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Proponent, HB 2598

House Federal State Affairs Committee
Dear Chairman Brunk and committee,

Feb. 8, 2012

Good afternoon,
I am Jeanne Gawdun, senior lobbyist for Kansans for Life, here today to support **HB 2598, the Pro-Life Protections Act.**

In 1989, the U. S. Supreme Court's Webster ruling examined the Missouri legislative findings of the preamble to an abortion bill. The pertinent section says:

- The life of each human being begins at conception;
- Unborn children have protectable interests in life, health, and well-being and
- the natural parents of unborn children have protectable interests in the life, health, and well-being of their unborn child.

The Court said the Missouri preamble offers "protections to unborn children in tort and probate law, which is permissible under Roe v. Wade...[and] This Court has emphasized that Roe implies no limitation on a State's authority to make a value judgment favoring childbirth over abortion...[including] withholding public funds for nontherapeutic abortions but allowing payments for medical services related to childbirth." *(See attachment A)*

Thus, HB 2598, the Pro-Life Protections Act, falls within the Court's outline of legislation which Kansas may confidently advance and can be conceptually grouped under three headings:

I. those consonant with the state interest in promoting childbirth,
II. those securing the life, health & well-being of unborn children and
III. those advancing accurate medical information for parents, and parents-to-be.

I.

Generally, society gets more of whatever it funds. While we believe it is a tragedy that the Courts legalized abortion nationwide, they have nowhere prohibited the state from choosing not to fund it. In fact, the Webster ruling upheld the state's right not to be in the 'abortion' business.

A strong majority of Americans oppose taxpayer funding of abortions in polling data covering the last few decades and there is a substantial body of peer-reviewed research that shows that public-funding restrictions reduce abortion rates. *(See attachm*

House Fed & State Affairs
Date: 2-9-12
Attachment 1

Under the state interest in **promoting childbirth,** the Pro-Life Protections Act prevents state funding of abortion, excluding those done to save the mother's life. (Medicaid–funded abortions are untouched.) HB 2598 also removes tax breaks for abortion-performing businesses.

HB 2598 prohibits state discrimination by any state agency towards individuals or healthcare entities that do not provide, pay for or refer for abortion. It is particularly appropriate for the state to set up a shield of protection when the federal health agency is pushing an aggressive healthcare agenda that has denied the traditional pride of place for religious freedoms.

II.

Roe does not bar the state from **securing "the protectable interests" of unborn children in tort and probate law.** Thus, the Pro-Life Protections Act corrects injustices in civil litigation for the unborn.

"Wrongful death" lawsuits on behalf of the unborn are currently actionable in Kansas only after viability. This does not match the criminal standard of the 2005 Alexa's law, which allows criminal prosecution for unborn victims of violence throughout the entire gestation. HB 2598 will extend the civil cause of action for **wrongful death throughout gestation.**

HB 2598 also would foster respect for babies with disabilities by **disallowing wrongful-life** lawsuits that claim life is a "wrong" for a baby with a disability – and that a less-than-perfect baby would have been better off being aborted. Similarly, this bill **disallows wrongful-birth** lawsuits that claim the birth of a child is a "wrong" committed against the parent if the baby has a disability and the parent claims that some screening test should have been done, or should have successfully discovered the baby's untreatable illness in the womb. In these wrongful-birth cases, the mother's claim is that she would have aborted the baby, thus being spared the "wrong" of giving birth to a less-than-perfect child. Such legal actions severely undermine society's respect for persons with disabilities, and promote eugenic abortions. *(See attachments C & D)*

Wrongful-life and wrongful-birth lawsuits prohibited by HB 2598 do not allege that someone caused the baby's condition, only that the health-care system did not discover before birth that a baby might have some untreatable condition. Some of the tests that might discover such a condition are, themselves, invasive, and run the risk of causing injury or death to the child in the womb. There are no studies showing the accuracy of such genetic tests available, and a study by the Centers for Disease Control suggests that this problem is likely to worsen as manufacturers market tests directly to consumers in national advertising campaigns. The pressure in our culture for "quality children" undermines ethical medical decisions with the threat of **uneven, coercive court rulings for not performing continuous "search and destroy missions."**

This is the same context for outlawing abortions done due to the unborn child's gender.

Permissive abortion laws and high-resolution ultrasounds make it easier than ever for parents to target and eliminate unwanted daughters (or sons) before birth. Generally sonograms are done at 20 weeks gestation. The male genitalia can sometimes be found earlier, but not before the 14th

week, although there is a new European blood test that can detect the male (Y) chromosome at 7 weeks.

This has been largely, but not solely, a culturally-linked trend. A 2008 analysis of 2000 United States Census data found clear evidence of sex-selective abortions in what the authors called "son-biased sex ratios," that is, a higher ratio of boys to girls than would occur in nature, among Chinese, Korean and Asian-Indian populations. This trend predates the census and is higher among U.S. citizens than immigrants. *(See attachments E, F & G)*

Nearly nine out of ten Americans *(2006 Zogby/USA Today poll)* oppose abortion for reasons of sex selection. Four other states already ban such abortions (PA 2008, IL 2010, OK 2010, AZ 2011) and a federal ban was filed in 2008 and again this year.

III.

The next provisions can be grouped as related to informed consent, again-- within the backdrop of the state's interest in promoting life. HB 2598 will help Kansas **protect the interests of parents to receive accurate medical information about human gestation and abortion risks as presented in state materials and inside the classroom.**

It is worth noting that there has never been even one study showing that abortion improves women's health. In fact, contrary to the Nuremberg protocol that safe human medical experiments be based on prior animal testing, there have never been any controlled animal studies examining the safety of abortion.

Abortion complications are sporadically reported and not routinely reported at physician and hospital visits. The official federal health bureaucracy does not even receive complete annual abortion occurrence and demographic statistics from all states, including the huge state of California. Thus, there is no scientific basis for abortion safety claims.

And since maternal mortality includes death by all causes (including homicide, car accidents, and other diseases occurring within 12 months of delivery), comparisons between abortion mortality and childbirth aren't productive. Women are thus lulled into a false sense of security that abortion is as normal as childbirth and even safer!

This is why the politically incorrect but biologically undeniable information how breast cancer risk is elevated by abortion and subsequent preterm birth(s), must be included in the informed consent (section 15 (a) 3). New Jersey surgeon, Dr. Angela Lanfranchi of the Breast Cancer Prevention Institute, will illuminate this topic. *(See attachments H, I)*

America's scary rise in pre-term birth and low and very-low birth rate babies is tied to this country's sanction of abortion through all nine months of pregnancy, in part due to the tools used in abortion that create microscopic tears and exacerbate infection. **Both sections on p.22 of the WRTK pamphlet under the title 'long-term medical risks' need strengthening.** *(See attachments J, K)*

Significant provisions commit to statute some of the fundamental developmental milestones. The development of the child in the womb through advanced ultrasound was created by the apolitical Endowment for Human Development foundation and is promoted by the National Geographic Society. Finally, this year, it is incorporated into the Woman's Right to Know materials and showcased online, making Kansas the best website in the nation for providing maximum information in the privacy of one's home, via computer. **This teaching tool should be a part of all school human sexuality classes, in direct opposition to materials tied to abortionists that flame sexual activity** as prohibited in section 9. *(see Attachment L)*

Not only should young adults learn about the unborn child's wondrous development in the womb, before any mother settles on abortion, **she will have a Doppler reading of the heartbeat** and, in most cases, will participate in the additional concrete confirmation of the living child. Dr. Melissa Colbern of Topeka will address how this provision confirms to standard of care informed consent.

The **posted sign inside abortion facilities**-- instituted in 2009 to alert abortion seekers of their legal rights-- has been clarified and expanded in the Pro-Life Protections Act. Disgruntled gastric bypass and plastic surgery patients are not hindered by any stigma when contemplating legal action against their physicians, but not so for aborted women. Were abortionists not cognizant that women and their families are generally too ashamed to sue for violations that prevented them from making free and fully informed decisions to abort, signs would not be needed.

Two provisions KFL recommends be added to this bill are:

- insure KDHE publishes the number of successful Doppler readings and how many women decided not to pursue abortion after hearing the heart beating; and
- delete the line in the WRTK materials that reads, "you are encouraged to seek information on abortion services"...once again, **the state is not required to advocate for abortion.** Abortion clinics advertise heavily already, with a hefty budget. To promote life, the state materials are designed to alert the mother to free support services (both from the state and private help centers) that do not have a budget for advertising.

In conclusion, Kansans for Life urges passage of the Pro-life Protections Act out of committee.

Pro-Life Protections Act: Foundation in U.S. Supreme Court rulings

In 1989, the **U. S. Supreme Court** reviewed Missouri abortion regulation *Webster v.Health Services* [492 U.S. 490]. The Court examined the bill's legislative findings in the preamble that say:

- The life of each human being begins at conception;
- Unborn children have protectable interests in life, health, and well-being and
- the natural parents of unborn children have protectable interests in the life, health, and well-being of their unborn child.

The Court reversed the appellate court ruling against the bill, saying the preamble does no more

> *"than **offer protections to unborn children in tort and probate law**, which is permissible under Roe v. Wade, [410 U.S. 113 at 161-162]. This Court has emphasized that Roe **implies no limitation on a State's authority to make a value judgment favoring childbirth over abortion**, Maher v. Roe, [432 U.S. 464, 474]; and the preamble can be read simply to express that sort of value judgment.*

Further on, the Court says,

> *"Missouri's decision to use public facilities and employees to **encourage childbirth over abortion** places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy...*
> *This Court has emphasized that **Roe implies no limitation on a State's authority to make a value judgment favoring childbirth over abortion,...** in Maher v. Roe, [432 U.S. 474]; Poelker v. Doe, [432 U.S. 519], and Harris v. McRae, [448 U.S. 297], this Court upheld governmental regulations **withholding public funds for nontherapeutic abortions but allowing payments for medical services related to childbirth**, recognizing that a government's decision to favor childbirth over abortion through the allocation of public funds does not violate Roe v. Wade."*

These pronouncements in Webster have not been overturned; rather they have been reinforced, for example:

> *"Regulations 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. ... a state **measure designed to persuade her to choose childbirth over abortion will be upheld** if reasonably related to that goal." Planned Parenthood v. Casey, [505 U.S. 833] (1992)*

Attachment A

20 of 24 Studies Agree: Public-Funding Restrictions Reduce Abortions

By Michael J. New July 16, 2009 12:00 P.M.
http://www.nationalreview.com/corner/184578/20-24-studies-agree-public-funding-restrictions-reduce-abortions/michael-j-new

The Guttmacher Institute recently released a literature review about the effects of restrictions on Medicaid funding for abortion. *[SEE HIGHLIGHTS BELOW]* Overall, the results indicate that there is a **very strong consensus among both public-health researchers and economists that public funding restrictions lower abortion rates.** The Guttmacher literature review contains citations to 20 academic studies documenting this. These studies analyze data from a range of sources including surveys and aggregate data from the federal, state, and local level. Conversely, Guttmacher identifies only about four studies which show that the effects of public-funding restrictions are inconclusive.

The evidence presented about the effectiveness of public funding restrictions is very persuasive. A 1999 study by Cook et al. analyzed North Carolina's provisions for public funding of abortions. North Carolina is unique because instead of funding abortions for low-income women through Medicaid, they did so through a separate state fund which periodically ran out of money. **When funds were unavailable, the authors found a consistent increase in the birth rate and a decrease in the abortion rate.** Furthermore, these trends were more pronounced among blacks. Another Guttmacher study found that the **abortion rate among Medicaid recipients was more than twice as high in those states that publicly funded** abortion through Medicaid.

Excerpt: June'09 Guttmacher (pro-abortion) report *(discussed above)*

- The Hyde Amendment bans the use of federal Medicaid funds for abortions except in cases of life endangerment, rape or incest. In addition, as of 2008, 32 states and the District of Columbia had prohibited the use of their state Medicaid funds for abortions except in the limited cases allowed under the Amendment.
- A literature search identified 38 studies of the impact of these laws on a range of outcomes.
- Approximately one-fourth of women who would have Medicaid-funded abortions instead give birth when this funding is unavailable.
- Medicaid restrictions lead to a reduction in the proportion of teenage pregnancies that end in abortion, but the long-term effect on the birthrate is less clear.
- Such restrictions appear to delay some women having abortions by 2–3 weeks and Medicaid-eligible women having first-trimester abortions by a few days on average; the net impact on second-trimester procedures is unclear.
- Studies have found little evidence that lack of Medicaid funding has resulted in illegal abortions, although one death was directly related to the restrictions and two were indirectly related.
- Studies of the impact of Medicaid restrictions on other outcomes—sexual behavior, prematurity, low birth weight, fatal injuries to children, late or no prenatal care, suicide and number of abortion providers—suffer from methodological limitations and are inconclusive, although there is some evidence of adverse effects on child health.

Attachment B

10 states statutorily prohibit wrongful birth suits:
Idaho Code section 5-334
Ind. Code Ann. Section 34-12-1-1
Mich. Comp. Laws. Ann. Section 600-2971
Minn. Stat. Ann. Section 145-424;
Mo. Ann. Stat. section 188.130;
N.D. Cent. Code section 32-03-43
Oklahoma Statutes 63-1-741.12
42 Pa. Cons. Stat. Ann. Section 8305(b)
S.D. Codified Laws section 21-55-1
Utah Code Ann.section 78-11-24.

Such statutes have been consistently upheld under both the State and Federal Constitutions.

Wrongful birth cases, sampler of actions

New Hampshire *Kingsbury v. Smith*, 122 N.H. 237, 442 A. 2d 1003 (1982) (parents of healthy child wrongfully born after negligent vasectomy recovered damages from defendant physician for hospital and medical expenses, cost of sterilization, pain and suffering, loss of mother's wages and father's consortium, but were denied costs for rearing);

Arkansas *Wilbur v. Kerr*, 275 Ark.239, 628 S.W. 2d 568 (1982) (parents of an unwanted, healthy child brought suit against physician who negligently and unsuccessfully performed vasectomy on father and were denied rearing costs on the basis of public policy);

Connecticut *Ochs v. Borrelli*, 187 Conn. 253,445 A. 2d 883 (1982) (parents of unplanned, healthy child, recovered costs of rearing offset by value of child's aid and comfort from physician who negligently performed a tubal ligation);

Pennsylvania *Speck v. Finegold*, 497 Pa. 77. 439 A. 2d 110 (1982) (parents of a genetically defective child brought action against physician who negligently performed vasectomy and abortion procedures and were awarded damages for expenses attributable to the birth and rearing of the child, mental distress and physical inconvenience attributable to the child's birth);

Virginia *Naccash v. Burger*, 223 Va. 406, 290 S.E. 2d 825 (1982) (parents of child born with Tay-Sach's disease brought wrongful birth action against physician who negligently failed to discover that fetus was affected with the disease, causing mother to forego abortion, and recovered damages for care and treatment of child, and emotional distress);

7th Circuit *Robak v. U.S.*, 658 F. 2d 8476 (7th Cir. 1981) (parents of rubella syndrome child brought wrongful birth action against physician who negligently failed to diagnose mother's rubella and inform her of possible damages to the fetus, and received damages for the costs of raising and supporting the child);

Kentucky *Maggard v. McKelvey*, 627 S.W. 2d 44 (Ky. App. 1981) (parents of unwanted, healthy child brought wrongful birth action against physician for negligent performance of vasectomy on father and were denied costs for rearing);

Washington, D.C. *Harke v. McKelway*, 526 F. Supp. 97 (D.D.C. 1981) (mother of unplanned child brought wrongful birth action against physician who negligently performed a laparoscopic cauterization and was denied recovery for the costs of raising healthy child);

Attachment C

Florida *Public Health Trust v. Brown*, 388 so. 2d 1084 (Fla. 1980) (mother of unplanned, healthy child brought wrongful birth action against physician who negligently performed tubal ligation and was denied rearing costs);

Illinois *Wilczynski v. Goodman*, 73 Ill. App. 3d 51, 391 N.E. 2d 479 (1979) (parents brought action against physician who negligently performed abortion and were precluded from recovering damages for costs incurred in raising and educating the child);

Minnesota *Sherlock v. Stillwater Clinic*, 260 N.W. 2d 169 (Minn. 1977) (parents of wrongfully born, healthy, child brought action against physician who negligently performed sterilization operation and were awarded damages for the prenatal and postnatal expenses, mother's pain and suffering during pregnancy and delivery, loss of consortium and reasonable cost of rearing the unplanned child subject to offset by the value of child's aid, comfort and society);

Ohio *Bowman v. Davis*, 356 N.E. 2d 496 (Ohio 1976) (parents of healthy child born as result of physician's negligent performance of tubal litigation recovered costs for rearing);

Wisconsin *Dumer v. St. Michael's Hospital*, 69 Wis. 2d 766, 233 N.W. 2d 372 (1975) (parents of child born with rubella syndrome brought wrongful birth action against physician for negligently failing to diagnose mother's condition and warn her of probable effects on fetus, and recovered damages limited to expenses which parents had reasonably and necessarily suffered and would suffer in the future due to the child's deformities);

New Jersey *Betancourt v. Gaylor*, 136 N.J. Super. 69, 344 A.2d 336 (1975) (parents of healthy child brought wrongful birth action against physician for negligence in performing a sterilization operation on mother and recovered damages for emotional upset, physical inconvenience and costs incurred in rearing the child offset by any benefits that they might receive as a result of the child's birth);

Texas *Jacobs v. Theimer*, 519 S.W. 2d 846 (Tex. 1975) (suit for recovery of expenses reasonably necessary for care and treatment of child who was born physically impaired because of mother's having contracted rubella is not barred by considerations of public policy);

New York *Ziemba v.Sternberg*, 45 A.D. 2d 230, 357 N.Y.S. 2d 265 (1974) (action in malpractice lies by parents against physician for his negligent failure to diagnose a pregnancy so that mother was prevented from aborting the child);

Michigan *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W. 2d 511 (1971) (benefits of an unwanted, healthy, child may be weighed against all elements of damage claimed by plaintiffs who had unplanned child as result of pharmacist's negligently supplying tranquilizer rather than birth control pill);

California *Custodio v. Bauer*, 251 Cal. App. 303, 59 Cal. Rptr. 463 (1967) (in action to recover damages for the birth of a normal, healthy child following failure of sterilization procedure, plaintiffs entitled to recover more than nominal damages);

West Virginia *Bishop v. Byrne*, 265 F. Supp. 460 (S.D.W.Va. 1967) (in an action brought by parents of child born as result of negligently performed sterilization, whether wife suffered mental or physical pain from pregnancy and subsequent Caesarean section presented disputed issues of fact which precluded grant of summary judgment).

The Disabling Impact of Wrongful Birth and Wrongful Life Actions

Wendy F. Hensel Assistant Professor, Georgia State University College of Law.
Harvard Civil Rights-Civil Liberties Law Review, Vol. 40, 2005 *(excerpts edited by KFL)*

... societal attitudes toward disability have been **challenged by prenatal genetic testing and the corresponding torts of wrongful birth and wrongful life.** For some time, tests have existed that, when used properly, could advise a pregnant woman of certain birth defects that her unborn child possessed or was likely to possess, like Down syndrome, anencephaly, or Tay-Sachs disease. With the completion of the Human Genome Project, scientific knowledge of genetic markers is exploding. Hundreds of tests now exist that give pregnant women the ability to detect human conditions ranging from the severely disabling to those that many people dismiss as insignificant afflictions.

Such scientific advancement has not come without a cost. As the number of tests has expanded, so too has the number of lawsuits alleging negligence against the medical profession. When genetic impairments are detected upon the birth of a child, some parents have chosen to sue under the **tort of wrongful birth**, claiming that they would have avoided conception or aborted their unborn child had the impairment been properly diagnosed. The **injury identified in these cases is the parents' lost choice** over whether or not to carry an impaired child to term. Alternatively or in addition to such claims, **wrongful life actions have been initiated in the impaired child's name.** Because the alleged negligence did not actually cause the child's impairment, but instead enabled the child to come into being, the **operable injury is the child's life itself, with non-existence identified as the preferred alternative**.

The controversy surrounding wrongful birth and wrongful life litigation has existed for many years and is well documented. The courts faced with these issues have overwhelmingly rejected wrongful life actions while at the same time approving those for wrongful birth. In part, this has occurred because courts have found it more palatable to identify lost parental choice as the injury than to answer the metaphysical question of whether non-existence is ever preferable to life, however burdened. In contrast, many tort scholars who have addressed this issue have concluded that both wrongful birth and wrongful life actions should be permitted to go forward. They reason that both torts correspond well, if not perfectly, with traditional negligence principles.

In the midst of this robust public debate, there is one point of view that has received less attention — that of individuals with disabilities. Although much has been written about the impact of genetic testing as a general matter, surprisingly little legal scholarship has focused on the impact that wrongful birth and wrongful life actions might have on the community of people with disabilities. Often, the consideration tort scholars give to this viewpoint is confined to a discussion about the benefits of providing needed compensation to disabled individuals and their caregivers. Particularly in the wrongful life context, scholars have argued that the theoretical difficulty in identifying "life" as an injury does not outweigh the practical reality of an injured party who needs assistance.

The problematic aspects of wrongful birth and wrongful life actions, however, far exceed the conceptual difficulties that attach to these torts. **Wrongful birth and wrongful life suits may exact a heavy price not only on the psychological well-being of individuals with disabilities, but also on the public image and acceptance of disability in society**. Rather than focusing on a defendant's conduct, as in a traditional tort action, both wrongful birth and

Attachment D

wrongful life suits ultimately focus on the plaintiff's disability, a status that is at least partially a societal construction. **Juries in such actions are required to evaluate whether a particular disability is so horrible, from the non-disabled perspective, as to make plausible the choice of abortion or contraception by the parent, or non-existence by the disabled child.**

Since only the child's diagnosis is ascertainable at this critical point in time, the centrality of impairment in defining personhood is reinforced and inescapable. Any benefits secured by individual litigants in court are thus taxed to the community of people with disabilities as a whole, placing at risk, in the drive for individual compensation, the gains secured by collective action and identity. ...just as in wrongful life actions, the implicit underlying injury in wrongful birth actions is the impaired child rather than the mother's lost reproductive choice. Even though the courts have treated the two torts differently, they are analytically similar and lead to equally problematic... consequences.

Tort law should not serve as a tool of injustice under the guise of benevolent intervention on behalf of individuals with disabilities. Because relief to individual litigants in wrongful birth and wrongful life actions is purchased at a cost to society as a whole, **neither action should be recognized by state legislatures or the courts....** Because wrongful birth and wrongful life actions **extend compensation only to those parents who would have chosen to abort an impaired child, these torts strengthen and reinforce the message that abortion is the preferred means of "curing" disability in society**. The potential impact of such messages is troubling. As one author explained, "[t]he belief that genetic conditions are 'defects' that can be avoided perpetuates a myth that leads to personal shame and family disgrace when such an event occurs." Against this background, abortion be comes both the preferred option and the morally correct choice upon a diagnosis of defect. ...No research has been conducted to test whether there are fewer incidents of negligence in prenatal genetic testing in those jurisdictions that recognize both wrongful birth and wrongful life actions.

... For example, one court may deem Down syndrome an insufficiently severe defect to render nonexistence preferable in a wrongful life action, while another may view the situation entirely differently. *[re: reliability of genetic testing]* Likewise, the laboratory which fails to test for rubella will be liable for significantly greater damages than one who fails to test for a hereditary hearing impairment... In fact, this is true for most genetic tests available on the market, and a recent study by the Centers for Disease Control suggests that this problem is likely to become even more widespread as manufacturers market tests directly to consumers in national advertising campaigns. ..

...wrongful birth and wrongful life actions inevitably reinforce the precarious position of individuals with disabilities in society, weakening family relationships and community bonds. **Once the non-disabled are given authority to judge from a "reasonable person" perspective whether or not the disabled life is worse than no life, the power of individuals with disabilities over their own identity and self-worth is seriously diminished.** When compensation is tied to maternal testimony that abortion or contraception was preferred to an existing child, the price of assistance is simply too high. The hard fought gains secured by the disability rights movement should not be placed at risk in the drive for individual compensation. Wrongful birth and wrongful life actions require courts to draw lines among different types of impairments, reinforcing the medical model of disability and creating deep divisions among individuals with disabilities. The objective of such litigation is not to highlight the potential richness of life with disabilities, but instead the severity of the functional impairment in order to maximize the damage award.

Ban Sex Selective Abortions in the U.S.

By Steven W. Mosher , Population Research Institute Weekly Briefing: 2011 (v13)

Nearly nine out of ten Americans (2006 Zogby/USA Today poll) **oppose abortion for reasons of sex selection,** but such acts of gender violence are neither illegal nor uncommon in our country. Permissive abortion laws and high-resolution ultrasounds make it easier than ever for parents to target and eliminate unwanted daughters (or sons) before birth.

Until the recent spate of negative publicity focused public attention on such crimes, it was not unusual to find abortionists advertising the availability of sex-selective abortions in newspapers such as the *New York Times*.

Anyone who has lived in and worked with the Asian-American community, as I have, is aware that the practice of selectively aborting female fetuses is disturbingly common. Women and their daughters are both victimized.

Sunita Puri, an Asian-Indian physician, interviewed **65 immigrant Indian women in the United States who had pursued fetal sex selection. Her study, published this year in *Social Science and Medicine*, found that a shocking 89% of the women carrying girls aborted during the study,** and that nearly half had previously aborted girls. These women told of how they had been mistreated by their families when they were found to be carrying girls; how their husbands or in-laws had shoved them around, kicked them in the abdomen, or denied them food, water, rest in an attempt to induce an abortion. Even the women who were carrying boys told of their guilt over past sex-selection abortion, and the feeling of being unable to "save" their daughters.

Many would deny that such things happen here, but the numbers do not lie. An analysis of 2000 Census data found clear **evidence of sex-selective abortions in what the authors called "son-biased sex ratios,"** that is, a higher ratio of boys to girls than would occur in nature.

The 2008 study, by Columbia University economists Douglas Almond and Lena Edlund, examined the sex ratio at birth among U.S.-born children of Chinese, Korean and Asian-Indian parents. They found that the first-born children of Asians showed **normal sex ratios at birth, roughly 106 girls for every 100 boys.** If the

Attachment E

first child was a son, the sex ratio of the second-born children was also normal.

But what happened **if the first child was a girl? In that case, they found, the sex ratio for second births was 117, meaning that the second child tended to be a boy. To put it another way, roughly 10 percent of girls had been eliminated.**

"This male bias is particularly evident for third children," they reported. "If there was no previous son, sons outnumbered daughters by 50%." Their raw numbers showed that, for every 151 boys, there were only 100 hundred surviving girls. The rest had been eliminated.

The authors quite rightly interpret this "deviation in favor of sons" the only way they possibly could, namely, as "evidence of sex selection, most likely at the prenatal stage." In other words, **as early as a decade ago, Asian-American communities in the U.S. were already practicing sex-selective abortion.**

Moreover, they went on to note, whether a mother gave birth to a boy could not be predicted by her immigration status. Indeed, mothers who were U.S. citizens were slightly more likely to have sons.

This means that sex selection is not a tradition from the old country that easily dies out, and further underlines the need to outlaw the process.

It is difficult to say how many sex-selection abortions take place in the U.S. each year. But consider that there are 3.9 million Chinese-Americans, 2.8 million Asian-Indians, and 1.6 million Korean-Americans living in the United States. The numbers of Asian-Indians, in particular, has doubled over the last two decades. The highly skewed sex ratios found by Almond and Edlund suggest that, among these groups alone, **tens of thousands of unborn girls have been eliminated for no other reason than they are considered by some to be the wrong sex.**

Those who argue against PreNDA* do so on the grounds that sex selective abortion is not really a problem here. They are wrong.

Even one death is too many.

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* On September 23rd, 2008, two congressmen, Trent Franks from Arizona and Jeff Fortenberry from Nebraska, introduced a bill to "prohibit discrimination against the unborn on the basis of sex or race" named the "Susan B. Anthony **PreNatal Non Discrimination Act** of 2008"

Keep sex of fetuses secret to prevent selective abortion of girls

By Michel Viatteau The National Post (Canada)Agence France-Presse **Jan 16, 2012**

MONTREAL • **An editorial in a major Canadian medical journal Monday urges doctors to conceal the gender of a fetus from all pregnant women until 30 weeks to prevent sex-selective abortion by Asian immigrants.**

A separate article in the same issue of the Canadian Medical Association Journal warns that **Canada has become "a haven for parents who would terminate female fetuses in favour of having sons" because of the country's advanced prenatal testing and easy access to abortion.**

"Female feticide happens in India and China by the millions, but it also happens in North America in numbers large enough to distort the male-to-female ratio in some ethnic groups," said the editorial by interim editor-in-chief Rajendra Kale.

While few studies have been done to assess how frequent the practice may be among immigrant communities in Canada, the editorial points to **research that suggests sex-selection is more common among immigrants from India, China, Korea, Vietnam and the Philippines** who already have at least one daughter.

It cites U.S. census data from 2000 that shows male-biased sex ratios among U.S.-born children of Asian parents, and a study of 65 Indian women in the United States from 2004-2009 that showed 89% of them terminated pregnancies with female fetuses.

Dr. Kale said in an interview he believes that several hundred sex-selective abortions take place in Canada each year.

"Should female feticide in Canada be ignored because it is a small problem localized to minority ethnic groups? No," said the editorial written by Dr. Kale, a Mumbai-born neurologist.

"The solution is to postpone the disclosure of medically irrelevant information to women until after about 30 weeks of pregnancy."

In 2004 Canada outlawed fertility practices that would increase the likelihood that an embryo will be a certain sex, or that would identify an in-vitro embryo by sex for any reason other than to diagnose a sex-linked disorder or disease.

Dr. Kale said the Canadian medical establishment needs to go further, and make express rulings that would ban fetal sex disclosure before seven months, when it is too late for an abortion.He added that doctors should nevertheless "avoid painting all Asians with the same broad brush and doing injustice to those who are against sex selection," but called for collective co-operation by women of all races.

"The execution of a 'disclose sex only after 30 weeks' policy would require the understanding and willingness of women of all ethnicities to make a temporary compromise," he wrote. **"Postponing the transmission of such information is a small price to pay to save thousands of girls in Canada."**

Attachment F

Will new gender-predicting blood test increase abortion rates?

By Andrea Whatcott, Deseret News Published: Thursday, Aug. 11 2011

Americans already seem to prefer boy babies over girls. **Could a new blood test that reveals a baby's gender at seven weeks — months before an ultrasound can — lead some parents to abort pregnancies in an effort to select their next child's gender?**

Scientists and ethicists are asking that and other questions today after news broke Tuesday that couples interested in learning the gender of their unborn baby won't have to wait until the **routine ultrasound at 20 weeks if a new blood test popular in Europe** makes its debut on American soil, according to Boston.com.

With the new blood test, parents with histories of genetic disorders, often tied to one gender over another, will be able to avoid undergoing invasive diagnostic procedures like amniocentesis. England has already seen a decline in women going in for such tests.

"It should only be used by families that are at risk for sex-linked diseases," Dr. Mary Rosser, an obstetrician and gynecologist at the Montefiore Medical Center in New York told Reuters, because the blood test can be misused. "What you have to consider is the ethics of this," Rosser said. "If parents are using it to determine gender and then terminate the pregnancy based on that, that could be a problem."

As countries like China experience extreme gender gaps due to the excessive use of sex-selective abortions, which are often performed to end pregnancies that would result in a female child, the ability to predict gender as early as seven weeks into a pregnancy raises concerns for scientist here in the United States. **Researchers worry the desire for a male child, even here in America, and the ability to learn gender so early will make sex-selective abortions more popular here in the U.S.**

"If couples get the results earlier, that makes abortion less burdensome," said Arthur Caplan, a bioethicist at the University of Pennsylvania, in the recent Boston.com article. "A woman can take the test, and then take pills to terminate the

pregnancy in the privacy of her home when it's that early on. I would say gender selection is a bad reason to have an abortion, which is tough for a pro-choicer like me to admit."

A study review published in the Journal of the American Medical Association found that a **simple blood test can check for the Y chromosome, which is present only in male cells, in the mother's blood as early as seven weeks into the pregnancy. And it can predict gender with a 95 percent accuracy rate.**

...

Some parents claim they need to know the gender earlier so they can start buying pink or blue onesies, but according to Susan Georgoussis, co-founder of a Toronto parenting center in an article from TheGlobeAndMail.com, this is not an issue at six weeks, as the risk for miscarriage in the first trimester is still 30 percent. Though it may put anxious parents at ease, or give them time to digest the news, Ann Douglas, a childbirth expert, said this test may give parents a false sense of control.

The author of the study review even suggested that couples who want to buy the blood test kit "should be questioned about how they plan to use the results," according to BioScienceTechnology.com.

As **these blood tests are not ready for "prime time,"** said Dr. Lee Shulman, a chief of clinical genetics at Northwestern Memorial Hospital in Chicago, according to BioScienceTechnology.com, the discussion over the ethical use of the tests will continue.

While some parents, according to the Philadelphia Magazine, will take an interest in knowing the baby's gender sooner because of family histories of genetic disorders tied to certain genders, the concern over increased sex-selective abortions because of simple gender preference remains in the forefront of researchers minds.

Shulman said, "I would have a lot of difficulties offering such a test just for gender identification. Gender is not an abnormality."

Abortion Has Caused 300K Breast Cancer Deaths Since Roe

by Steven Ertelt | Washington, DC | LifeNews.com | January 2011

A leading breast cancer researcher says **abortion has caused at least 300,000 cases of breast cancer causing a woman's death since the Supreme Court allowed virtually unlimited abortion in its 1973 case.**

With tens of millions of abortions since the high court's decision and research confirming abortion increases the risk of contracting breast cancer, undoubtedly a large number of breast cancer cases, caused by abortion, have occurred over the last 38 years.

Professor Joel Brind, an endocrinologist at Baruch College in New York, worked with several scientists on a 1996 paper published in the Journal of Epidemiol Community Health showing a "30% greater chance of developing breast cancer" for women who have induced abortions. He recently commented on how many women have become victims.

"If we take the overall risk of breast cancer among women to be about 10% (not counting abortion), and raise it by 30%, we get 13% lifetime risk," Brind explains. Using the 50 million abortions since Roe v. Wade figure, we get 1.5 million excess cases of breast cancer. At an average mortality of 20% since 1973, that would mean that legal abortion has resulted in some 300,000 additional deaths due to breast cancer since Roe v. Wade."

Brind said his estimate excludes deaths from the use of abortion to delay first full term pregnancies – a recognized breast cancer risk.

Karen Malec, the head of the Coalition on Abortion/Breast Cancer, a public awareness group, says the number of studies showing the abortion-breast cancer link continues to grow in the years since Brind's groundbreaking 1996 analysis of the major studies at that time.

"During the last 21 months, four epidemiological studies and one review reported an abortion-breast cancer link," she noted. "One study included National Cancer Institute branch chief Louise Brinton as co-author. We count nearly 50 published epidemiological studies since 1957 reporting a link. Biological and experimental studies also support it."

"Experts proved in medical journals that nearly all of the roughly 20 studies denying the link are seriously flawed (fraudulent). Like the tobacco-cancer cover-up, these are used to snow women into believing abortion is safe," Malec added.

Surgeons like Dr. Angela Lanfranchi, a Clinical Assistant Professor of Surgery at Robert Wood Johnson Medical School in New Jersey who has extensively explained how abortion increases the breast cancer risk, have seen first-hand how abortion hurts women.

In 2002, Angela Lanfranchi, MD testified under oath in a California lawsuit against Planned

Attachment H

Parenthood that she had private conversations with leading experts who agreed abortion raises breast cancer risk, but they refused to discuss it publicly, saying it was "too political."

As the co-director of the Sanofi-aventis Breast Care Program at the Steeplechase Cancer Center, Lanfranchi has treated countless women facing a breast cancer diagnosis. Lanfranchi was named a 2010 Castle Connolly NY Metro Area "Top Doc" in breast surgery.

In an article she wrote for the medical journal Linacre Quarterly, Lanfranchi talks about why abortion presents women problems and increases their breast cancer risk:

Induced abortion boosts breast cancer risk because it stops the normal physiological changes in the breast that occur during a full term pregnancy and that lower a mother's breast cancer risk. A woman who has a full term pregnancy at 20 has a 90% lower risk of breast cancer than a woman who waits until age 30.

Breast tissue after puberty and before a term pregnancy is immature and cancer-vulnerable. Seventy five percent of this tissue is Type 1 lobules where ductal cancers start and 25 percent is Type 2 lobules where lobular cancers start. Ductal cancers account for 85% of all breast cancers while lobular cancers account for 12-15% of breast cancers.

As soon as a woman conceives, the embryo secretes human chorionic gonadotrophin or hCG, the hormone we check for in pregnancy tests.

HCG causes the mother's ovaries to increase the levels of estrogen and progesterone in her body resulting in a doubling of the amount of breast tissue she has; in effect, she then has more Type 1 and 2 lobules where cancers start.

After mid pregnancy at 20 weeks, the fetus/placenta makes hPL, another hormone that starts maturing her breast tissue so that it can make milk. It is only after 32 weeks that she has made enough of the mature Type 4 lobules that are cancer resistant so that she lowers her risk of breast cancer.

Induced abortion before 32 weeks leaves the mother's breast with more vulnerable tissue for cancer to start. It is also why any premature birth before 32 weeks, not just induced abortion, increases or doubles breast cancer risk.

By the end of her pregnancy, 85% of her breast tissue is cancer resistant. Each pregnancy thereafter decreases her risk a further 10%.

A woman can use this information to make an informed decision about her pregnancy. If she chooses to abort her pregnancy for whatever reason, she should start breast screening about 8-10 years later so that if she does develop a cancer, it can be found early and treated early for a better outcomes.

National Cancer Institute Researcher Admits Abortion-Breast Cancer Link True

by Steven Ertelt | WASHINGTON, DC | LIFENEWS.COM | 1/1/09

Washington, DC (LifeNews.com) – The National Cancer Institute gained a reputation for putting politics over science when it did everything possible to deny dissenting opinion during a meeting to establish whether or not a link exists between abortion and breast cancer.

Now, **the main NCI activist who got the agency to deny the abortion-breast cancer link has co-authored a study admitting the abortion-breast cancer link is true**, calling it a "known risk factor."

Scientists and educators about the abortion-breast cancer link point to a new study that shows a top NCI official may be re-thinking the refusal to acknowledge the link.

The study, conducted by Jessica Dolle, appears in the April, 2009 issue of the prestigious cancer epidemiology journal Cancer Epidemiology, Biomarkers and Prevention.

The Dolle study, conducted with the prestigious Janet Daling group of the Fred Hutchinson Cancer Research Center in Seattle — one of the first to receive recognition for highlighting the abortion-breast cancer link — concerns the link between oral contraceptives and breast cancer.

The study examined women for triple-negative breast cancer, a subset of breast cancer cases with a particularly aggressive and treatment-resistant cancer type.

The data yielded a strong association between TNBC and oral contraceptives and found a 320% risk increase for breast cancer over those who never used contraception.

When it comes to the abortion link, the study did not produce any new results but it cited the Daling studies from 1994 and 1996 that showed between a 20 and 50 percent increased breast cancer risk for women having abortions compare to those who carried their pregnancies to term.

As Dr. Joel Brind, a prominent breast cancer researcher, says, "what was striking was the way in which the finding of a significant ABC link was characterized."

"Specifically, abortion appears in the data table which lists the associations found for 'known and suspected risk factors,'" he explains. "In the text, the effect of the significant risk factors, including induced abortion, were described as 'consistent with the effects observed in previous studies on younger women.'"

"Hence, this paper provides clear support for the existence of the abortion-breast cancer link," Brind said.

Attachment I

Brind says the kicker is that one of the coauthors of this new study is Louise A. Brinton of the NCI.

While the NCI maintains no abortion-breast cancer link exists, **Brinton is the co-author of a study that is cited in this new research.**

"Importantly, Brinton was the chief organizer for the 2003 NCI (U.S. National Cancer Institute) 'workshop' on 'early reproductive events and breast cancer,' **a panel which reported that the lack of an ABC link had been 'established,'**" Brind says.

"In other words, since 2003, the NCI has firmly maintained the position that there is no ABC link; that the studies which had reported such a link were deemed unreliable. However, two of these prior studies were the very studies by the Daling group (of which one Brinton also was a co-author)," he continues.

"Now, in 2009, Brinton is on record reiterating findings of the ABC link and reporting them as 'consistent' with earlier studies that found induced abortion to be a risk factor," Brind says. "Can it not therefore be argued that the NCI is backing off its denial of the ABC link? This is big news, to be sure, but no one has challenged the NCI with it, yet."

Karen Malec, president of the Coalition on Abortion/Breast Cancer, a women's group that educates about the abortion link, calls the admission a scandal.

"Less than two months since the U.S. Preventative Services Task Force issued new guidelines recommending against routine mammograms for women in their forties, a second breast cancer scandal involving a U.S. government panel of experts has come to light which has implications for healthcare reform," she told LifeNews.com.

"Although the study was published nine months ago, the **NCI, the American Cancer Society, Susan G. Komen for the Cure and other cancer fundraising businesses have made no efforts to reduce breast cancer rates by issuing nationwide warnings to women,**" she added.

She says Dolle's team reported in Table 1 a statistically significant 40% risk increase for women who have had abortions and listed it among "known and suspected risk factors."

"Obviously, more women will die of breast cancer if the NCI fails in its duty to warn about the risks of OCs and abortion and if government funds are used to pay for both as a part of any healthcare bill," Malec said.

Last year, studies from Turkey and China also reported statistically significant risk increases for women who had abortions.

BRIND ANALYSIS OF NEW STUDY here:
http://www.abortionbreastcancer.com/download/Brind_Dolle_2009_analysis.PDF

DOI: 10.1111/j.1471-0528.2009.02278.x
www.bjog.org

Systematic review

Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analyses

PS Shah,[a,b] J Zao[a] on behalf of Knowledge Synthesis Group of Determinants of preterm/LBW births*

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Accepted 19 May 2009.

Background History of induced termination of pregnancy (I-TOP) is suggested as a precursor for infant being born low birthweight (LBW), preterm (PT) or small for gestational age (SGA). Infection, mechanical trauma to the cervix leading to cervical incompetence and scarred tissue following curettage are suspected mechanisms.

Objective To systematically review the risk of an infant being born LBW/PT/SGA among women with history of I-TOP.

Search strategy Medline, Embase, CINAHL and bibliographies of identified articles were searched for English language studies.

Selection criteria Studies reporting birth outcomes to mothers with or without history of induced abortion were included.

Data collection and analyses Two reviewers independently collected data and assessed the quality of the studies for biases in sample selection, exposure assessment, confounder adjustment, analytical, outcome assessments and attrition. Meta-analyses were performed using random effect model and odds ratio (OR), weighted mean difference and 95% confidence interval (CI) were calculated.

Main results Thirty-seven studies of low–moderate risk of bias were included. A history of one I-TOP was associated with increased unadjusted odds of LBW (OR 1.35, 95% CI 1.20–1.52) and PT (OR 1.36, 95% CI 1.24–1.50), but not SGA (OR 0.87, 95% CI 0.69–1.09). A history of more than one I-TOP was associated with LBW (OR 1.72, 95% CI 1.45–2.04) and PT (OR 1.93, 95% CI 1.28–2.71). Meta-analyses of adjusted risk estimates confirmed these findings.

Conclusions A previous I-TOP is associated with a significantly increased risk of LBW and PT but not SGA. The risk increased as the number of I-TOP increased.

Keywords Birth outcomes, infant-low birthweight, infant-premature, therapeutic termination of pregnancy.

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Background

Low birthweight (LBW) and preterm (PT) births are public health issues with physical, emotional, psychological and financial impact.[1] The research to identify relative contribution of various factors leading to preterm births spans several decades. First or even second-trimester-induced termination of pregnancy (I-TOP) are often considered minor and benign procedures; however, some studies report significant consequences to childbearing potentials and possibilities of LBW and PT births. Current theories linking previous I-TOP to PT/LBW births include (a) overt or covert infection following I-TOP,[2] (b) mechanical trauma to the cervix leading to increased risk of cervical insufficiency[3] and (c) surgical procedures including curettage resulting in scarred tissue that may increase the probability of faulty placental implantation and subsequent placenta previa.[4] It is also likely that circumstances that made women to choose I-TOP such as socio-economic status may lead to LBW. Women who chose I-TOP may be inherently different from women who continue pregnancy and may be a risk factor for adverse pregnancy outcomes.

* Members of Knowledge Synthesis Group of Determinants of LBW/preterm births are listed in the Appendix.

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Attachment J
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Abortion and the Risk of Subsequent Preterm Birth

A Systematic Review with Meta-analyses

Hanes M. Swingle, M.D., M.P.H., Tarah T. Colaizy, M.D., M.P.H., M. Bridget Zimmerman, Ph.D., and Frank H. Morriss, Jr., M.D., M.P.H.

OBJECTIVE: To conduct a systematic review and meta-analyses of studies that test the association between induced or spontaneous abortion and subsequent preterm birth.

STUDY DESIGN: International databases were reviewed (1995–2007) using the terms preterm, premature, birth, labor, delivery, abortion, induced abortion, miscarriage *and* spontaneous abortion. *Only studies that met prespecified objective criteria for methodologic design and reporting were included in the meta-analyses.*

RESULTS: Twelve induced and 9 spontaneous abortion studies met inclusion criteria. Common adjusted odds ratios (ORs) for preterm birth following 1 and ≥2 induced abortions were 1.25 (95% confidence interval [95% CI] 1.03–1.48) and 1.51 (95% CI 1.21–1.75), respectively. Four studies provided a common adjusted OR for ≤32 weeks' births of 1.64 (95% CI 1.38–1.91). Meta-regression analysis revealed a previously unrecognized inverse relationship between the ln OR and the control population preterm birth rate, explaining in part the observed heterogeneity among studies. Analysis of spontaneous abortion and subsequent preterm birth revealed a similar common adjusted OR and inverse meta-regression on the control preterm birth rates.

CONCLUSION: Induced and spontaneous abortion are associated with similarly increased ORs for preterm birth in subsequent pregnancies, and they vary inversely with the baseline preterm birth rate, explaining some of the variability among studies. (J Reprod Med 2009; 54:95–108)

Our systematic review with meta-analyses demonstrates that induced and spontaneous abortions are similarly associated with increased ORs for subsequent PTB....

Keywords: abortion, induced; abortion, spontaneous; preterm birth.

Preterm birth (PTB) (delivery at <37 weeks) contributes to infant mortality and childhood morbidity, including chronic lung disease, sensory deficits, cerebral palsy, cognitive impairments and behavioral problems.[1,2] Despite improvements in maternal nutrition, access to prenatal care, early identification of preterm labor and treatment of maternal infections, PTB rates have risen in the United States, from 9.4% in 1981 to 12.8%* in 2006, for a 36% in-

*National Center for Health Statistics preliminary data for 2006.

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PUSHING "INTER-GENERATIONAL SEX"

http://www.lifenews.com/2011/12/28/planned-parenthood-texts-sex-information-to-teenage-kids/ Planned Parenthood Federation of America has proclaimed a right to sexual enjoyment as a basic human right for all people, including children, and is pushing that goal in every arena, including schools, community groups, and particularly the United Nations. It hires children as young as 14 to promote sex to their peers, and one affiliate recently posted a job listing for a state-funded peer educator position that requires that the **teens must attend the annual gay pride parade in order to work for PP.**

When Planned Parenthood of Greater Northern New Jersey held its annual national sex educators' conference, it promoted a website pushing such resources as "Unequal Partners, Teaching about Power and **Consent in Adult-Teen and Other Relationships**." Planned Parenthood is actively involved in trying to push the boundaries that separate and protect children from sexual activity.

PP TEXTING SEX INFO TO KIDS

"In Case You're Curious" SEX info is obtained by texting ICYC to 66746.

http://townhall.com/columnists/michaelnorton/2012/01/04/is_planned_parenthood_texting_your_kids Planned Parenthood of the Rocky Mountains (PPRM) is now in the business of texting with today's teens about matters that earlier generations would have either never voiced or at least would have only voiced to a parent or close friend. Yet in 2012, setting up this quasi-cyber texting relationship with PPRM is as easy as one, two, three – and parents likely won't know anything about it.

For starters, a teen with questions simply goes to PPRM's "In Case You're Curious" webpage. Once there, teens with questions about their "sexual health" are encouraged to text PPRM—a number is provided—and told that their questions will be kept anonymous and that they will receive a response via text within 24 hours.

ONE CLICK TO ABORTION Among the information available from PPRM by texting are locations of "health centers" where teens can get HIV testing, contraceptives, and, of course, abortions. Moreover, teens don't even have to text to find out where to have an abortion. Rather, they can just click the link marked "find one here."

Even President Obama's HHS Secretary Kathleen Sebelius recently acknowledged, in rejecting over-the-counter availability of the so-called morning after abortion pill, that "there are **significant cognitive and behavioral differences between older adolescent girls [over the age of 17] and the youngest girls of reproductive age."** Nonetheless, it's as if PPRM has availed itself of texting in order **to position itself between the parent and the teen, with a view to exploiting** the child the way a perverted stalker in the park would do.

Attachment L