Associate Professor of Medicine, Yale University, hereto attached as Exhibit B.

20. North Dakota Century Code 14-02.1-02 defines the term viable to mean the ability of an unborn child to live outside the mother's womb, albeit with artificial aid. Also, as noted previously, this North Dakota statute defines the term "unborn child" to mean the offspring of human beings from conception until birth. There is no mention as to how long or when the unborn child must live outside the mother's womb, albeit with artificial aid, to be viable or to have viability.

21. As pointed out in Paragraphs 26-28 below, the use of viability as the standard to determine when a woman's choice to abort an unborn child outweighs the state's interests is medically invalid. However, assuming viability is the standard, the United States Supreme Court, consistent with the North Dakota statutory definition, has stated an unborn child is considered viable if the unborn child is "potentially able to live outside the mother's womb, albeit with artificial aid." *Colautti v. Franklin*, 439

U.S. 379, 387 (1979). The United States Supreme Court has also stated for there to be viability "there must be a potentiality of 'meaningful life . . . not merely momentary survival. *Colautti v. Franklin*, 439 U.S. 379, 387 (1979). However, the United States Supreme Court went on to explain that an unborn child is viable when there is "potential, rather than actual survival" of the unborn child outside the womb. *Anders v. Floyd*, 440 U.S. 445 (1979). Ultimately, the determination of whether an unborn child is viable is a medical judgment. *Colautti v. Franklin*, 439 U.S. 379, 388 (1979).

22. In rendering the opinions expressed herein, I reviewed the October 13, 2013 declaration of Plaintiff s expert Dr. Iverson that was filed with the Court (being Court document 42-2). I have reviewed the transcript from her deposition that was taken on December 6, 2013. I understand the deposition transcript is being submitted by the State of North Dakota in response to the Plaintiffs' motion for summary judgment. It is my opinion and conclusion that the opinions and conclusions expressed by Dr. Iverson found in her declaration and explained in her deposition regarding when an unborn child is viable are not medically valid.

23. Dr. Iverson testified that her definition of viability, found at Paragraph 6 of her October 13, 2013 declaration, was no different than the definition of viable found in North Dakota Century Code section 14-02.1-02. Iverson Deposition, pp. 41-42. Dr. Iverson explained that viability of an unborn child, as she

described in Paragraph 6 of her October 13, 2013 declaration, occurs "when you have an opportunity to survive to adulthood." Iverson Deposition, p. 55. Dr. Iverson then explained that her conclusion, found in Paragraph 6 of her October 13, 2013 declaration, that viability does not occur until approximately twenty-four weeks last menstrual period (LMP), is based on the following information she provides to parents: being that viability exists when the unborn child has a 10% chance of surviving intact to adulthood. Iverson Deposition, p. 55.

24. I disagree with Dr. Iverson's conclusion and opinion that an unborn child is not viable unless it has a chance – whether a 10% or greater – to survive to adulthood, and in my opinion, these conclusions and opinions of Dr. Iverson as to when an unborn child is viable are medically and legally without merit and are unsound.

25. To begin, in contrast to Dr. Iverson's opinion, the United States Supreme Court has not stated an unborn child, to be medically judged to be viable, must have some percent of survival to adulthood. There exists nothing in the North Dakota statute that requires an unborn child have a chance to live to adulthood for the unborn child to be medically judged to be viable. Rather in order for an unborn child to be medically judged to be viable, it does not require survival, let alone survival to adulthood as Dr. Iverson has concluded, but instead the unborn child must have potential for survival. Thus, in my opinion, to a reasonable degree of medical certainty, Dr. Iverson's

opinions and conclusions – that to be medically judged to be viable the unborn child must have some chance to survive intact to adulthood – lack merit.

26. In addition, Dr. Iverson's opinion that viability requires a percent chance the unborn child will survive to adulthood is medically erroneous. Viability in Obstetrics and Human Reproduction has vastly changed over the past decades. Viability was once thought to mean or be defined as only the ability of the unborn child to survive outside the uterus, albeit under the sophisticated care of the Neonatologist in the highly complex medical environment of the Neonatal Intensive Care unit (NICU). In modern and current medical and clinical practice, the embryo is able to survive as a human being independently at conception. This occurred for the first time in 1978 with the successful birth of Louise Brown and was known as the "test tube baby". Dr. Robert G. Edwards, the physiologist who developed the technology to successfully achieve this goal, was awarded the Nobel Prize in Medicine in 2010. Today in vitro fertilization (IVF) is commonly practiced and actually, Reproductive Endocrinology and Infertility (REI) has evolved into a well recognized subspecialty of the field of Obstetrics and Gynecology. It is my medical opinion that the development of Reproductive Technology has caused and allowed an embryonic unborn child to live outside the human uterus (womb) for 2-6 days after conception – which is viability as defined by the United States Supreme Court and in the North Dakota statutes because this embryonic unborn child

is not just potentially but is in fact living outside the woman's womb, albeit through artificial means. This viable unborn child is then transferred into the human uterus (womb) to continue its gestation. Once a heartbeat is detected in this implanted or any other unborn child within the womb, there exists a medically recognized 98% rate of survival and live birth for the unborn child and this medically recognized rate of survival and live birth drops only slightly to 82% when the woman has a history of recurrent pregnancy loss (being three or more consecutive spontaneous losses of the unborn child). *See Predictive value of the presence of an embryonic heartbeat for live birth: comparison of women with and without recurrent pregnancy loss. Hyer, et al, Sterility and Fertility, vol 82, no 5, November, 2004*. Since in vitro fertilization (IVF) or "test tube baby" – a colloquial term for babies conceived as the result of IVF, first occurred in 1978, 5 years after the decision of *Roe vs. Wade*, this information was unavailable to the United States Supreme Court for deliberation. However, since 1973, tremendous medical advancements have occurred throughout all areas of Medicine, including the development of completely new areas such as the field of Reproductive Medicine.

27. Therefore based on the foregoing, it is my opinion, to a reasonable degree of medical certainty, an unborn child is viable or viability occurs, as medically defined as well as legally defined, from the time of conception.

*(d) Viability at a time other than at conception is not a medically valid basis to determine whether state's interests to preserve life of unborn child are sufficiently strong to preclude an abortion.*

28. It behooves the legal profession to acknowledge the medical developments and advancements, and in turn appropriately act upon the current medical standards to change existing law, which is based on either old, outdated medical science, or previously unknown medical science and fact, or both. Viability now determined to occur at conception (see Paragraphs 19-27 above) provides a solid basis that will stand the test of time because it is not based on the ever shifting and changing neonatal definition, which currently plagues the legal and medical profession. For example, some like Dr. Iverson now conclude viability only can occur at 22-24 weeks last menstrual period (LMP) when only a few years ago, these same parties concluded viability could only occur at 28-30 weeks last menstrual period (LMP). This standard of viability occurring at any time other than conception, being not only medically unsound, plagues the medical profession because of the uncertainty and vagueness when rendering a medical judgment as to whether viability is present for ongoing clinical decision making. Viability at conception is based on medical science and fact and is in alignment with natural law. It is clearly and succinctly defined.

29. Furthermore, the following sets forth the medically recognized attributes that exist in an

unborn child demonstrate the framework of viability, at a time other than at conception, is no longer a medically valid basis:

(i) At the moment of conception, an unborn child has a unique set of DNA that never previously existed in the history of the world. Also, the hair and eye color, along with facial features are established at conception.

(ii) By 22 days after conception, the unborn child's heart was already beating and for some, with a different blood type than the unborn child's mother.

(iii) At 6 weeks after conception, an unborn child has brain function because the unborn child has detectable brain waves. Neurological development of the unborn child begins as early as the fourth week of development. The processes involved in the formation of the neural plate and neural folds and closure of the folds to form the neural tube constitute neurulation. Neurulation is completed by the end of the fourth week. *Moore et al: The Developing Human 9E, Clinically Oriented Embryology, 9th edition, 2013, Chapter 4, Third Week Of Human Development*, page 61. Neurological development not only involves the development of the central nervous system (brain and spinal cord), but the peripheral nervous system as well (sensory and motor (muscle)).

(iv) By the 8th week of development, the unborn child experiences pain in any capacity.

(Testimony of Maureen L. Condic, PhD, University of Utah, School of Medicine, Department of Neurobiology and Anatomy, before the Subcommittee on the Constitution and Civil Justice, Committee on the Judiciary, U.S. House of Representatives, May 23, 2013 (judiciary.house.gov/hearings/113th/05232013/Condic%2005232013.pdf). Therefore, by the 8th week of development, at the latest, the unborn child has brain function.

(v) Further, by 8 weeks after conception, every major organ of the unborn child is in place.

30. Therefore, in my opinion, to a reasonable degree of medical certainty, establishing viability of an unborn child at a time other than at conception is not a medically valid basis to determine whether the state's interests to preserve the life of an unborn child are sufficiently strong to preclude an abortion. Rather, viability being established at conception, and precluding the ending of the life of the unborn intentionally thereafter, is consistent with the state's and the medical profession's obligation to protect the health of the woman and the life of the unborn child and avoids the uncertainty and vagueness that exists with the current standard that will be ever evolving and changing.

*(e) Duty of Care and Ethical Duty of Physician to Unborn Child*

31. I would be remiss if the concept of physician-patient relationship is not understood. In the field of Obstetrics (being any care provided by any and all healthcare providers to a pregnant woman) unlike any other specialty in Medicine, the health care provider has two patients simultaneously. The Obstetrician cares for the adult woman as well as the developing embryo or fetus, depending upon the gestational age being discussed. This concept is taught to all medical student clerks in their third year of medical school education. Many times, interventional clinical decisions are made to solely benefit the unborn child. This includes medications given to the mother, such as tocolytics, which are medications to treat preterm contractions, to continue the pregnancy as long as possible. Surgical procedures are likewise carried out to benefit the unborn child. Such an example includes cerclage placement, which is tying the cervix shut to prevent preterm delivery. In this critical and sacred (Webster definition: highly valued and important <a *sacred* responsibility>) relationship between the Obstetrician, mother, and the unborn child, a human being in its earliest stage of life, at no time is the unborn child ever referred to as "tissue, in utero contents," or other such minimizing attempts to address the evolving human being.

32. My opinion that viability commences at conception also reflects the duty of a state or government to protect the constitutional rights of its citizens,

regardless of age. It is perhaps, even more so, the duty of a state or government to protect the rights of its citizens who are unable, incapable, or are not given the opportunity to fend for themselves, as in the case of the very old, physically and mentally incapacitated, and certainly the unborn, in my medical opinion. In fact, this principle of protection of citizens who are unable to fend for themselves is practiced consistently in medicine through beneficence, a principle of medical ethics, according to which, a physician should do good to others, especially when one has a professional duty to do so. The Oath of Hippocrates (Hippocrates of Cos (470-380 BC), delineated in the 5th century BC, recited by contemporary medical students in their White Coat ceremony at the very beginning of their medical education, continues to play a central role in preserving the sanctity of the patient-physician relationship in the practice of private medicine. Another familiar precept, *First, to do no harm* ("Primum non nocere"), is used in the concept of non-maleficence, also central to the practice of medicine. These longstanding, time tested, and ongoing medical principles continue to provide the basis on which difficult medical decisions are made on a daily basis in the best interest of the patient or the ***two*** patients in Obstetrics.

33. It is my medical opinion a physician or any other clinician who performs an abortion to end the life of an unborn child, is in violation of his or her duty of care to the unborn child, as well as violating his or her ethical duties and responsibilities. Further,

HB 1456 is a reasonable and necessary regulation of such said procedures to promote the State of North Dakota's substantial interest, recognized by the United States Supreme Court, of protecting the integrity and ethics of the medical profession and ensuring the medical profession and its members "be viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others." *Stenberg v. Carhart*, 530 U.S. 914, 962 (2000).

*(f) Harm to Women from Abortion*

34. It is well documented that there is a deep bond between a woman and the developing unborn child within the uterus. Important biochemical, physiologic, and emotional changes occur during pregnancy such that when pregnancy loss occurs, a time of grief occurs. When grief does not successfully provide closure, significant physical, psychological, and emotional harm occurs, oftentimes, for months to years. Even when the 5 stages of grief are successfully completed, developed by Dr. Elizabeth Kubler-Ross, *On Death and Dying*, 1969, pregnancy loss remains permanently and forever in the mind and heart of the woman who suffers this loss. In my practice, I have many patients who remember the "birthday" of their pregnancy loss, a solemn reminder of "their child". Many patients have named their baby. Many patients suffer from Posttraumatic Stress Disorder (PTSD) and suffer pregnancy loss symptoms,

including depression, anxiety, guilt, remorse, helplessness, and loneliness surrounding their loss. These patients are at increased risk for developing self-degrading behaviors, including eating disorders, drug or alcohol abuse, promiscuity, promoting loss of self-esteem and impairment of mental and physical health. ***A Solitary Sorrow***, *Paul C. Reisser, MD, Teri Reisser, M.S., M.F.T. (Marriage and Family Therapy), Shaw books, 2000*. Additionally, Priscilla K. Coleman, PhD, developmental Psychologist and Professor of Human Development and Family Studies (HDFS) at Bowling Green State University (BGSU) in Ohio, has conducted extensive research on the psychology of abortion. Please refer to these findings in her expert report.

35. In addition to the psychological discord and experienced grief, as reviewed in the previous paragraph, physical complications occur with pregnancy loss. To begin, there are significant biochemical and physiological physical changes that occur to a pregnant woman, and an abortion adversely impacts the health and well-being of the woman because of these changes are now abruptly terminated. Further, complications occur secondary to surgical procedures, such as dilation and curettage (D&C), dilation and evacuation (D&E), and associated blood loss with either surgical or medical approaches. Surgical complications include uterine perforation (surgical instruments passing through the uterus, injuring intestines) as well as lacerating major pelvic blood vessels, resulting in catastrophic hemorrhage, including exsanguination

and subsequent death. In addition to acute complications, long term risk exposure is present. In one recent study, a 44% increase in the risk of acquiring breast cancer occurs with one pregnancy loss with a dose effect also noted (risk increases as more losses occur). *A meta-analysis of the association between induced abortion and breast cancer risk among Chinese females,* ***Yubei Huang****, et al. Cancer Causes and Control, November, 2013*. Other long term consequences include uterine scarring resulting in the surgical condition of Asherman's syndrome, weakening of the cervix resulting in the inability of the cervix to hold subsequent pregnancies in place (incompetent cervix), resulting in miscarriage or preterm delivery.

36. Based upon the foregoing, it is my opinion, to a reasonable degree of medical certainty, that abortions have a significant and profoundly adverse effect upon the health and well-being of women.

## IV. Conclusions

37. In conclusion, based upon the foregoing, I offer the following opinions, that are to a reasonable degree of medical certainty and based on my professional and ongoing education in Obstetrics and Gynecology, ongoing practice of 22 years as an Attending Obstetrician, and Medical educator as Clinical Professor and Vice Chairman in the Department of Obstetrics and Gynecology, University of North Dakota School of Medicine:

(a) An unborn child is viable or viability occurs, as medically defined as well as legally defined, from the time of conception. It is based on medical science and fact, not yet elucidated in 1973, having occurred in 1978 with the first "test tube baby", Louise Brown, and continuing to the present in the now well developed field of Reproductive Medicine and in vitro fertilization (IVF). Additionally, new media and research capabilities clearly reveal the developing unborn child – please see the work of Dr. Alexander Tsiarias [sic] – Exhibit B.

(b) Viability, that some currently feel to be somewhere between 22-24 weeks last menstrual period (LMP), previously has been and will continue to be a "moving target on shifting sand," and problematic both in the legal definition and in clinical management for physicians. Therefore, in my opinion, to a reasonable degree of medical certainty, establishing viability of an unborn child at a time other than at conception is not a medically valid basis to determine whether the state's interests to preserve the life of the unborn child are sufficiently strong to preclude an abortion.

(c) It is the duty of every health care provider that provides any medical services to a pregnant woman to provide care to both patients, which is the mother and unborn child for previously cited reasons. Not providing care to the unborn child is violation of duty to the second person. Therefore, in my opinion, to a reasonable degree of medical certainty, a physician or any other health care provider who performs

an abortion to end the life of an unborn child, is in violation of his or her duty of care to the unborn child, as well as in violation of his or her ethical duties and responsibilities.

(d) It is my opinion, to a reasonable degree of medical certainty, that abortions have a significant and profoundly adverse effect upon the health and well-being of women, which not only does the state have an obligation to protect against, but also the medical profession has an obligation to protect against and not perform procedures, like abortions, that have an adverse effect upon the health and well-being of their patients.

(e) For the foregoing reasons, it is my opinion HB 1456 is medically and scientifically sound and reasonable.

## V. Expert Testimony: Fees and Recent Experience

38. Fees for expert services: $350 per hour for all in-office work, including record review, attorney consultation, client interviews, scientific literature searches, report-writing, affidavit construction, and testimony preparation, and $4,000 per day for depositions and courtroom testimony.

39. I have not been deposed or testified at trial as an expert witness.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 19th day of December, 2013.

/s/ Jerry M. Obritsch, MD

## APPENDIX H

## IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NORTH DAKOTA SOUTHWESTERN DIVISION

| | |
|---|---|
| MKB MANAGEMENT CORP, d/b/a RED RIVER WOMEN'S CLINIC, and KATHRYN L. EGGELSTON, M.D.,<br><br>Plaintiffs,<br><br>-vs-<br><br>BIRCH BURDICK, in his official capacity as State Attorney for Cass County; WAYNE STENEHJEM, in his official capacity as Attorney General for the State of North Dakota; and LARRY JOHNSON, M.D.; ROBERT TANOUS, D.O.; KATE LARSON, P.A.C.; NORMAN BYERS, M.D.; CORY MILLER, M.D.; KAYLEEN WARDNER; GAYLORD KAVLIE, M.D.; KENT MARTIN, M.D.; KENT HOERAUF, M.D.; BURT RISKEDAHL; JONATHAN HAUG, M.D.; GENEVIEVE GOVEN, M.D.; AND ROBERT J. OLSON, M.D., in their official capacities as members of the North Dakota Board of Medical Examiners,<br><br>Defendants. | Civil No. 1:13-CV-071 |

**DECLARATION OF**
**JOHN THORP, JR., M.D., M.H.S.**

John Thorp, Jr., M.D., M.H.S. declares and states the following:

## I. QUALIFICATIONS.

1. I received my M.D. degree from East Carolina University Medical School in 1983. My residency training took place at the University of North Carolina (Chapel Hill) School of Medicine in general obstetrics and gynecology (1983-1987). I also completed my fellowship in Maternal-Fetal Medicine at the University of North Carolina (Chapel Hill) School of Medicine in 1989. I received my Master's of Health Sciences in Clinical Leadership from Duke University School of Medicine in 2009.

2. Since 1991 I have been a board-certified obstetrician/gynecologist and since 1992 I have also had a certification in the sub-specialty of Maternal-Fetal medicine. I am a Fellow of the American Gynecological and Obstetrics Society and a member of the American College of Obstetricians and Gynecologists.

3. I am the Hugh McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina (Chapel Hill) School of Medicine. I am also a Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. In those roles I teach both medical students and

residents in Obstetrics and Gynecology. Up until very recently, I had administrative oversight of the Family Planning Fellowship and Residency training programs at UNC.

4. I am the Deputy Director of the Center for Women's Health Research, at the University of North Carolina School of Medicine and School of Public Health (Department of Obstetrics and Gynecology and Department of Epidemiology, respectively).

5. I am also the Vice Chair for Research and Division Director of Women's Primary Healthcare, University of North Carolina School of Medicine.

6. In addition, I am a Fellow of the Carolina Population Center and have been the Director of the Biomedical Core of the Carolina Population Center of the University of North Carolina at Chapel Hill since 2003.

7. I have authored 21 book chapters and serve as a journal referee (reviewer) for 39 different medical journals, including *The New England Journal of Medicine, Mayo Clinic Proceedings, Obstetrics & Gynecology, The American Journal of Obstetrics and Gynecology, British Journal of Obstetrics and Gynecology, Lancet, Journal of Perinatal Medicine and Journal of the American Medical Association – Archives of General Psychiatry*. I am currently the deputy editor-in-chief of the *British Journal of Obstetrics & Gynecology*, an international journal which is considered one of the most prestigious in my field. I

also serve on the Editorial Board of the *Obstetrics and Gynecological Survey.*

8. I have written or co-written 317 peer-reviewed articles in the professional literature, 157 abstracts discussing medical research, and 39 non-peer reviewed articles.

9. Other professional activities of mine include being an oral examiner for the American Board of Obstetrics and Gynecology, and a member of the science and grant review panels for the National Center for Research and the National Institute for Child and Human Development, National Institutes of Health. My research responsibilities include administrative and scientific leadership in multiple active grants exceeding $12 million.

10. For a complete listing of my professional background, experience, responsibilities, and publications, please see my attached Curriculum Vitae (Exhibit A).

11. The opinions I express herein are to a reasonable degree of medical certainty, and are based upon my medical education, training and thirty years of clinical experience, as well as my familiarity with the medical literature. As Division Director of UNC's Women's Primary Healthcare, which up until recently included abortion and reproductive health services, I oversee and guide the credentialing process for 12 Obstetrician-Gynecologists, 3 Fellows, and 3 Advanced Practice Nurses. Throughout this declaration, I may sometimes refer to an abortion, as that term is

defined at North Dakota Century Code §14-02.1-02(1), as "TOP" (which is an acronym for "termination of pregnancy") in this declaration. The opinions I express herein are my own and do not represent the institutions with which I am affiliated.

12. I provide these opinions in opposition to Plaintiffs' Motion for Summary Judgment against enforcement of North Dakota House Bill 1456, now codified at North Dakota Century Code Sections 14-02.1-05.1 14-02.1-05.2 and 43-17-31, referred to herein as "the Act." I understand, among other provisions of the Act, that before a TOP may be performed on a pregnant woman, an individual is required to determine, in accordance with standard medical procedure, if the unborn child[1] the pregnant woman is carrying has a detectable heartbeat. If the individual determines, in accordance with standard medical procedure, the unborn child the pregnant woman has a detectable heartbeat, then a TOP may not be performed, unless the individual performs a medical procedure designed to or intended, in that individual's reasonable medical judgment, to prevent the death of a pregnant woman, to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, or to save the life of an unborn child. However, the Act

[1] I may sometimes refer to the term "unborn child," which shall have the same meaning as that term is defined in N.D.C.C. § 14-02.1-02(18) to mean the offspring of human beings from conception until birth.

permits a TOP if the individual has performed an examination for the presence of a heartbeat in the unborn child, utilizing standard medical procedures, and that examination does not reveal a heartbeat in the unborn child or the individual has been informed by a physician who has performed the examination for the unborn child's heartbeat that the examination did not reveal a heartbeat in the unborn child. In my opinion these requirements are reasonable and medically necessary to protect women from the adverse consequences of a TOP, promote and protect the health, safety and well-being of women and their families, and the protection of every human life, whether unborn or aged, healthy or sick.

## II. THE UNIQUENESS OF TOP IN MEDICINE

13. Numerous factors are illustrative as to why TOP services are unlike any others in the provision of medical care and thus require special statutory safeguards to protect mothers from increased risks of harm:

a. The relationship between a TOP provider and a pregnant woman begins and ends on the same day of the TOP procedure, there generally being no prior physician-patient relationship;

b. Pre-TOP counseling at these clinics is generally not provided by a licensed health care or mental health professional

c. Often screening for risk factors for adverse post-TOP outcomes is not provided;

d. Pre-TOP counseling is often deficient, excessively time-constrained, minimal or non-existent thereby reducing the likelihood of providing high quality counseling and meeting the needs of the pregnant woman

e. In the absence of a physician-patient relationship and given the poor quality of pre-TOP counseling, the likelihood of exploring the unique circumstances of the mother is minimal, increasing the risk that coercion or pressure in her decision-making will go unaddressed;

f. The patient is unlikely to be counseled on pregnancy outcome options other than TOP as this is optional or not provided;

g. Because the physician provides diagnosis, counseling and surgery on the same day when the patient presents for treatment, the pregnant woman is at increased risk for being "rushed" into treatment;

h. Not being able to obtain the patient's fully informed consent is more likely given the above circumstances;

i. TOP services generally require payment prior to being rendered, thus inducing pressure to proceed which can override patient ambivalence or contraindications

j. The procedure is intended to terminate the life of the mother's child resulting in the deliberate death by the physician by his or her other patient to whom he owes a legal and professional duty

k. TOP intentionally ends the legally protected relationship of a mother and her child which has life-long consequences

l. The physical and psychological health risks of TOP are serious and significant;

m. Due to the scenarios described above, the likelihood of physician bias and conflict of interest with TOP is more than in any other field of medicine;

14. Considering the above, the need for state regulation is paramount to protect the unique nature of the mother's special interests, to protect her health, safety and well-being, and to decrease the risks of injury and harm to these pregnant women from the possible adverse affects of and consequences of a TOP. In my opinion, the Act does that and is a medically and scientifically reasonable and necessary regulation that protect women from the adverse consequences from TOP, and in turn protects and promotes women's health, safety and well being.

## III. THE DUAL PATIENT OF THE OB-GYN

15. It is incontrovertible in obstetrics that the physician has two separate patients: the mother and her unborn child. As an OB-GYN, I have a professional

and a legal duty to both patients, including the obligation to inform the mother of the risks and impact of a particular procedure on each of these patients. The physician owes a duty of care to *both* of these patients. In compliance with this ethical and legal duty, I inform the mother of the risks the procedure poses for the unborn child and I inform the mother of the risks to her. My duty to the unborn child is discharged by advising the pregnant mother of the risks to the unborn child. The mother then becomes the informed decision maker for both herself and her unborn child, weighing the various risks and benefits to both of them. This dual duty of care is applicable in every situation where a pregnant woman is under a physician's care. Therefore, in contradiction of the duty of care and ethical responsibilities, a physician who proposes to perform a TOP is then proposing to terminate the life of one of his patients to whom he owes a duty of care.

16. In addition, there is the reality of the *relationship* between the pregnant woman and her unborn child. Irrespective of the wantedness or unexpectedness of the pregnancy, the biological and psychological connection between the mother and her unborn child cannot be denied, minimized or dismissed. This connection or relationship is not some biological potential, nor is it just something that could occur in the future. It already exists and will be ended in a TOP. If TOP is elected, the mother loses her lifelong relationship with her child which has the

potential to bring satisfaction, new meaning, and happiness to her.

17. It is also incontrovertible that when a woman elects to terminate her pregnancy, she is terminating the life of a whole, separate, unique, living human being, a member of the species Homo sapiens, as enumerated in North Dakota law (N.D.C.C. § 14-021-02(9). This is an accurate statement of scientific and medical fact, and it is a fact that is generally known and accepted among medical providers and scientists, and was legally recognized in *Planned Parenthood Minn., ND., S.D. v. Rounds*, 530 F.3d 724, 735-36 (8th Cir. 2008) (en banc).

18. The fact that the unborn child is a distinct, and therefore separate, human being from his or her mother, makes it clear that there exists a unique relationship between a mother and a child. This unique relationship continues throughout their lives. The fact that it takes on a different character at different moments in the life does not alter the fact that the relationship exists during the pregnancy. There is substantial evidence in the medical literature that there is not only a relationship, but an attachment between mother and unborn child. Early on, maternal-fetal attachment (MFA) was defined as the extent to which women engage in behaviors that represent an affiliation and interaction with their unborn child. Twenty years ago critical attributes of MFA were identified: *cognitive attachment*, i.e., the desire to know the baby, *affective attachment*, i.e., the pleasure related to interactions with the unborn

child, and *altruistic attachment*, i.e., the desire to protect the fetus (Yarcheski et al., 2009). MFA helps explain how a mother seeks to know, be with, to avoid separation or loss, to protect, and to identify the needs of the fetus, occurring independent of whether the pregnancy is wanted and irrespective of the intention to terminate the pregnancy.

19. The biological status of the human unborn child as patient is now well established in medicine. The treatment of this patient has and continues to be based upon the ever growing ability to assess, diagnose and treat the human unborn child during pregnancy. Over the past 30 years, fetal surgery for congenital disease has evolved from fanciful concepts to an evidenced based treatment. Major advances in understanding fetal pathophysiology, fetal imaging and diagnosis, anesthesia, and tocolysis (delaying delivery) have spawned new approaches and innovative fetal interventions in this fast-moving frontier of medicine (Jancelewicz & Harrison, 2009).

20. Maternal fetal medicine (MFM) is a subspecialty of obstetrics that focuses on identified risk pregnancies. The specialty of MFM has emerged as a result of the high value we place on children (Chescheir, 2009), the long-standing duty of the Ob-Gyn to treat both of his/her patients, and the confluence of improved assessment and intervention modalities. The role includes obstetric ultrasound for fetal assessment and diagnosis of anomalies, prenatal diagnosis, and management of pregnancies complicated by maternal medical disorders, multiple fetuses and

the antenatal management of extreme prematurity. Skills within MFM includes fetal interventions such as fetal shunting procedures, intrauterine transfusion, fetoscopic laser photocoagulation of anastomotic vessels for twin to twin transfusion syndrome and ex utero intrapartum treatment.

21. In summary, it is my opinion a physician or any other clinician who proposes to perform a TOP to terminate the life of an unborn child, violates his or her duty of care to the unborn child – the physician's or clinician's patient – along with violating his or her ethical duties and responsibilities. Therefore, in my opinion, the Act is a reasonable and necessary regulation of TOP procedures to promotes [sic] the State of North Dakota's substantial interest, recognized by the United States Supreme Court, of protecting the integrity and ethics of the medical profession and ensuring the medical profession and its members "be viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others." *Stenberg v. Carhart*, 530 U.S. 914, 962 (2000).

## IV. TOP MORBIDITY AND MORTALITY & COMPARISONS TO CHILDBIRTH TO DECLARE TOP IS SAFE IS SCIENTIFICALLY WITHOUT MERIT

22. Plaintiffs alleged in their Complaint the following:

> Legal abortion is one of the safest medical procedures in the United States. The risk of carrying a pregnancy to term carries much higher risks of both morbidity and mortality than does obtaining an abortion through around twenty weeks. The mortality rate associated with pregnancy in the United States is approximately fifteen times higher than the risks associated with abortion. Access to safe and legal abortion benefits the health and wellbeing of women and their families.

Plaintiffs' Complaint, ¶ 32 (Court Doc. 1). Plaintiff Kathryn L. Eggleston stated the following regarding the safety of a TOP:

> Abortion is one of the safest medical procedures in the United States. A recent study found that the prevalence of any complication of first-trimester surgical abortion performed by physicians was 0.89%; the prevalence of major complications requiring treatment at a hospital was 0.05%. Carrying a pregnancy to term carries much higher risks of both morbidity and mortality than does obtaining an abortion through around twenty weeks lmp. The mortality rate associated with continuing a pregnancy in the United States is approximately fifteen times higher than that associated with abortion.

*See* Eggleston June 20, 2013 Declaration ¶ 19 (Court Doc. 3-1). These allegations found in Plaintiffs' complaint and in Eggleston's declaration are unfounded, and lack scientific rigor and reality.

23. These unfounded allegations and statements are based upon a 2012 report by Raymond and Grimes[2] that was provided by Plaintiffs in response to discovery in this case. The Raymond and Grimes report had similar unfounded conclusions as is now being asserted by the Plaintiffs in this case. There are multiple methodological weaknesses abound in this Raymond and Grimes research: (a) reliance on voluntary and incomplete state reporting of TOP; (b) data misclassification, i.e., deaths are reported by complication (e.g., infection or hemorrhage) and not from the procedure (e.g., TOP); (c) suicide deaths are rarely if ever linked back to TOP and are thus unreported; (d) failure to include TOP related deaths beyond the first trimester where TOP mortality risks equal and exceed childbirth; and (e) failure to account for evidence that childbirth is protective in the immediate and long-term against death from non-obstetrical causes including natural causes (e.g., breast cancer) and unnatural causes (e.g., suicide).[3]

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[2] Raymond, E., Grimes, D. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology* 2012. 119:215-9.

[3] *See*: Appleby, L. *Suicide after Pregnancy and the First Postnatal Year*. *British Medical Journal*, 1991. 302: 137-140; Carroll, P. S. *The Breast Cancer Epidemic: Modeling and Forecasts Based on Abortion and Other Risk Factors*. *Journal of American Physicians and Surgeons*, 2007, 12: 72-78; Daling, J. R., Malone, K.E., Voigt, L., White, E. & Weiss, N. S. (1994). *Risk of Breast Cancer among Young Women: Relationship to Induced Abortion*. *Journal of the National Cancer Institute*, 1994, 86: 1584-1592.; Marzuk, P. M., et al. *Lower Risk of Suicide during*

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24. As far back as 1998, long-time Guttmacher Institute researcher, Stanley Henshaw, concluded: "reporting of abortions is incomplete in most states."[4] Thus, if the data is incomplete, i.e., the incidence of the number of TOPs and the number of complications are either not reported or unreliable, statements about TOP safety are questionable and in turn lack credibility.

25. Two of the major issues confounding any valid comparison between maternal and TOP mortality are measurement and data quality. Without agreement about what is being measured, how, when and on what basis any conclusions are drawn is meaningless. Because the data are so incomplete, the World Health Organization (WHO) has used seven different methods to estimate maternal death.[5] This is indeed the case here. Consider the following:

a. According to the World Health Organization, "[m]easuring maternal mortality accurately is difficult except where

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*Pregnancy*. *American Journal of Psychiatry*, 1997, 154: 122-123; Thorp, J., Hartmann, K., & Shadigan, E. *Long-term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*. *Obstetrical and Gynecological Survey*, 2002, 58: 67-79.

[4] Henshaw, S. *Abortion Incidence and Services in the United States, 1995-1996*. *Family Planning Perspectives*. 1998, 30: 263.

[5] World Health Organization, *Maternal Mortality in 2005 – Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva, Switzerland: Department of Reproductive Health & Research, 2007.

comprehensive registration of deaths and of causes of death exists" (WHO, 2013). Since the US does not possess this capacity, the basis of our information about maternal mortality and TOP mortality is severely limited.

b. Accurate capture of the precise number of maternal deaths is further compounded by multiple variations in definitions and usage of these terms. For example:

> "*Maternal deaths*" are defined by the World Health Organization as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."
>
> "*Late maternal deaths*" are defined as "the deaths of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy."
>
> "*Pregnancy-related deaths*" are defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death."

> "*Direct obstetric deaths*: those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above."
>
> "*Indirect obstetric deaths*: those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy." (ICD-10, Hoyert, 2007:8)

Therefore, the estimative nature of the data and the use of differential definitions severely limit the conclusions drawn and the generalizability of any findings. Implicit in any discussion about TOP safety is the presumption that the data upon which this assertion rests are reliable and complete. This is not insignificant as there are only two primary sources of data for TOP: the Centers for Disease Control and Prevention[6] (CDC) and the Guttmacher Institute

[6] The CDC obtains its TOP data from state health departments. Beginning in 1969, state health departments have voluntarily provided annual reports on TOP procedures and patients. These data are incomplete due to the wide variability in state requirements for reporting of TOP procedures, the voluntary nature of participation with some states choosing to not do so periodically, marked variation in the information each state obtains, and the lack of specific funding for TOP data

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(GI).[7] The former does not provide surveillance data of non-fatal TOP complications, only mortality. The latter does not systematically gather this data either, but instead relies upon non-GI individual studies.[8] Even so, GI acknowledges: "Additionally, much of

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accumulation. For instance, the sizable State of California has not reported in the past decade. Thus, any report on TOP epidemiology from the US is fraught with numerous assumptions and lack of any clear standardization. *See*: Cates, W., Grimes, D. & Schulz, F. *Abortion Surveillance at CDC. Creating Public Health Light Out of Political Heat*. 19 *American Journal of Preventative Medicine 2000*, 12-17; Pazol, K., Creanga, A., & Zane, S. *Trends In Use of Medical Abortion in the United States: Reanalysis of Surveillance Data from the Centers for Disease Control and Prevention, 2001-2008*. 86(6) *Contraception* 2012, 746-751.; Pazol, K., Zane, S., Parker, W., et al., Abortion Surveillance in the United States, 2008. 60(15) *MMWR Surveillance Summaries* 2011, 1-41.; Pazol,K., Zane, S., Parker, W., et al., *Abortion Surveillance-United States, 2007*. 60(1) *Morbidity and Mortality Weekly Report* 2011, 1-39.; Pazol, K., Zane, S., Parker, W., et al. *Erratum: Abortion Surveillance-United States, 2007*. 60(10) *MMWR Surveillance Summaries* 2011, 315.

[7] GI obtains its estimated number of TOP procedures from periodic surveys of all known US TOP providers. Reporting is voluntary and the surveys are done at irregular intervals up to five years apart. *See*: Jones, R. & Kooistra, K. *Abortion Incidence and Access to Services in the United States, 2008*. 43(1) *Perspectives on Sexual and Reproductive Health* 2011, 41-50.; Jones, R., Kost, K., Singh, S., Henshaw, S., & Finer, L. *Trends in Abortion in the United States*. 52(2) *Clinical Obstetrics and Gynecology* 2009, 119-129.

[8] For example, see Boonstra, H. et al. *The Long-Term Safety of Abortion* in Boonstra, Ch. 4 in *Abortion in Women's Lives*, Guttmacher Institute, 2006. Available at: http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf.

what is known about women having abortions is incomplete or out of date."[9]

26. Up until recently, but throughout its history, GI has been affiliated with and/or funded by the largest TOP provider in the U.S., Planned Parenthood Federation of America. This conflict of interest has created a systematic information bias which should not be discounted. GI has a TOP advocacy agenda that is evident to any reasonable reader reviewing their website.[10] On the other hand, the CDC relies upon state health department data which is subject to considerable underreporting by TOP providers due to the voluntary nature of the reporting and obvious conflict of interests. Likewise, GI's TOP reporting is based upon periodic provider estimates and is also subject to provider conflict of interests. In the U.S., it is estimated that only one-third to one-half of TOP patients return to the clinic for their

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[9] Jones, R., Finer, L. & Singh, S. *Characteristics of U.S. Abortion Patients, 2008.* N.Y.: Guttmacher Institute, 2010, p. 2.

[10] "The Institute works to protect, expand and equalize universal access to information, services and rights that will enable women and men to exercise the right to choose safe, legal abortion . . . " and "The Institute also recognizes a responsibility to document, and address through policy advocacy, the disparities in sexual and reproductive health and rights between and within countries across the globe, and to support the efforts of colleagues advocating for enlightened policies in their own countries and internationally." Mission of Guttmacher Institute, 2013. Available at: http://www.guttmacher.org/about/mission.html

follow-up care.[11] Accordingly, many complications delayed or otherwise, are unlikely to even be known to the TOP provider. Moreover, there is no national mandatory registry or reporting of the incidence of elective TOP or its complications. It is my understanding that North Dakota is one only [sic] a handful of states that does require TOP providers to report complications of terminations.[12] However, even when TOP complications are required to be reported, in my opinion, significant underreporting occurs due to provider conflict of interests.

27. Given the inherent weaknesses of TOP mortality and morbidity data, it is inconceivable to me how TOP safety can be alleged with any reasonable degree of epidemiological certainty.

28. Furthermore, the paucity of good data on the serious complications of TOP does not warrant

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[11] *See*: Picker Institute, *From the Patient's Perspective: Quality of Abortion Care*, 1999 at 33, and Grossman, D. et al., *Routine Follow-up Visits after First-Trimester Induced Abortion*. *Obstetrics & Gynecology* 2004, 103: 738-745.

[12] According to a recent nationwide survey, there are only 16 states that require reporting of TOP complications, and only 8 states that publish summary information which includes abortion complications in their annual report. See: Donovan C & Sullivan N. *Abortion Reporting: Tears in the Fabric*. 2013, Washington, D.C.: Charlotte Lozier Institute, Table 5, available at: http://www.lozierinstitute.org/abortionreporting/. According to another report, only 27 states have mandated TOP complications reporting. See: Guttmacher Institute, *Abortion Reporting Requirements*, *State Policies in Brief*. August 1, 2013, available at: http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf

the manufacturing of medical "certainty" based upon a self-citing cycle of institutional informational bias. Dr. Stephen Henshaw, a long time Guttmacher researcher, who has repeatedly testified in opposition to any regulation of TOP and has concluded in a 1999 published chapter that the risk of women expiring complication requiring hospitalization from a first trimester abortion is 0.3%. Coincidentally, the book in which Dr. Henshaw's chapter appears is a clinical text of the National Abortion Federation.[13] In that chapter, Dr. Henshaw bases his estimate on his own 1986 report co-written with Dr. Tietze, a Planned Parenthood biostatistician who received their annual Margaret Sanger Award in 1973, which examined data that is 38 years old.[14] The 1986 Henshaw & Tietze report was published by Guttmacher. It is difficult if not impossible to draw valid conclusions about contemporary TOP practices based upon data nearly four decades old, and it is certainly questionable for public policy to rely upon Plaintiff Planned Parenthood's employees for conclusive scientific evidence as to the safety of TOP.

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[13] Henshaw, SK. Unintended pregnancy and abortion: a public health perspective. In: Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield, PG, eds, *A Clinician's Guide to Medical and Surgical Abortions*. New York: Churchill Livingston;1999:11-22.

[14] Tietze, C. & Henshaw, SH. *Induced Abortion: A World Review*. Alan Guttmacher Institute, 1986.

29. Existing and scientifically valid research demands revisiting this issue. Two Canadian articles produced population-based maternal mortality rates[15] (MMR) from a developed country in "healthy women." Though neither controlled for age, their findings are illustrative here. One focused on excess risk associated with elective abdominal delivery and found an MMR of 1.2/100,000.[16] The other focused on vaginal birth after caesarean section which is a higher risk condition due to uterine scarring and found a risk of 1.6/100,000.[17] One can safely speculate that this number would be lower in women with an unscarred uterus. Both of these MMRs are well within the 1-2/100,000 quoted for TOP in the US with all its limitations. In my epidemiological opinion, it is misleading to assert that TOP is safer than pregnancy in low risk, healthy women. An additional factor

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[15] The maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births for a specified geographical area from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year, and for a specified geographical area.

[16] *See: Wen, S. et al. Comparison of Maternal Mortality and Morbidity between Trial of Labor and Elective Cesarean Section among Women with Previous Cesarean Delivery*, *American Journal of Obstetrics & Gynecology*, 2004, 191: 1263-1269).

[17] Liu, S et al. *Maternal Mortality and Severe Morbidity Associated with Low-risk Planned Cesarean Delivery versus Planned Vaginal Delivery at Term. Canadian Medical Association Journal*, 2007, 176, 455-460.

that should be considered is age and maternal mortality. Younger women between the ages of 20-39 are generally healthier than older women and thus less likely to die from uncomplicated pregnancy and childbirth, which is a normal and natural process. In developing countries when direct obstetric deaths which are largely preventable are excluded, a "healthy pregnant woman effect" has been reported in which women currently or recently pregnant were up to five times less likely to die than women who had not been recently pregnant.[18]

30. Given the poor ascertainment and reporting of deaths after TOP in the US due to insufficient administrative oversight and subsequent inability to link TOP occurrence to death certificates,[19] it is imprecise at best to compare TOP-related deaths to pregnancy-related deaths and claim TOP is one of the safest medical procedures in the United States, and much more safe than childbirth. Pregnancy related deaths are systematically sought and investigated by state government sponsored commissions and the majority of states formally link birth certificates to death certificates. These efforts, which cannot

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[18] Ronsmans, C. et al. *Evidence for a "Healthy Pregnant Woman Effect" in Niakkar, Senegal*. *International Journal of Epidemiology*, 2001, 30, 467-473.

[19] Reardon, D., Strathan, J. Thorp, J. & Shuping, M. *Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications*. *Journal of Contemporary Health Law & Policy*, 2004, 20: 279-327.

currently be done for TOP, *double* the number of pregnancy related deaths discovered. Moreover, deaths after pregnancy cover an interval from conception to 42 days after delivery while TOP covers a much shorter window. An analogy would be comparing a full length film to a snapshot. For these reasons, comparing death rates and their derivative, safety claims, are inaccurate and imprecise. Such claims are not supported by adequate epidemiological methods and at this time, the comparative differences in the U.S cannot be quantified with precision.

31. The U.S. has no national health registry identifying and linking all individual healthcare interventions, diagnoses, hospitalizations, births, deaths and other vital statistics, unlike Scandinavian countries. Accordingly, epidemiological studies using these national data sets from abroad are methodologically superior to U.S. data. In a recently published study of 463,473 women using Danish linked birth and death registry records for an epoch of 25 years, when compared to women who delivered, women with TOP < 12 weeks gestation had higher cumulative mortality rates from 180 days to 10 years later.[20] In a second study using the same national registries, the researchers again found increased risks of death for

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[20] Reardon, D. & Coleman, P. *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004. Medical Science Monitor, 2012*, 18: PH71-Ph76.

women electing abortion compared to childbirth.[21] Record linkage studies of the population of Finland and of low income women in California have also reported higher death rates associated with abortion than childbirth.[22]

32. Indeed, large-scale studies based on data linkage from the US, Britain, Denmark and Finland, have shown that women who undergo induced abortion have a sharply increased death rate compared to women who give birth. Having TOP also greatly increases a woman's chance of later attempting or committing suicide, while carrying a baby to term

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[21] Coleman, P. Reardon, D. & Calhoun, B. *Reproductive History Patterns and Long-term Mortality Rates: A Danish, Population-Based Record Linkage Study*. *European Journal of Public Health* (September 5, 2012, Epub ahead of print).

[22] Post-pregnancy death rates within one year were nearly 4 times greater among women who had an induced abortion (100.5 per 100,000) compared to women who carried to term (26.7 per 100,000). Gissler, M. et al. *Pregnancy Associated Deaths in Finland 1987-1994: Definition Problems and Benefits of Record Linkage*. 76 *A Acta Obstetricia et Gynecologica Scandinavica*. 1997, 76: 651-7; mortality was significantly lower after a birth (28.2 per 100,000) than after an induced abortion (83.1 per 100,000). Gissler, M. Berg, C., Bouvier-Colle, M. Buekins, P. *Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000*. *American Journal of Obstetrics and Gynecology*, 2004, 190: 422-427; women who aborted, when compared to women who delivered, were 62% more likely to die over an 8 year period from any cause after adjustments were made for age. Reardon, D. et al. *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*. *Southern Medical Journal*, 2002, 95: 834-841.

greatly reduces that likelihood. As two recent researchers write, "pregnant women considering their options deserve accurate information about comparative risks."[23] Yet, as already noted above, purporting to show that induced abortion is safer than childbirth is based on faulty methodology and incomplete data, and is in any case limited to the period immediately after childbirth or termination of pregnancy. It completely ignores four data-linkage studies, which are based on a far more objective and neutral methodology, as well as complete and reliable data. Those and other studies effectively explode the myth that abortion is safer for a woman than childbirth.

33. Yet, Plaintiffs argue that TOP is safe despite the lack of valid scientific evidence. No evidence is presented or exists to corroborate this extreme position. After reviewing such opinions and allegations comparing the relative safety of childbirth to TOP, one could reasonably draw the conclusion that human pregnancy and delivery is a disease state that is unsafe and should be managed by the safer choice of pregnancy termination, notwithstanding common sense and conventional medical science. Indeed, such a one-sided view would seemingly question why a woman would ever choose conception and childbirth.

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[23] Raymond, E., Grimes, D. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology* 2012. 119:215-9, pp. 187-91

34. In summary, there are numerous and complex methodological factors that make a valid scientific assessment of TOP mortality and morbidity impossible: incomplete reporting, definitional incompatibilities of measures, voluntary data collection, investigator bias, reliance upon estimations, inaccurate and/or incomplete death certificate completion, incomparability with maternal mortality statistics, and failing to include other causes of death such as suicides. Numerous other methodological issues abound in TOP epidemiology. Further discussion of this is presented in my 2012 article in *Scientifica* entitled: *Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later*. Therefore, in my opinion any assertion that TOP is safer than childbirth lacks medical and scientific merit – it is not and any contention otherwise is misleading.

## V. ADVERSE CONSEQUENCES TO WOMEN FROM TOP: SHORT & LONG TERM RISKS OF TOP

35. With the caveats identified above, and acknowledging the weaknesses of existing epidemiological research on TOP outcomes, in my opinion, there are significant risks from surgical TOP, which include bleeding, infection, and damage to bowel, bladder, or upper genital tract. The risks from medical TOP include failed abortion, incomplete abortion, bleeding, and infection which are greater than for

surgical TOP, according to existing research.[24] Heavier bleeding and more severe cramping are more common in medical TOP. Off-label use of medical TOP is inadvisable given the number of adverse event reports and deaths.[25] Complication rates range from 1-10% and most complications can be managed without major surgery. While TOP complication rates tend to increase proportionately with gestational age, based upon the limited and incomplete data available, and while the magnitude of risk remains small, after 16 weeks, risks from TOP may exceed the risks

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[24] Similar to the findings of other studies, the incidence of hemorrhage is 15.6 percent following medical abortions, compared to 5.6 percent for surgical abortions; 6.7 percent of medical abortions result in incomplete abortion, compared to 1.6 percent of surgical abortions; and the rate of need for surgery following medical abortion is 5.9 percent. M. Niinimaki, et al., *Immediate Complications after Medical Compared with Surgical Termination of Pregnancy*, *Obstetrics & Gynecology*. 2009,114:795-799 (2009). For a discussion of complications associated with medical TOP <49 weeks gestation versus 49>, see: Amici Curiae Brief of Dr. John Thorp et al., *Cline, et al. v. Oklahoma Coalition for Reproductive Justice, et al*., U.S. Supreme Court, No. 12-1094, 2013.

[25] The FDA relies on "adverse event reports" as one method to determine whether to remove a drug from the market after approval. An FDA report in 2011 acknowledged at least 2,207 cases of severe adverse events, including hemorrhaging, blood loss requiring transfusion, serious infection, and 14 deaths. U.S. Food & Drug Administration. *Mifepristone U.S. Postmarketing Adverse Events Summary Through 04/30/2011*. RCM 2007-525 (July 2011) available at: http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf.

of carrying a pregnancy to term and certainly do so by 20 weeks.

36. While there have been numerous claims that TOP has no long-term health consequences beyond the immediate complications identified above, these assertions are based upon the data limitations previously discussed, particularly lack of completeness and the sole use of observational data generated by self-report of TOP exposure. Methodologically sound research has, however, indicated significant associations between TOP and preterm birth that appear to be causal and association with placenta previa, breast cancer, and mental health problems, i.e., mood disorders, substance abuse and suicide, that are suggestive of causality.[26]

37. When one reviews countries where TOP is freely available, like in certain Latin American, African and European countries, there is next-to-no evidence to support the proposition that legalizing abortion leads to improved maternal and infant health. On the contrary, we find that those countries which do not permit abortion, or which have banned it in the past two decades, have a consistently better record in caring for mothers and newborns. This is clearly evident in Chile, Poland and Ireland. What is beyond dispute is that countries that have made

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[26] Thorp, J. *Scientifica*, 2012, op. cit.; Thorp, J. Hartman, K. & Shadigian, E. *Obstetrical & Gynecological Survey*, 2004, op. cit.

strides in improving the education of women, in emergency obstetric care (such as caesarean sections), in skilled attendance at birth, as well as community outreach, improved referral systems and transportation for emergency care – most notably Chile, Uganda and Egypt – have been rewarded with greatly improved maternal and infant health.

38. A woman who is pregnant will increase her risk of breast cancer if she aborts that pregnancy, given the protective effect of delivery on breast cancer risk. The woman who does have a TOP procedure will either remain childless, which in itself increases breast cancer risk, or she will delay her first full-term pregnancy, another known risk for breast cancer. The woman having a TOP procedure is also deprived of breastfeeding her baby, which would further reduce her breast cancer risk. By the end of a full-term pregnancy, a woman will cause 85 percent of the Type 1 and 2 breast lobules she developed at puberty (where ductal and lobular cancers start respectively) to mature to Type 4 lobules which are cancer-resistant. There are documented changes in the breast cells' genomes which have been studied and provide the known molecular basis for the protective effect of a full-term pregnancy.

39. The rate of infection for women undergoing a TOP ranges from <1% to as high as 10%. Pelvic inflammatory disease (PID) is a consequence both of sexually transmitted infections (STIs) and medical procedures like a surgical TOP that introduces bacteria from the vagina or cervix into the uterus, uterine

tubes or ovaries. Women with an STI who procure an induced TOP are therefore up to 72 percent more likely to contract PID; this association is most commonly seen among women with Chlamydia. Even with the administration of antibiotics prior to a TOP, women still risk the sequelae of infection. The consequences most discussed in the literature are subfertility, infertility, and ectopic pregnancy. Studies also show that PID can cause tubal pathology that renders a woman infertile. Ectopic pregnancy is one of the leading causes of pregnancy-related deaths, and because of the scarring caused by PID, the risk of ectopic pregnancy rises seven- to ten-fold in infected women. There is a correlation between abortion and subsequent ectopic pregnancy. In my opinion a women that has a TOP significantly increases her risk of PID and a subsequent ectopic pregnancy that is itself life threatening.

40. In the past fifteen to twenty years the medical literature has increasingly documented the immediate hazards of a surgical TOP: perforation of the uterus, causing scarring, which in turn can result in Asherman's syndrome and infertility. The risk of placenta previa in a subsequent pregnancy may also be increased. The necessity to force open the cervix (dilation) during a surgical TOP can weaken the cervix and render it incapable of performing its primary function during pregnancy: holding in the baby. A weakened or "incompetent" cervix will mean a higher rate of miscarriage and premature births. In my opinion, these are very real hazards stemming

from a surgical TOP, which are significantly increased when a woman has a TOP.

41. TOP greatly elevates the subsequent risk of bearing a premature baby. Two systematic reviews published in the British Journal of Obstetrics and Gynaecology and the Journal of Reproductive Medicine, as well as two recently completed, massive studies from Scandinavia and Britain have established that preterm and low-birth-weight children have a much greater chance of dying in childhood.[27] These unfortunate children also have a much higher incidence of medical disabilities, most notably cerebral palsy and mental retardation. They fare worse in the educational system, on the job market, and in finding a life partner. Furthermore, four studies have documented a link between autism and prior abortions. The association between having one or more TOP procedures and later giving birth to a premature child has also been clearly established, most recently by two major Canadian studies this year. The more TOP procedures a woman has, the greater her chances of later delivering a preterm or low-birth-weight child. Surgical TOP procedures also elevate the risk of uterine scar tissue (also known as adhesions) and

[27] Shah, PS, Zao J. Induced termination of pregnancy and low birth rate and preterm birth: a systematic review and meta-analysis. BJOG: An International Journal of Obstetrics & Gynecology, May 2009; 116(1): 1425-42. Swingle, HM, Colaizy, TT, Zimmerman MB, Morriss, FH. Abortion and the risk of subsequent pre-term birth. The Journal of Reproductive Medicine 2009, February; 54(2): pp. 95-108.

cervical insufficiency (also called incompetent cervix), both of which raise the risk of a future premature delivery. An "incompetent cervix" raises cerebral palsy risk, as do maternal infections. Consequently, it is fair to say that TOP is producing a medical and social disaster in those countries where it is freely available. Writing in the Journal of Reproductive Medicine, a group of researchers has estimated that in the United States in one year alone, prior induced abortions caused at least 1096 cases of cerebral palsy in very low birth weight newborns. Globally this translates into well over 15,000 cases of cerebral palsy annually attributable to prior induced abortions. It is interesting to compare this with the birth of an estimated 10,000 babies with serious defects in the late 1950s as a consequence of thalidomide use. This personal and collective tragedy was then greeted with universal horror. A glimpse of the benefits that might accrue from reducing the number of induced abortions is furnished by the experience of Poland. Twenty-three years ago the new democratic regime took the drastic step of banning almost all TOP procedures in that country. As we have seen, this action was followed by a more than 70 percent drop in the deaths of children under the age of five from cerebral palsy in the succeeding fifteen years. Moreover, in the three-year period from 1995 to 1997 Poland's extreme preterm birthrate dropped by 21 percent, while the total of all births declined by only five percent. No other country has achieved such a dramatic reduction in extremely preterm births in such a short time. By contrast, both the US and

Canada, where TOP is freely available, experienced a rise in preterm births during the same period.

## VI. ADVERSE CONSEQUENCES TO WOMEN FROM TOP: COERCION, PRESSURE AND UNDUE INFLUENCE IN TOP DECISION-MAKING

42. Current research informs and alerts ob-gyns to the importance of screening for intimate partner violence and reproductive coercion (Miller & Silverman, 2010). The American College of Obstetricians and Gynecologists has issued Committee Opinion #554 on reproductive and sexual coercion indicating: "Obstetrician-gynecologists are in a unique position to address reproductive and sexual coercion and provide screening and clinical interventions to improve health outcomes" (ACOG, 2013). Forcing a female partner to terminate a pregnancy when she does not want to is reproductive coercion according to ACOG and others (Chamberlain & Levenson, 2012). Research indicates that past year prevalence of physical and sexual intimate partner violence (IPV) among abortion-seeking women is estimated to be 14% to 25.7% for sexual intimate partner violence. This estimate is more than 6 times the estimated national prevalence of 3.7% among US women who continue their pregnancy; accordingly, women in violent relationships are much more likely to seek TOP services (Saftlas et al, 2010; Woo, Fine & Goetzl, 2005). Men who perpetrate IPV are more likely to report conflicts with pregnant female partners

regarding TOP decisions (Silverman et al., 2011), and thus these women are in danger of being coerced.

43. Teens and women seeking terminations of pregnancy are 3 times more likely to be victims of partner violence (Chamberlain & Levenson, 2012; Taft & Watson (2007), and women presenting for a third or subsequent abortion were more than 2.5 times as likely as those seeking a first abortion to report a history of physical abuse by a male partner or a history of sexual abuse/violence (Fisher et al, 2005). The association between TOP and sexual coercion reflects a situation of gender vulnerability and reveals young women's precariousness in sex negotiation and reproduction (Pilecco, Knauth & Vigo, 2011).

44. While estimates vary according to the study, coercion or pressure among women seeking TOP ranges between 11%-64%. Even the National Abortion [providers] Federation identifies "perceived coercion to have the abortion" as a risk factor for negative postabortion emotional sequelae (Baker & Beresford, 2009: 57). Given the nature, gravity and prevalence of IPV, and the common association between IPV and TOP, coercion or pressure prior to the termination of pregnancy occurs with frequency.

45. An associated factor with coercion, pressure and undue influence is the age of the father of the unborn child. For pregnant adolescents, the majority of these pregnancies are fathered by older, adult men (Males and Chew, 1996), and these men are in a

position to exert an inordinate and potentially unhealthy influence over pregnant girls resulting in STIs, non-marital births, and TOPS. Half of the births to teen mothers involve men who are 20-24 years old, and an additional one-sixth are over age 25; teens who date older partners have a lower likelihood of consistent contraceptive use and for each year a partner is older than the teen, the likelihood of always using contraception decreased by 11 percent (Males, 2004). Adolescent girls with older male partners are more likely to have earlier sexual debut, multiple sexual partners, unprotected and non-voluntary sex, non-marital births, high-risk partners, STIs, and experience IPV (Manlove et al., 2006). Low relationship power can be one explanation, i.e., an adolescent girl's ability to act independently of her partner's control is compromised, and his influence and dominance in decision-making is prevalent. A noteworthy example of this occurred in Cincinnati, Ohio where a 22 year old soccer coach impregnated a 14 year old girl who subsequently went to Planned Parenthood for an abortion and did not tell her parents. Planned Parenthood did not inform the parents nor the authorities of this statutory rape and ongoing sexually abusive relationship. The fact that adolescents are exposed to so many individuals and forces outside the family makes them particularly vulnerable to undue influence, pressure and even coercion. Clearly, "Clinicians need to screen for partner age differences and recognize the possible association between partner age differences and IPV" (Volpe et al., 2013:14).

46. Abortionists, like Plaintiffs, all too often focus on decisional certainty, without examining those risk factors that may predispose pregnant women to postabortion emotional injury, including coercion. A pregnant woman's decision can indeed be certain but also be coerced at the same time. Dr. Eggleston comes in from out of state and is paid only if sufficient numbers of women consent to abortion. This pressure, combined with the above, in my medical opinion, constitutes a serious conflict of interest that in turn harms women.

## VII. SUMMARY

47. It is my opinion that TOP has a significant and profoundly adverse effect on the physical health, safety and well-being of women. Further, it is my opinion that a physician or any other clinician who performs a TOP to terminate the life of an unborn child, violates his or her duty of care to the unborn child – the physician's or clinician's patient – along with violating his or her ethical duties and responsibilities. Therefore in my opinion the Act protects women from the adverse effects of a TOP and in turn promotes the health, safety and well-being of women and their families, and the protection of every human life, whether unborn or aged, healthy or sick, protects and promotes the integrity and ethics of the medical profession, and is medically and scientifically sound and reasonable.

## VIII. LIST OF ALL CASES IN WHICH, DURING THE PAST FOUR YEARS, I HAVE TESTIFIED AS AN EXPERT AT TRIAL OR BY DEPOSITION.

### A. Constitutional Cases in Which I Have Provided Testimony:

- *Planned Parenthood of Arizona, Inc. v. Goddard et. al.*, Case No.: CV2009-029110. Superior Court of Arizona, County of Maricopa. Provided declaration 9/25/09.
- *Stuart et al., v. Huff, et al*. CV No.: 1:11-cv-804-CCE. U.S. District Court, Greensboro, North Carolina. Provided declaration and deposition. 2011-12.
- *Planned Parenthood of the Great Northwest, et al., v. State of Alaska*. Case No.: 3AN-10-12279 CI. Superior Court in Anchorage, Alaska, 2012.
- *Planned Parenthood of Greater Texas Surgical Health Services, et al. v. Abbott, et. al*. Case No. 1:13-cv-862 U.S. District Court, Middle District of Alabama.
- *Planned Parenthood Southeast, Inc., et. al. v. Bentley, et al.* Case NO. 2:13-cv-00405. U.S. District Court, Western District of Texas.
- *Planned Parenthood v. Daugaard, et. al*. Case No. 11-4071-KES, U.S. District Court, South Dakota

**B. Medical Malpractice Cases in Which I Have Provided Testimony:**

I do not maintain records that will allow me to provide names of cases and courts for the medical malpractice cases listed below. I maintain only contact information regarding the attorneys and law firms that I provided expert witness assistance to and the dates of my work.

- Trial testimony on 3/1/13, 1/28/11; Deposition testimony on 3/22/10, 2/19/10, 10/9/09, 8/21/09, 6/9/09, Shumaker, Loop & Kendrick, Charlotte NC.
- Deposition testimony on 10/11/12, Heath & Carcioppolo, Ft. Lauderdale FL
- Trial testimony on 8/24/12; Deposition testimony on 4/7/11, 3/7/09, Huff, Powell & Bailey, Atlanta GA.
- Trial testimony on 7/23/12, Tharrington & Smith, Raleigh NC
- Trial testimony on 5/21/12; Deposition testimony on 12/22/11, Wilson Helms & Cartledge, Winston-Salem NC
- Deposition testimony on 4/30/12, Mundy Rogers & Assoc., Roanoke VA
- Deposition testimony on 3/20/12, 1/27/11, 1/3/09, 7/28/09, Haliczer, Pettis & Schwamm, Ft. Lauderdale FL.

- Deposition testimony on 3/15/12, 9/3/10, Wilson, Elser, Moskowitz, Edelman & Dicker, Washington DC.
- Trial testimony on 3/9/12, 4/4/11, 5/13/10; Deposition testimony on 5/6/09, Walker, Allen, Grice, Ammons & Foy, Goldsboro NC.
- Deposition testimony on 3/2/12, Hamilton, Altman, Canale, & Dillon, Fairfax VA
- Trial testimony on 1/25/12, Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, Raleigh NC.
- Trial testimony on 1/20/12, Adams Coogler, West Palm Beach FL.
- Deposition testimony on 1/17/12, Law Office of Michael Goodman, Englewood CO
- Deposition testimony on 11/3/11, Cecily E. Steele, Cary NC.
- Deposition testimony on 9/1/11, Shuttleworth & Ingersoll, Cedar Rapids IA.
- Deposition testimony on 7/8/11, 6/3/11, 1/3/11, Baker & Whitt, Memphis TN.
- Deposition testimony on 6/1/11, 5/10/1 [sic], Feldman Shepherd, Philadelphia PA.

- Deposition testimony on 5/16/11, Owen, Gleaton, Egan, Jones & Sweeney, Atlanta GA.
- Deposition testimony on 5/13/11, 12/18/09, 10/15/09, 7/10/09, 5/26/09, 4/22/08, 1/24/08; Trial testimony on 1/26/11, Cranfill, Sumner & Hartzog, Raleigh NC.
- Deposition testimony on 1/4/10, Parker Poe, Charlotte NC.
- Deposition testimony on 12/2/10, 10/25/10, Yates, McLamb & Weyher, Raleigh NC.
- Deposition testimony on 11/19/10, Harris, Ward & Blackerby, New Bern NC.
- Trial testimony on 9/24/10, Dameron Burgin, Parker, Lorenz & Jackson, Marion NC.
- Deposition testimony on 1/4/10, 6/25/09, Parker Poe, Adams & Bernstein, Charlotte NC.
- Deposition testimony on 12/4/09, Forrester & Brim, Gainesville GA.
- Trial testimony on 10/20/09; Deposition testimony on 5/29/09, Goodell, DeVries, Leech & Dann, Baltimore MD
- Deposition testimony on 9/29/09, 6/9/09, Rodney Dickanson, Sloan, Akin & Robb, Albuquerque NM.

- Deposition testimony on 9/4/09, Leech & Dann, Baltimore MD.
- Deposition testimony on 9/1/09, Daniel Weinstock, Feldman Shepherd, Philadelphia PA.
- Deposition testimony on 9/1/09, Paralegal to Rishard [sic] Ramsey, Wicker, Smith, O'Hara, McCoy & Ford, Jacksonville FL.
- Deposition testimony on 8/28/09, Adams & Bernstein, Charlotte NC.
- Deposition testimony on 8/28/09, Nancy E. Carr Claims and Risk Management Services, Miami FL.
- Deposition testimony on 7/23/09. The Keenan Law Firm, Atlanta GA.
- Deposition testimony on 7/20/09, 5/27/09, 1/22/08, 12/21/07, Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, Raleigh NC.
- Deposition testimony on 7/12/09, Dickie, McCamey & Chilcote, Pittsburg PA.
- Deposition testimony on 6/31/09, Matthew W. Sowell, Jacksonville FL.
- Deposition testimony on 3/12/09, 6/20/08, 1/29/08; Trial testimony on 11/18/08, Wilson & Coffey, Winston-Salem NC.
- Deposition testimony on 3/3/09, 4/17/08, Upton & Hatfield, Concord NH.

- Deposition testimony on 2/2/09, 1/22/08, 12/11/07, Hood Law Firm, Charleston SC.

## IX. COMPENSATION.

I will be compensated at the rate of $500 per hour for work performed in this case. I charge $500 per hour for time spent testifying either in deposition or at trial, and it is also my understanding that if travel is required, that all of these expenses will also be paid in conjunction with my testifying.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: December 10, 2013

/s/ John Thorp, Jr., M D
John Thorp, Jr., M.D., M.H.S.

## APPENDIX I

### Safe Haven Laws in the United States

**Ala.** Code §§ 26-25-1 to -5 (2013); **Alaska** Stat. §§ 47.10.013, .990 (2013); **Ariz.** Rev. Stat. Ann. § 13-3623.01 (2013); **Ark.** Code Ann. §§ 9-34-201, -202 (2013); **Cal.** Health & Safety Code § 1255.7 (West 2013); Cal. Penal Code § 271.5 (West 2013); **Colo.** Rev. Stat. § 19-3-304.5 (2013); **Conn.** Gen. Stat. §§ 17a-57, -58 (2012); **Del.** Code. Ann. tit. 16, §§ 902, 907-08 (2013); **D.C.** Code §§ 4-1451.01 to .08 (2013); **Fla.** Stat. § 383.50 (2013); **Ga.** Code Ann. §§ 19-10A-2 to -7 (2013) **Hawaii** Rev. Stat. §§ 587D-1 to -7 (2013); **Idaho** Code Ann. §§ 39-8201 to -8207(2013); 325 **Ill.** Comp. Stat. 2/10, 2/15, 2/20, 2/27 (2013); **Ind.** Code § 31-34-2.5-1 (2013); **Iowa** Code §§ 233.1, .2 (2014); **Kan.** Stat. Ann. § 38-2282 (2012); **Ky.** Rev. Stat. Ann. §§ 216B.190, 405.075 (LexisNexis 2013); **La.** Child. Code Ann. arts. 1149-53 (2013); **Me.** Rev. Stat. tits. 17-A, § 553, 22 § 4018 (2013); **Md.** Code Ann. Cts. & Jud. Proc. § 5-641 (LexisNexis 2013); **Mass.** Gen. Laws Ch. 119, § 39 1/2 (2013); **Mich.** Comp. Laws §§ 712.1, .2, .3, .5, .20 (2013); **Minn.** Stat. §§ 145.902, 260C.139, 609.3785 (2013); **Miss.** Code Ann. §§ 43-15-201, -203, -207, -209 (2013); **Mo.** Rev. Stat. § 210.950 (2013); **Mont.** Code Ann. §§ 40-6-402 to -405 (2013); **Neb.** Rev. Stat. § 29-121 (2012); **Nev.** Rev. Stat. §§ 432B.160, .630 (2013); **N.H.** Rev. Stat. Ann. §§ 132-A:1 to :4 (2013); **N.J.** Stat. Ann. §§ 30:4C-15.6 to -15.10 (West 2013); **N.M.** Stat. Ann. §§ 24-22-1.1, -2, -3, -8 (2013); **N.Y.** Penal Law §§ 260.00, .10 (McKinney 2013); N.Y. Soc. Serv. Law § 372-g (McKinney 2013);

**N.C.** Gen. Stat. § 7B-500 (2012); **N.D.** Cent. Code §§ 27-20-02, 50-25.1-15 (2013); **Ohio** Rev. Code Ann. §§ 2151.3515, .3516, .3523 (LexisNexis 2013); **Okla.** Stat. tit. 10A, § 1-2-109 (2013) **Or.** Rev. Stat. § 418.017 (2011); 23 **Pa.** Cons. Stat. §§ 4306, 6502, 6504, 6507 (2013); **R.I.** Gen. Laws §§ 23-13.1-2, -3 (2012); **S.C.** Code Ann. § 63-7-40 (2012); **S.D.** Codified Laws §§ 25-5A-27, -31, -34 (2013); **Tenn.** Code Ann. §§ 36-1-142, 68-11-255 (2013); **Tex.** Fam. Code Ann. §§ 262.301, .302 (West 2013); **Utah** Code Ann. §§ 62A-4a-801, -802 (LexisNexis 2013); **Vt.** Stat. Ann. tit. 13, § 1303 (2013); **Va.** Code Ann. §§ 8.01226.5:2, 18.2-371.1, 40.1-103 (2013); **Wash.** Rev. Code § 13.34.360 (2013); **W. Va.** Code § 49-6E-1 (2013); **Wis.** Stat. § 48.195 (2013); **Wyo.** Stat. Ann. §§ 14-11-101, -102, -103, -108 (2013).