



BARBARA DITTRICH

STATE REPRESENTATIVE • 38th ASSEMBLY DISTRICT

October 7, 2021

Assembly Committee on Health

RE: Rep. Dittrich Testimony on AB 595 - sex-selective, disability-selective, and other selective abortions and providing a penalty.

Greetings, Committee Chair Sanfelippo and members of the committee. I appreciate the opportunity to speak to you yet again on another topic that is extremely close to my heart and personal to me, discrimination and genocide of pre-born people.

Again, this specific bill along with several others, were vetoed by Governor Evers last session. However, the fight for these lives is just as worthy this session as it was last session.

Current culture has matured and evolved to be inclusive and accepting of people of all abilities, races, sexes, and backgrounds. I recently authored a separate resolution extolling the virtues of having a full array of work opportunities open to people with disabilities. This bill prohibits a person from performing/attempting to perform or inducing an abortion if the person knows the woman is seeking an abortion solely because of the race, color, national origin, ancestry, gender, or diagnosis or potential diagnosis of a congenital disability.

In my myriad personal experiences, I have witnessed many beautiful, unique individuals that would have been otherwise “written off” by society flourish and live full and meaningful lives as members of our society. While I appreciate the angst and fear of a woman seeking an abortion, I want to discourage the elimination of an unborn child due to a diagnosis or potential diagnosis. Rather, I believe we should encourage and support women, even helping them to make the difficult decision to place a child for adoption if they feel unable to parent the child. I speak to countless families that would welcome and have welcomed a child into their lives regardless of that child’s ability level, through biological birth or the miracle of adoption. Additionally, a child should not be killed due to their race, color, national origin, ancestry, or gender as it is equivalent to discrimination in the womb. If we wouldn’t discriminate after birth, we surely should not prior to birth. Every human being should expect the protection of life as stated in our Constitution.

Deciding which life is worthy of saving even up to birth, while seeming to avoid the challenges of living with difficulties, unwittingly practices eugenics, something humanity has decried throughout history. Further, it deprives us of the rich diversity people of every type add to our world. We cannot both say that we support individuals of every race, gender, nationality, ethnicity, and ability level yet use the same criteria to kill an unborn child.

Let’s do the right thing and put an end to this horrible discrimination and genocide. I thank you for your time, and welcome any questions you may have.



PATRICK TESTIN

STATE SENATOR

DATE: October 7, 2021

RE: **Testimony on Assembly Bill 595**

TO: The Assembly Committee on Health

FROM: Senator Patrick Testin

Thank you Chairman Sanfelippo and members of the Assembly Committee on Health for accepting my testimony in support of Assembly Bill 595.

This legislation, which I have authored with Representative Dittrich, is an important step for the State of Wisconsin. In other areas of the world, there are observable instances of selective abortions that occur due to the characteristics of the unborn child.

Iceland has been pointed to as one of the most prominent examples of these practices in action. In an article published by CBS, almost one hundred percent of women who undergo prenatal tests and receive a positive test result for Down syndrome terminate their pregnancy. Many other countries have data that reveal high abortion rates following a diagnosis of Down syndrome. This includes the United States, which had a rate of 67% as of 2011.

There are many instances of sex-selective abortions that occur around the world as well. The 2020 State of World Population Report shows that over 140 million females are absent from the world due to discriminatory sex-selective abortion.

Assembly Bill 595 seeks to add into statute that the State of Wisconsin will not allow abortions solely for the purpose of eliminating an unborn child because of his or her characteristics – whether it be their sex, race, national origin, ancestry or a diagnosis or potential diagnosis of Down syndrome or another congenital disability. The bill will require physicians to make this known to the woman on which an abortion is to be performed in addition to the other informational requirements currently in law.

Assembly Bill 595 also includes provisions that specify the procedure to bring forward claims for civil damages for violations of the terms of this bill. Claims may be filed by the mother, father or the parent/guardian of a woman if the woman was a minor at the time or dies as a result of the abortion. Additionally, should a physician perform an abortion for any of the prohibited reasons included in the bill, that physician must be investigated for unprofessional conduct by the Medical Examining Board.

It is important that our state be proactive rather than reactive and make it clear in statute that this kind of prejudice will not be tolerated. Deciding that a life is unwanted or unfit to live because of their attributes is inhumane and is a practice that should be declared unlawful in Wisconsin.

Thank you for taking the time to listen to my testimony today, and I respectfully ask that you join me in supporting Assembly Bill 595.

CHARLOTTE
LOZIER
INSTITUTE

Testimony of Tara Sander Lee, Ph.D.
Senior Fellow and Director of Life Sciences, Charlotte Lozier Institute

Assembly Committee on Health, Wisconsin
October 2021

To the Distinguished Chair and Honored Members of the Committee.

Thank you for the opportunity to testify on Assembly Bill 595, which would prohibit a person from performing or inducing an abortion because of race, color, national origin, ancestry, sex, or solely because the unborn child has been diagnosed with or has potential diagnosis of Down syndrome or another congenital anomaly.

I am a scientist with over 20 years' experience in basic science research and clinical medicine. My education and experience involve a PhD in Biochemistry from the Medical College of Wisconsin followed by postdoctoral training at Harvard Medical School and Boston Children's Hospital in molecular and cell biology. I held faculty appointments at the Medical College of Wisconsin and the Children's Research Institute, with a focus on the pathologic mechanisms of childhood disease. My clinical experience includes appointments as Scientific Director of Molecular Diagnostics at Children's Hospital of Wisconsin and Children's Specialty Group with credentialed hospital privileges. I also served as a molecular pathology inspector for the College of American Pathologists and scientific consultant for various entities. I am testifying in my capacity as a scientist, with expertise in molecular genetics and diagnostic testing, and as Senior Fellow and Director of Life Sciences with the Charlotte Lozier Institute.

The purpose of this bill is to prevent eugenic discrimination and induced termination of a pre-born child based on race, sex, or the presence or presumed presence of a genetic abnormality like Down syndrome. Down syndrome is a trisomy disorder genetically caused by the presence of an extra copy of chromosome 21. This genetic anomaly occurs at conception, when the man's sperm fuses with a woman's egg to form a single-cell embryo—the creation of a new, totally distinct, integrated organism or human being.¹ Most children with Down syndrome survive to birth, often with medical conditions, such as congenital heart defects, eye disease, thyroid

¹ Ronan O'Rahilly and Fabiola Müller, *Developmental Stages in Human Embryos: Including a Revision of Streeter's "Horizons" and a Survey of the Carnegie Collection* (Washington D.C.: Carnegie Institution of Washington, 637, 1987); and *The Endowment for Human Development*. Available at: <https://www.ehd.org/prenatal-summary.php>; See also Charlotte Lozier Institute, "The Voyage of Life: Dive Deeper – Down Syndrome." Available at: <https://lozierinstitute.org/dive-deeper/down-syndrome/>

disease, and hearing loss. With appropriate medical care, children born with Down syndrome can lead healthy, happy lives with an average life expectancy of 60 years.²

The frequency of Down syndrome in the population is estimated to be 1 in 700 live births.³ And the Center for Disease Control estimates that each year, 6,000 babies are born with Down syndrome in the United States.⁴

Down syndrome can be diagnosed in a newborn baby at birth or shortly thereafter. However, early prenatal screening and testing for Down syndrome are being used to target babies inside the womb for destruction based on their presumed risk for trisomy 21. Some view the ability to detect trisomy 21 in the first trimester as a “benefit” so that “decisions regarding pregnancy termination may be made at a time when services are more readily available.”⁵ A survey in Australia found that 97% of women who had already undergone non-invasive prenatal screening had a personal interest in using a cell-free prenatal screening test to identify a Down syndrome trait and 43% of women were likely or definitely likely to terminate a pregnancy if the result came back positive (38% were unsure).⁶

AB 595 is needed to protect babies diagnosed or at risk of trisomy 21 against disability discrimination through abortion. There is well-documented evidence in the U.S. and abroad showing that babies are being aborted at an alarming rate after receiving a “positive” prenatal trisomy 21 result.

In the U.K., a 1999 study found a 92% abortion rate for children diagnosed in the womb with Down syndrome.⁷ Maxwell and co-workers reported a 93% abortion rate in Western Australia for babies diagnosed in the womb with Down syndrome.⁸ De Graaf and colleagues looked at the Down syndrome population throughout Europe and found that there were 50% fewer babies born with Down syndrome looking back 40 years up to 2015, and that just over the period of 2011-

² National Association for Down Syndrome. Available at: <https://www.nads.org/resources/facts-about-down-syndrome/#:~:text=However%2C%20with%20appropriate%20medical%20care,into%20their%20sixties%20and%20seventies.>

³ Mai CT, Isenburg JL, Canfield MA, Meyer RE, Correa A, Alverson CJ, Lupo PJ, Riehle-Colarusso T, Cho SJ, Aggarwal D, Kirby RS. National population-based estimates for major birth defects, 2010–2014. *Birth Defects Research*. 111(18): 1420-1435, 2019.

⁴ Centers for Disease Control and Prevention (CDC), Data and Statistics on Down Syndrome. Available at: <https://www.cdc.gov/ncbddd/birthdefects/downsyndrome.html>.

⁵ Rink, B.D. and M.E. Norton, *Screening for fetal aneuploidy*. *Semin Perinatol*, 2016. 40(1): p. 35-43.

⁶ Bowman-Smart H, et al. ‘Is it better not to know certain things?’: views of women who have undergone non-invasive prenatal testing on its possible future applications. *J Med Ethics* 2019;45:231–23.

⁷ Mansfield C *et al.* Termination rates after prenatal diagnosis of Down syndrome, spina bifida, anencephaly, and Turner and Klinefelter syndromes: a systematic literature review, *Prenatal Diagnosis* 19, 808, 1999.

⁸ Maxwell S *et al.*, Impact of prenatal screening and diagnostic testing on trends in Down syndrome births and terminations in Western Australia 1980 to 2013, *Prenatal Diagnosis* 35, 1324–1330, 2015; doi: 10.1002/pd.4698.

2015, abortions decreased the Down syndrome population in Europe by a rate of 27%.^{9,10} A recent report out of Ireland reports 79/113 (69.9%) women chose a termination of pregnancy (TOP) following a prenatal diagnosis of trisomy 21.¹¹

In the U.S., a 2012 review of the literature on this topic found a range from 61% up to 93% of those diagnosed with Down syndrome in the womb who were aborted.¹² More recent data show that abortion accounts for a 33% reduction in the number of babies with Down syndrome born in 2014. This means that in recent years there were 33% fewer babies with Down syndrome born in the U.S. than could have been.¹³

In 2009, Skotko posed the question of whether the new, non-invasive prenatal testing would mean babies with Down syndrome would slowly disappear.¹⁴ In less than a decade, his question was answered. In 2017, Iceland reported that it was on pace to virtually eliminate Down syndrome through abortion.¹⁵ Denmark was the first country to institute a national screening program, and it has seen Down syndrome births drop dramatically.¹⁶ Denmark is moving closely on the heels of Iceland, getting ever closer to “eliminating” Down syndrome in their population.¹⁷ A systematic review and analysis of global trends published in 2021 showed an overall declining trend in birthrates for the total population with Down syndrome following the world-wide expansion of prenatal testing.¹⁸

⁹ de Graaf G *et al.*, Estimation of the number of people with Down syndrome in Europe, *European Journal of Human Genetics* published online 31 October 2020, doi: [10.1038/s41431-020-00748-y](https://doi.org/10.1038/s41431-020-00748-y).

¹⁰ de Graaf G *et al.*, Factsheet: People living with Down syndrome in Europe: BIRTHS AND POPULATION, 11 November 2020, accessed at: <https://go.downsyndromepopulation.org/europe-factsheet>.

¹¹ O'Connor C, Moore R, McParland P, Hughes H, Cathcart B, Higgins S, Mahony R, Carroll S, Walsh J, McAuliffe F: The Natural History of Trisomy 21: Outcome Data from a Large Tertiary Referral Centre. *Fetal Diagn Ther* 2021. doi: 10.1159/000517729

¹² Natoli JL *et al.*, Prenatal diagnosis of Down syndrome: a systematic review of termination rates (1995–2011), *Prenatal Diagnosis* 32, 142–153, 2012; doi: 10.1002/pd.2910.

¹³ de Graaf G *et al.*, Estimates of the live births, natural losses, and elective terminations with Down syndrome in the United States, *American Journal of Medical Genetics Part A* 167A, 756–776, 2015, doi: 10.1002/ajmg.a.37001.

¹⁴ Skotko BG, With new prenatal testing, will babies with Down syndrome slowly disappear? *Arch Dis Child* 94, 823–826, 2009; doi: 10.1136/adc.2009.166017.

¹⁵ Julian Quinones and Arijeta Lajka, “What kind of society do you want to live in?": Inside the country where Down syndrome is disappearing, CBS News August 14, 2017, accessed at: <https://www.cbsnews.com/news/down-syndrome-iceland/>.

¹⁶ Lou S *et al.*, National screening guidelines and developments in prenatal diagnoses and live births of Down syndrome in 1973–2016 in Denmark, *Acta Obstet Gynecol Scand* 97, 195–203, 2018; doi: 10.1111/aogs.13273.

¹⁷ Sarah Zhang “The Last Children of Down Syndrome. Prenatal testing is changing who gets born and who doesn't. This is just the beginning.” *The Atlantic* December 2020; accessed at: <https://www.theatlantic.com/magazine/archive/2020/12/the-last-children-of-down-syndrome/616928/>

¹⁸ Huete-García A, Otaola-Barranquero M. Demographic Assessment of Down Syndrome: A Systematic Review. *Int J Environ Res Public Health*. 2021;18(1):352. Published 2021 Jan 5. doi:10.3390/ijerph18010352

Standard prenatal screening for Down syndrome is often performed during the first and second trimester to calculate the risk of having a baby with trisomy 21. Maternal age, serum analyte screening for biochemical markers (such as the triple screen or quad screen), and fetal nuchal translucency (NT) measurement are considered first-line screening.¹⁹ However, these standard screening tests do not accurately predict the risk of Down syndrome. There is a high false-positive rate of incorrect reporting (where a negative result is reported as positive) ranging from 1-14% and incredibly low positive predictor values (PPV, the proportion of positive test results that are true positives) of 4.2%.²⁰

Traditional screening for trisomy 21 may be combined with other DNA screening and diagnostic testing, usually between 10-18 weeks gestation, to increase the chance of correctly predicting a Down syndrome risk. Diagnostic DNA tests can be performed using fetal samples obtained via amniocentesis and chorionic villus sampling. These tests are accurate, but the means to obtain fetal samples for DNA testing from the amniotic sac and placenta are invasive and carry their own risks for pregnancy loss.²¹

A new, advanced method of non-invasive prenatal screening (NIPS; also known as NIPT) is on the market, reducing the need for invasive techniques. NIPS uses cell-free fetal DNA (also known as cffDNA) found in the maternal circulation to screen for chromosomal aneuploidy such as trisomy 21. Scientists can detect cell-free fetal DNA from a mother's blood sample as early as 4 weeks and 5 days after fertilization.²² Cell-free fetal DNA is consistently detected from seven weeks²³, remains level between 10 and 21 weeks,²⁴ steadily increases after 24 weeks, peaks at birth, and then declines postpartum.²⁵ NIPS is the predominant method used in both low- and high-risk patients and is endorsed by all major medical organizations to be used as the "primary test in all women."²⁶

Once the cell-free DNA sample is collected, NIPS uses advanced molecular techniques to determine a child's genetic susceptibility to Down syndrome.²⁷ Various platforms analyze cell-

¹⁹ Rink, B.D. and M.E. Norton, *Screening for fetal aneuploidy. Semin Perinatol*, 2016. 40(1): p. 35-43.

²⁰ Bianchi, D.W. et al., DNA sequencing versus standard prenatal aneuploidy screening. *N Engl J Med* 370:9, 2014.

²¹ Rink, B.D. and M.E. Norton, *Screening for fetal aneuploidy. Semin Perinatol* 40(1): p. 35-43, 2016.

²² G. S. Dawe et al., Cell migration from baby to mother. *Cell Adhesion & Migration* 1:19-27, 2007.

²³ *Ibid.*

²⁴ Wapner, R.J and Dugoff, L. *Prenatal diagnosis of congenital disorders*, in Creasy and Resnik's *Maternal-Fetal Medicine: Principles and Practice 8th Edition*, R., Resnik, Lockwood, C.J., Moore, T.R., Greene, M.F., Copel, J.A., and Silver, R.M., Editor. 2019, Elsevier: Philadelphia, PA. p. 506.

²⁵ H. Ariga et al., Kinetics of fetal cellular and cell-free DNA in the maternal circulation during and after pregnancy: implications for noninvasive prenatal diagnosis. *Transfusion* 41:1524-30, 2001.

²⁶ Wapner, R.J and Dugoff, L. *Prenatal diagnosis of congenital disorders*, in Creasy and Resnik's *Maternal-Fetal Medicine: Principles and Practice 8th Edition*, R., Resnik, Lockwood, C.J., Moore, T.R., Greene, M.F., Copel, J.A., and Silver, R.M., Editor. 2019, Elsevier: Philadelphia, PA. p. 510.

²⁷ ACOG Committee on Genetics, Committee Opinion No. 640: Cell-Free DNA Screening For Fetal Aneuploidy. *Obstet Gynecol.* 126(3): p. e31-7, 2015.

free fetal DNA fragments across the whole (or part) of the genome using next generation sequencing (NGS), targeted sequence analysis, and array-based techniques. NGS platforms that screen fragments from the entire genome can be reliable, specific, and sensitive with a reported failure rate of 0.1% (inconclusive result) and false-positive rate of <0.1%.²⁸

NIPS may be less invasive compared to amniocentesis and CVS, but it is far less accurate and is not diagnostic, because the cell-free fetal DNA that is collected is fragmented. Therefore, NIPS can only report whether the patient's results *are consistent with* an increased risk for trisomy 21 that causes Down syndrome. Even with the most comprehensive molecular platform (i.e., NGS, array technology), NIPS will never be a diagnostic test that can definitively report a person's known risk of having Down syndrome.

With any clinical laboratory test, especially NIPS, there are inherent limitations. No test or screen will always perform the way it should 100% of the time. From my own experience directing a genetic testing lab for almost 10 years—the DNA test is never 100% accurate every time. Underlying conditions can limit NIPS performance and interfere with test results including placental mosaicism, maternal chromosomal abnormality, vanishing twin, organ transplant, etc. Incorrect reporting due to erroneous results, technical problems, and lab errors (i.e., false positives, false negatives, mixed specimens, mislabeling, etc.) is also a possibility.

Past pregnancies may also interfere with the NIPS result. Some studies have shown that cell-free fetal DNA is rapidly cleared from the maternal blood, with 100% clearance within 1-2 days postpartum^{29,30}, suggesting that fetal DNA from past pregnancies should not interfere with current tests. However, other studies have found the persistence of fetal DNA for decades in the mother.^{31,32}

NIPS limitations will affect correct result reporting and interpretation. One widely utilized NIPT screening test on the market has a positive predictive value (PPV) of 81%, meaning that there is a significant chance that a positive test result is NOT a true positive.³³ But even this reported PPV value is deceiving, because PPV is based on test sensitivity, specificity, *and* the prevalence of the condition in the population being tested. Because the prevalence of Down syndrome increases

²⁸ Illumina Verifi Prenatal Test: <https://www.illumina.com/clinical/reproductive-genetic-health/nipt/sendout-testing-for-labs.html>.

²⁹ A. Kolialexi *et al.*, Rapid Clearance of Fetal Cells from Maternal Circulation After Delivery. *Ann N Y Acad Sci* 1022, 113-8, 2004.

³⁰ Y. M. D. Lo *et al.*, Rapid Clearance of Fetal DNA from Maternal Plasma. *Am. J. Hum. Genet.* 64:218–224, 1999.

³¹ D. W. Bianchi *et al.*, Male progenitor cells persist in maternal blood for as long as 27 years postpartum. *Proc Natl Acad Sci USA.* 93:705-708, 1996.

³² Invernizzi P. *et al.*, Presence of fetal DNA in maternal plasma decades after pregnancy. *Human Genetics*, 110(6): 587-591, 2002.

³³ Norton ME *et al.*, Cell-free DNA Analysis for Noninvasive Examination of Trisomy, *New England Journal of Medicine* 372, 1589, 2015; doi: 10.1056/NEJMoa1407349.

with maternal age, PPVs will be higher in patients of advanced maternal age (>35 years old) and will likely increase when other aneuploidy risk factors are known (e.g., ultrasound abnormalities).³⁴

A comprehensive study across 21 different centers in the United States, which included 1,914 women (mean age, 29.6 years), observed much lower positive predictive values of 45.5% for trisomy 21. This indicates that a significant proportion (over 50%) of “positive” test results for Down syndrome may not be truly positive when screening women mostly at low risk.³⁵ For this reason, the authors from this study highlight the “need for follow-up diagnostic testing to confirm true positive results before decisions are made about irrevocable clinical intervention.”³⁶ They know that a woman might tragically abort her child based on an erroneous and incorrect NIPS lab result.

There are significant medical advancements that use prenatal screens and tests to heal and not harm the developing baby. The perinatal revolution has made it possible to perform interventions on the preborn before birth while still in the womb, through neonatal and fetal surgeries, potential pharmaceutical treatments as well as cell-based and genetic therapies.³⁷ There is even evidence that babies with Down syndrome may one day benefit in the future from research of a prenatal treatment with neuroprotective peptides or fluoxetine that can prevent learning deficits, correct intellectual disability, and even improve cognitive performance in a Down syndrome mouse model.³⁸

We need to consider these young individuals as equally valued human lives. Eliminating young lives is not the answer to eliminating disease and disability once a risk of the disorder is identified.³⁹ Destroying the patient is not curative medicine. Such acts become a modern-day form of eugenics.

AB 595 would provide necessary, distinct protections for developing human beings at risk for Down syndrome, preventing discrimination based on genetics or disability. Thank you for the opportunity to contribute to the discussion on this important issue.

³⁴ National Society of Genetic Counselors, NIPT/Cell free DNA screening predictive value calculator. Available at: <https://www.perinatalquality.org/Vendors/NSGC/NIPT/>.

³⁵ Bianchi, D.W. et al., DNA sequencing versus standard prenatal aneuploidy screening. *N Engl J Med* 370:9, 2014.

³⁶ *Ibid.*

³⁷ Malloy C et al., The Perinatal Revolution, *Issues in Law and Medicine* 34, 15-41, 2019.

³⁸ Guidi, S., et al., *Prenatal pharmacotherapy rescues brain development in a Down's syndrome mouse model.* *Brain*, 2014. 137(Pt 2): p. 380-401; and Incerti, M., et al., *Prenatal treatment prevents learning deficit in Down syndrome model.* *PLoS One*, 2012. 7(11): p. e50724.

³⁹ Chuck Donovan, “Eliminating Down Syndrome Children Is Not Something to Be Proud Of,” *The Daily Signal*, Aug. 16, 2017, accessed at: https://www.dailysignal.com/print?post_id=351821.



WISCONSIN FAMILY ACTION
Marriage|Family|Life|Liberty

PO Box 7486 • Madison WI 53707-7486
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
info@wifamilyaction.org • www.wifamilyaction.org

**TESTIMONY ON ASSEMBLY BILL 595
ASSEMBLY COMMITTEE ON HEALTH
THURSDAY, OCTOBER 7, 2021
JULAIN K. APPLING, PRESIDENT**

Thank you, Chairman Sanfelippo and committee members, for holding this hearing on Assembly Bill 595. Wisconsin Family Action supports this bill with one reservation.

Assembly Bill 595 bans discrimination against specified ones of Wisconsin's most vulnerable citizens—her unborn children. That said, we would contend that every abortion is discriminating against unborn babies. Regardless of the reason for an abortion, the stark reality remains: a child's life has been intentionally taken. The characteristics of that child, such as sex, race, color, ancestry, national origin, or congenital disability are really not material when it comes to this life-taking procedure. The result is always the same: another life snuffed out.

So, in one sense we are tempted to take a neutral stand on this bill, but in another sense, we have always supported incremental proposals that will actually save unborn babies from abortion. We believe this bill does that with its prohibition on abortions for reasons of the race, color, national origin, ancestry, or sex of the baby or because the baby has been diagnosed with a congenital disease, defect, or disorder.

In part because we have not required enough information from abortion providers, we are not able to know for certain how many unborn babies are aborted in our state each year for one of these enumerated characteristics. Hopefully, we will soon see a time when more specific data are required from abortionists and abortion facilities. Nevertheless, we know that at least the potential is there for a woman deciding on an abortion solely for one of these reasons. We do know that a significant number of babies *in utero* who have been diagnosed with Down Syndrome are aborted. Statistics range widely on this—from 67% to 90%—and, again, lack of reported data hampers specificity here, but we know enough to know these children are being aborted at disproportionately high rates.

And that brings us to our reservation, and the reason we can not unequivocally support AB 595. The bill explicitly exempts a child who has been diagnosed with, in the words of the bill, “a life-limiting fetal anomaly, which is a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth and does not include any condition that can be treated.” That is an exception we cannot accept.

We know personally at least two couples who were told their unborn child had a “life-limiting fetal anomaly,” and doctors recommended abortion. Both couples refused. And today, one of those children is about 10 years old and the other 7. Do they have disabilities, and are they profound? Undoubtedly, but both of these precious children have exceeded every expectation any doctor had for their future and/or their abilities. Why make an exception for these children? They are no less valuable than those that have the other enumerated characteristics in this bill. Let the child be born. He or she may succumb to the anomaly, but then again, maybe not. God may have a completely different plan for these precious children. That plan should not be cut short by abortion. We urge the others to amend the bill to remove this exemption. Should that happen, we will give 100% support to the proposed legislation.

Thank you for your thoughtful and careful attention to our position on this bill.



Gracie Skogman, Legislative Director, Wisconsin Right to Life
Assembly Committee on Health
AB 595, sex-selective, disability-selective, and other selective abortions and providing a penalty
Thursday, October 7, 2021

Discrimination against anyone should not be allowed, including unborn children in the womb. Whether that discrimination is based on sex, race or a disability diagnosis, it should not be allowed to be a deciding factor in the death of the unborn child's life to an abortion.

Abortion can be used as a method of preventing the birth of a child of an unwanted race, color, national origin, ancestry, sex, or the birth of a child who was diagnosed with a disability. Physicians can recommend, perform, induce, or attempt to perform or induce an abortion on a woman solely based on the qualities of the unborn child. This discriminatory behavior should not be acceptable.

Although more common in Asian countries, the practice of sex-selection abortion is increasing in the United States. Baby girls are deemed less valuable than baby boys, resulting in their termination.

Upon receiving a potential disability diagnosis of her unborn child, mothers are sometimes encouraged to abort the baby. Physicians use quality of life, caretaking, and medical expenses as reasons to terminate. As a society, we strive to recognize that individuals with special needs are no less valuable than any other human life. Additionally, prenatal diagnoses are not always accurate.

67 – 85% of unborn children diagnosed with Down Syndrome are terminated in the United States. This practice has decreased the Down Syndrome population by as much as 30%. As technology has advanced, other countries have begun to abort 100% of unborn babies diagnosed with Down Syndrome.

We live in a world where anti-discrimination laws affect our work environments, our school environments, our housing environments and now we must extend this to those unborn children in the womb.

Wisconsin Right to Life thanks Representative Dittrich and Senator Testin for bringing AB 595 forward.

To the attention of the State of Wisconsin Legislature (2021-2022)

This is the testimony of Charles Nevsimal in support of 2021 Assembly Bill 594 and 2021 Assembly Bill 595.

Date: Oct 7, 2021

The doctor told her the baby she was carrying in her womb had Down syndrome. He looked at her chart, then spoke again: "I see you have *No Termination* written here in your chart. Now would be the time to change that decision." Before she was given time to fully process what was happening, the information coming at her so quickly, the doctor spoke again, letting her know she could have it "taken care of right now." By "it," he meant her baby. And by "taken care of," he meant have an abortion.

Thankfully, this woman did not have it "taken care of" that day. Hard as it was for her to reconcile the situation she was in—married, mother of five boys, one of whom stricken with severe cerebral palsy—she knew she wouldn't be able to appropriately care for another child with special needs, not in the way the child deserved. Still, she opted for life. These events transpired in 2008, the year my wife and I became parents. That woman is our daughter's birth mother, and the child she refused to abort is our daughter.

Indeed, our daughter was born with the gift of Down syndrome—which is how we describe it, as a *gift*. Her name is Gianna Mia Rose, and she turned 13 this past September. She has a smile that lights up the room and eyes like little pools of galaxy. She loves zebras and dogs and unicorns and Disney princesses. She loves to sing, and has dreams of becoming a YouTube star one day. But she also wants to be a hairstylist—and practices cutting hair on her many Barbie dolls (despite us telling her over and over again that her Barbies' hair won't grow back). She loves Starbucks smoothies (has to be strawberry, though ... and her cup better have a sleeve on it!) She loves swimming and bowling and riding horses and baseball and Friday movie night and praying the rosary, and she insists upon knowing the dinner plans of everyone she encounters throughout her day. She's an exceptional reader, and she writes with *fairly* decent penmanship. She enjoys learning new things in school. Right now, she's thrilled to be learning about the human heart, given that she had open-heart surgery when she was only five months old. Her teachers are helping her put together a presentation. I know because I got a notification at work today that my daughter had shared her Google doc with me. She won a gold medal in the 200 meter race at the state Special Olympics in 2019. She loves to chitchat (as she calls it), telling jokes and being silly, especially with her little brother, who she makes laugh hysterically. I could go on and on (and on, trust me), but I won't. I merely wanted to share a glimpse of a life—a life that might otherwise never have existed, had her birth mother taken the advice of her ultrasound specialist. Our daughter brings joy to so many lives. And it's not always easy—sometimes, it's hard as hell. But that's what makes it so special. That's how you know it's something worth fighting for. Something worth defending.

Oh, and one more thing: Gianna always makes a point of knowing who's birthday it is, so she can celebrate their big day by sending them a video of her singing *Happy Birthday* and wishing them the best day ever. The utter serendipity at play here is prophetic! Our daughter, whose very life was threatened by the possibility of abortion—who could very well have been denied a birthday of her own—has become innately driven to celebrate the birthdays of others. To celebrate their *birth*. Because she knows life is a gift. And birthdays are emblematic of every breath of treasured air you've ever taken into your lungs.

Our daughter has taught me more about joy and love of life than I could ever deign to teach her. I encourage you to pass these bills, because no child deserves to be discriminated against—especially while still in the womb. Every unborn child deserves the opportunity to live and teach the world the same joy and love and laughter our daughter has shared with us. Just as every pregnant woman deserves to understand the full potential of joy and love and laughter they bear within their womb.



WISCONSIN CATHOLIC CONFERENCE

TO: Members, Assembly Committee on Health

FROM: Barbara Sella, Associate Director for Respect Life and Social Concerns

DATE: October 7, 2021

RE: AB 595, Selective Abortions

The Wisconsin Catholic Conference (WCC), the public policy voice of the Catholic bishops of Wisconsin, urges you to support Assembly Bill 595, which prohibits abortions solely because of race, color, national origin, ancestry, sex, or disability.

As has been widely reported, unborn children with certain congenital conditions are aborted at very high rates. In 2012, researchers estimated that between 1995 and 2011 over 67 percent of unborn children diagnosed with Down syndrome in the U.S. were aborted.¹ Similar high abortion rates have been found for those diagnosed with anencephaly and spina bifida.²

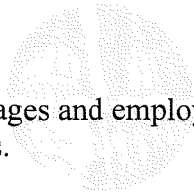
High rates of abortion have also been recorded in other parts of the world for children deemed to be of the unwanted sex, usually females. In 2012, the Guttmacher Policy Review issued a paper on sex-selective abortions, which recognized the widespread use of such abortions in Asian countries.³ The paper concluded that the real way to stop sex-selection abortions is not to prohibit such abortions, but to address the underlying conditions that can lead to them, namely an end to poverty and violence, and an increase in access to health care and education for women.

We agree that there is much work to be done on these underlying issues. The Catholic Church runs charities, hospitals, schools, and prison ministries precisely to assist the most vulnerable. Here in Wisconsin, the bishops have long supported efforts to expand educational opportunities,

¹ Jaime Natoli, et al., "Prenatal diagnosis of Down syndrome: a systematic review of termination rates (1995–2011)" *Prenatal Diagnosis*, Vol. 32, Issue 32 (March 14, 2012), <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/pd.2910>.

² Candice Johnson, et al., "Pregnancy termination following prenatal diagnosis of anencephaly or spina bifida: a systematic review of the literature" *Birth Defects Research, Part A*, Vol. 94, Issue 11 (October 25, 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4589245/>.

³ Sneha Barot "A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans" *Guttmacher Policy Review*, Vol.15, Issue 2 (May 16, 2012), <https://www.guttmacher.org/gpr/2012/05/problem-and-solution-mismatch-son-preference-and-sex-selective-abortion-bans>.



increase access to health care, improve wages and employment, increase housing, reform criminal justice, and welcome immigrants.

But serving the needs of the poor and the vulnerable – as vital as it is – is not enough to halt the spread of selective abortions or abortion in general. For that to happen, a cultural shift must take place and the law can play an important part in that shift. The law signals what is and is not acceptable behavior. Choosing to abort, and facilitating an abortion, based on some perceived “defect” is simply wrong.

True freedom is not absolute choice – a choice without limits. True freedom involves living in such a way that one does not deny freedom to others. AB 595 forces us to confront once again the question of what truly furthers respect for women: absolute freedom that would deny the right to life to a girl because she is not a boy, or an affirmation that her life is worthy of respect both inside and outside the womb; absolute freedom to eliminate humans seen as “defective” or support for children and adults with special needs.

Even as we urge you to support AB 595, we also urge you to do more to help children and adults with disabilities. At every level, we need more funding to ensure that these individuals can reach their full potential and that their burdens and those of their families are shared by the community.

At no other time in human history have we made so many social, medical, and technological strides to assist those with medical conditions. It is time we make the moral stride to protect all unborn lives.

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRBa0841/1dn
TJD:emw

October 5, 2021

Representative Wichgers:

2021 Assembly Bill 595 prohibits abortions that are performed solely because the unborn child has a diagnosis of a congenital disability among other abortions. Assembly Bill 595 defines “congenital disability” but excludes from the definition any life-limiting fetal anomaly. Under Assembly Bill 595, an abortion may not be performed solely because of a congenital disability, unless that congenital disability is a life-limiting fetal anomaly.

This amendment (LRBa0841) eliminates the exception for life-limiting fetal anomalies. The effect of this amendment is that a person may not perform an abortion solely because the unborn child has a congenital disability regardless of whether or not the congenital disability is incompatible with sustaining life after birth.

Tamara J. Dodge
Senior Legislative Attorney
(608) 504-5808
tamara.dodge@legis.wisconsin.gov



State of Wisconsin
2021 - 2022 LEGISLATURE

LRBa0841/1
TJD:emw

**ASSEMBLY AMENDMENT ,
TO ASSEMBLY BILL 595**

- 1 At the locations indicated, amend the bill as follows:
- 2 **1.** Page 2, line 9: delete “except a life-limiting fetal anomaly.”
- 3 **2.** Page 3, line 11: delete lines 11 to 14.
- 4 (END)

To: Assembly Committee on Health
From: American College of Obstetricians and Gynecologists –
Wisconsin Section
Date: October 7, 2021
Re: Legislation to Restrict Access to Women's Health Care



The Wisconsin Section of American College of Obstetrician Gynecologists (ACOG), an organization focused on providing quality, compassionate and often life-saving health care to women, strongly denounces the rhetoric that is being used to promote the bills before you today. Assembly Bills 6, 262, 493, 528, 593, 594 and 595 spread false, dangerous information and undermine the public's trust in OB/gyns. These bills insert legislative interference in the patient-physician relationship and decrease access to preventative health care and constitutionally protected women's health care, namely abortion care.

Assembly Bill 6 comprises inflammatory language that intentionally mischaracterize the provision of health care. This bill is irresponsible and dangerous. In the rare case that a woman undergoes an abortion via induction of labor during the periviable period and a baby is born alive, all decisions regarding possible resuscitation are made between herself and a multidisciplinary team of doctors who use compassion, ethics, and evidence-based expertise to help navigate what are often difficult decisions. These decisions are complex, nuanced, often heart wrenching and are quite simply not conducive to a one-size-fits-all law that all but ignores not only the scientific facts at hand, but also the individual circumstances that a woman and her family are faced with. We oppose this bill in the strongest terms.

The reporting of certain vital statistics information is generally important and useful to furthering legitimate public health interests. However, **Assembly Bill 262** is motivated by animus to abortion and exploits reporting that exists for public health purposes to shame women and intimidate health care providers. Alarming, this bill attempts to create and maintain a public list of medical practices that provide abortion care. Such a public registry would be an invitation for intimidation, threats, and even violence against women's health care providers and their patients. There is real fear that providers could be targeted using this information. In this way, abortion is distinct from other types of health care procedures and vital health statistics about which the state collects information. Stigma, harassment, and violence discourage abortion access and provision and harm patients. Acts of harassment include picketing, picketing with physical contact or blocking, vandalism, picketing of homes of staff members, bomb threats, harassing phone calls, noise disturbances, taking photos or videos of patients and staff, tampering with garbage, placing glue in locks or nails on the driveway of clinics, breaking windows, interfering with phone lines, approaching cars, and recording license plates.

Instead of increasing health care access for patients who already suffer disproportionately poor health outcomes – including high rates of breast and cervical cancer, sexually transmitted infection, premature birth, infant mortality, and maternal mortality – **Assembly Bills 493 and 528** further restrict access to basic health care for women in our state. As is well known, there is already a shortage of primary care physicians in Wisconsin and many providers limit the number of uninsured, underinsured, and Medicaid patients they serve. At a time when we should be focused on improving the health of ALL Wisconsinites, it is unconscionable to cut off access to preventive care for women at highest risk. The best way to reduce costly public health problems is to provide preventative healthcare, health education, prenatal and postpartum care, and reliable contraception, not further restrict access to basic health care for women.

Assembly Bill 593 would mandate that physicians provide information to patients which is not based on rigorous scientific evidence. If this bill becomes law physicians would be required to misled patients into believing that evidence-based treatment is available to “reverse” the effects of mifepristone. So-called “abortion reversal” regimens have not been adequately studied or evaluated for the safety of the mother or the fetus, and do not meet clinical standards of care. Legislative mandates based on unproven, unethical research are dangerous to women’s health. Politicians should never mandate treatments or require that physicians tell patients inaccurate information. Requiring doctors to offer a medical therapy that lacks the requisite evidence base is unethical at best and harmful at worst. We cannot allow political interference to compromise the care and safety of our patients.

Assembly Bill 594 would require physicians to give legislatively mandated information regarding a fetal condition to a patient. It is the ethical responsibility of a physician, and indeed we take an oath, to provide patients with medically correct information to help them make their own informed choices regarding their diagnosis and based on their individual prognosis. It is not the place of politicians to interfere into the patient-physician relationship. Physicians have open, honest, and confidential discussions with their patients about the diagnosis, prognosis, and appropriate treatment options a patient may be faced with. Politicians should be looking to scientific data and the knowledge and experience of our excellent and compassionate physicians to be providing evidence-based, safe, and quality care to our patients.

We are additionally opposed to **Assembly Bill 595** which represents gross interference in the patient-physician relationship. People seek abortion for many different reasons, which can be complex, and reflect a variety of considerations including her health, her family, and her future. Ob-gyns will tell you that some of the most difficult decisions are made by women whose pregnancies are affected by genetic disorders, and they are not taken lightly. This proposed bill stigmatizes women who seek abortion care by

questioning the motivation behind their decisions; invites discriminatory profiling by doctors against our own patients; and discourages honest, confidential conversations between patients and their doctors. When health care providers must question their patients’ motivations for obtaining an abortion, some patients may feel forced to withhold information or lie to their provider—or they may be dissuaded from seeking care from a provider altogether. Such legislation not only restricts a woman’s constitutional right to access safe abortion, but it jeopardizes her ability to access accurate medical information and safe, timely and compassionate health care.

In closing, as the largest organization of women's health care providers, ACOG proudly stands behind our members who provide comprehensive health care for women, delivered with quality, safety, integrity, and compassion. The bills before us today create a dangerous and hostile environment for physicians and patients, and ultimately prevent doctors from providing a patient with the best possible health care.