SB

24

SENATE COMMITTEE REPORT

DATE: 2/3/97

FURTHER: Finance

DATE TURNED IN TO OFFICE: 2/21/97

Judiciary Committee considered SENATE BILL NO. 24

Require consent before minors receive an abortion; amend Rules 40 and 79, Alaska Rules of Civil Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate Procedure; and Rule 9, Alaska Administrative Rules.

and recommends:

[✓] be replaced with ______ CS SB 24 (JUD)

[ ] adopt previous _____ CS ______ (______)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ______ Committee

[ ] further referral to the ______ Committee

Senate Bill:
[✓] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical change
[ ] new: SCR# ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
Mike Miller	✓	[signature]		X	
Sean R. Parnell	✓				
CHAIR: [signature]	✓	CHAIR:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Court System	1/28		✓
DPA	1/28		✓
Public Defender	1/28	0	
HSS	1/24	0	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
previous FN's			
apply to Jud CS			

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

0-LS0210\E
Lauterbach
2/19/97

CS FOR SENATE BILL NO. 24(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE SENATE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS LEMAN, Halford, Green, Miller, Taylor

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to a requirement that a parent, guardian, or custodian consent
2 before certain minors receive an abortion; establishing a judicial bypass procedure
3 by which a minor may petition a court for authorization to consent to an
4 abortion without consent of a parent, guardian, or custodian; amending the
5 definition of 'abortion'; and amending Rules 40 and 79, Alaska Rules of Civil
6 Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate
7 Procedure; and Rule 9, Alaska Administrative Rules."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE; FINDINGS. (a) It is the intent of the legislature in enacting this
10 Act to further the important and compelling state interests of
11 (1) protecting minors against their own immaturity;
12 (2) fostering the family structure and preserving it as a viable social unit;
13 (3) protecting the rights of parents to rear children who are members of their

1 household; and
2 (4) protecting the health of minor women.
3 (b) The legislature finds that
4 (1) immature minors often lack the ability to make fully informed choices that
5 take account of both immediate and long-range consequences;
6 (2) the physical, emotional, and psychological consequences of abortion are
7 serious and can be lasting particularly when the patient is immature;
8 (3) the capacity to become pregnant and the capacity for mature judgment
9 concerning the wisdom of an abortion are not necessarily related;
10 (4) parents ordinarily possess information essential to a physician's or
11 surgeon's best medical judgment concerning the child;
12 (5) parents who are aware that their minor daughter has had an abortion may
13 better ensure that the daughter receives adequate medical attention after the abortion;
14 (6) parental consultation is usually desirable and in the best interest of the
15 minor; and
16 (7) parental involvement legislation enacted in other states has shown to have
17 a significant effect in reducing abortion, birth, and pregnancy rates among minors.
18 *** Sec. 2.** AS 18.16.010(a) is amended to read:
19 (a) An abortion may not be performed in this state unless
20 (1) the abortion is performed by a physician or surgeon licensed by the
21 State Medical Board under AS 08.64.200;
22 (2) the abortion is performed in a hospital or other facility approved for
23 the purpose by the Department of Health and Social Services or a hospital operated by
24 the federal government or an agency of the federal government;
25 (3) **before an abortion is knowingly performed or induced on an**
26 **unmarried, unemancipated woman under 18 years of age, consent has been given**
27 **as required under AS 18.16.020 or a court has authorized the minor to consent**
28 **to the abortion under AS 18.16.030 and the minor consents; for purposes of**
29 **enforcing this paragraph, there is a rebuttable presumption that a woman who**
30 **is unmarried and under 18 years of age is unemancipated** [CONSENT HAS BEEN
31 RECEIVED FROM THE PARENT OR GUARDIAN OF AN UNMARRIED WOMAN

1 LESS THAN 18 YEARS OF AGE]; and
2 (4) the woman is domiciled or physically present in the state for 30
3 days before the abortion.
4 * Sec. 3. AS 18.16.010 is amended by adding new subsections to read:
5 (e) A person who performs or induces an abortion in violation of (a)(3) of this
6 section is civilly liable to the pregnant minor and the minor's parents, guardian, or cus-
7 todian for compensatory and punitive damages.
8 (f) It is an affirmative defense to a prosecution or claim for a violation of
9 (a)(3) of this section that the pregnant minor provided the person who performed or
10 induced the abortion with false, misleading, or incorrect information about the minor's
11 age, marital status, or emancipation, and the person who performed or induced the
12 abortion did not otherwise have reasonable cause to believe that the pregnant minor
13 was under 18 years of age, unmarried, or unemancipated.
14 (g) It is an affirmative defense to a prosecution or claim for violation of (a)(3)
15 of this section that compliance with the requirements of (a)(3) of this section was not
16 possible because an immediate threat of serious risk to the life or physical health of
17 the pregnant minor from the continuation of the pregnancy created a medical
18 emergency necessitating the immediate performance or inducement of an abortion. In
19 this subsection, "medical emergency" means a condition that, on the basis of the
20 physician's or surgeon's good faith clinical judgment, so complicates the medical
21 condition of a pregnant minor that
22 (1) an immediate abortion of the minor's pregnancy is necessary to
23 avert the minor's death; or
24 (2) a delay in providing an abortion will create serious risk of
25 substantial and irreversible impairment of a major bodily function of the pregnant
26 minor.
27 * Sec. 4. AS 18.16 is amended by adding new sections to read:
28 **Sec. 18.16.020. Consent required before minor's abortion.** A person may
29 not knowingly perform or induce an abortion upon a minor who is known to the
30 person to be pregnant, unmarried, under 18 years of age, and unemancipated unless,
31 before the abortion, at least one of the following applies:

1 (1) one of the minor's parents or the minor's guardian or custodian has
2 consented in writing to the performance or inducement of the abortion;
3 (2) a court issues an order under AS 18.16.030 authorizing the minor
4 to consent to the abortion without consent of a parent, guardian, or custodian, and the
5 minor consents to the abortion; or
6 (3) a court, by its inaction under AS 18.16.030, constructively has
7 authorized the minor to consent to the abortion without consent of a parent, guardian,
8 or custodian, and the minor consents to the abortion.
9 **Sec. 18.16.030. Judicial bypass for minor seeking an abortion.** (a) A
10 woman who is pregnant, unmarried, under 18 years of age, and unemancipated who
11 wishes to have an abortion without the consent of a parent, guardian, or custodian may
12 file a complaint in the superior court requesting the issuance of an order authorizing
13 the minor to consent to the performance or inducement of an abortion without the
14 consent of a parent, guardian, or custodian.
15 (b) The complaint shall be made under oath and must include all of the
16 following:
17 (1) a statement that the complainant is pregnant;
18 (2) a statement that the complainant is unmarried, under 18 years of
19 age, and unemancipated;
20 (3) a statement that the complainant wishes to have an abortion without
21 the consent of a parent, guardian, or custodian;
22 (4) an allegation of either or both of the following:
23 (A) that the complainant is sufficiently mature and well enough
24 informed to decide intelligently whether to have an abortion without the
25 consent of a parent, guardian, or custodian; or
26 (B) that one or both of the minor's parents or the minor's
27 guardian or custodian was engaged in a pattern of physical, sexual, or
28 emotional abuse against the minor, or that the consent of a parent, guardian, or
29 custodian otherwise is not in the minor's best interest;
30 (5) a statement as to whether the complainant has retained an attorney
31 and, if an attorney has been retained, the name, address, and telephone number of the

1 attorney.

2 (c) The court shall fix a time for a hearing on any complaint filed under (a)
3 of this section and shall keep a record of all testimony and other oral proceedings in
4 the action. The hearing shall be held at the earliest possible time, but not later than
5 the fifth business day after the day that the complaint is filed. The court shall enter
6 judgment on the complaint immediately after the hearing is concluded. If the hearing
7 required by this subsection is not held by the fifth business day after the complaint is
8 filed, the failure to hold the hearing shall be considered to be a constructive order of
9 the court authorizing the complainant to consent to the performance or inducement of
10 an abortion without the consent of a parent, guardian, or custodian, and the
11 complainant and any other person may rely on the constructive order to the same
12 extent as if the court actually had issued an order under this section authorizing the
13 complainant to consent to the performance or inducement of an abortion without such
14 consent.

15 (d) If the complainant has not retained an attorney, the court shall appoint an
16 attorney to represent the complainant.

17 (e) If the complainant makes only the allegation set out in (b)(4)(A) of this
18 section and if the court finds by clear and convincing evidence that the complainant
19 is sufficiently mature and well enough informed to decide intelligently whether to have
20 an abortion, the court shall issue an order authorizing the complainant to consent to
21 the performance or inducement of an abortion without the consent of a parent,
22 guardian, or custodian. If the court does not make the finding specified in this
23 subsection, it shall dismiss the complaint.

24 (f) If the complainant makes only the allegation set out in (b)(4)(B) of this
25 section and the court finds by clear and convincing evidence that there is evidence of
26 a pattern of physical, sexual, or emotional abuse of the complainant by one or both of
27 the minor's parents or the minor's guardian or custodian, or that the consent of the
28 parents, guardian, or custodian of the complainant otherwise is not in the best interest
29 of the complainant, the court shall issue an order authorizing the complainant to
30 consent to the performance or inducement of an abortion without the consent of a
31 parent, guardian, or custodian. If the court does not make the finding specified in this

1 subsection, it shall dismiss the complaint.

2 (g) If the complainant makes both of the allegations set out in (b)(4) of this
3 section, the court shall proceed as follows:

4 (1) the court first shall determine whether it can make the finding
5 specified in (e) of this section and, if so, shall issue an order under that subsection;
6 if the court issues an order under this paragraph, it may not proceed under (f) of this
7 section; if the court does not make the finding specified in (e) of this section, it shall
8 proceed under (2) of this subsection;

9 (2) if the court under (1) of this subsection does not make the finding
10 specified in (e) of this section, it shall proceed to determine whether it can make the
11 finding specified in (f) of this section and, if so, shall issue an order under that
12 subsection; if the court does not make the finding specified in (f) of this section, it
13 shall dismiss the complaint.

14 (h) The court may not notify the parents, guardian, or custodian of the
15 complainant that the complainant is pregnant or wants to have an abortion.

16 (i) If the court dismisses the complaint, the complainant has the right to appeal
17 the decision to the supreme court, and the superior court immediately shall notify the
18 complainant that there is a right to appeal.

19 (j) If the complainant files a notice of appeal authorized under this section, the
20 superior court shall deliver a copy of the notice of appeal and the record on appeal to
21 the supreme court within four days after the notice of appeal is filed. Upon receipt of
22 the notice and record, the clerk of the supreme court shall place the appeal on the
23 docket. The appellant shall file a brief within four days after the appeal is docketed.
24 Unless the appellant waives the right to oral argument, the supreme court shall hear
25 oral argument within five days after the appeal is docketed. The supreme court shall
26 enter judgment in the appeal immediately after the oral argument or, if oral argument
27 has been waived, within five days after the appeal is docketed. Upon motion of the
28 appellant and for good cause shown, the supreme court may shorten or extend the
29 maximum times set out in this subsection. However, in any case, if judgment is not
30 entered within five days after the appeal is docketed, the failure to enter the judgment
31 shall be considered to be a constructive order of the court authorizing the appellant to

1 consent to the performance or inducement of an abortion without the consent of a
2 parent, guardian, or custodian, and the appellant and any other person may rely on the
3 constructive order to the same extent as if the court actually had entered a judgment
4 under this subsection authorizing the appellant to consent to the performance or
5 inducement of an abortion without consent of another person. In the interest of justice,
6 the supreme court, in an appeal under this subsection, shall liberally modify or
7 dispense with the formal requirements that normally apply as to the contents and form
8 of an appellant's brief.

9 (k) Each hearing under this section, and all proceedings under (j) of this
10 section, shall be conducted in a manner that will preserve the anonymity of the
11 complainant. The complaint and all other papers and records that pertain to an action
12 commenced under this section, including papers and records that pertain to an appeal
13 under this section, shall be kept confidential and are not public records under
14 AS 09.25.110 - 09.25.120.

15 (l) The supreme court shall prescribe complaint and notice of appeal forms that
16 shall be used by a complainant filing a complaint or appeal under this section. The
17 clerk of each superior court shall furnish blank copies of the forms, without charge,
18 to any person who requests them.

19 (m) A filing fee may not be required of, and court costs may not be assessed
20 against, a complainant filing a complaint under this section or an appellant filing an
21 appeal under this section.

22 (n) Blank copies of the forms prescribed under (l) of this section and
23 information on the proper procedures for filing a complaint or appeal shall be made
24 available by the court system at the official location of each superior court, district
25 court, and magistrate in the state. The information required under this subsection must
26 also include notification to the minor that

27 (1) there is no filing fee required for either form;

28 (2) no court costs will be assessed against the minor for procedures
29 under this section;

30 (3) an attorney will be appointed to represent the minor if the minor
31 does not retain an attorney;

1 (4) the minor may request that the superior court with appropriate
2 jurisdiction hold a telephonic hearing on the complaint so that the minor need not
3 personally be present.
4 **Sec. 18.16.090. Definitions.** In this chapter,
5 (1) "abortion" means the use or prescription of an instrument, medicine,
6 drug, or other substance or device to terminate the pregnancy of a woman known to
7 be pregnant, except that "abortion" does not include the termination of a pregnancy if
8 done with the intent to
9 (A) save the life or preserve the health of the unborn child;
10 (B) deliver the unborn child prematurely to preserve the health
11 of both the pregnant woman and the woman's child; or
12 (C) remove a dead unborn child;
13 (2) "unemancipated" means that a woman who is unmarried and under
14 18 years of age has not done any of the following:
15 (A) entered the armed services of the United States;
16 (B) become employed and self-subsisting;
17 (C) been emancipated under AS 09.55.590; or
18 (D) otherwise become independent from the care and control of
19 the woman's parent, guardian, or custodian.
20 * **Sec. 5.** AS 44.21.410(a) is amended to read:
21 (a) The office of public advocacy shall
22 (1) perform the duties of the public guardian under AS 13.26.360 -
23 13.26.410;
24 (2) provide visitors and experts in guardianship proceedings under
25 AS 13.26.131;
26 (3) provide guardian ad litem services to children in child protection
27 actions under AS 47.17.030(e) and to wards and respondents in guardianship
28 proceedings who will suffer financial hardship or become dependent upon a
29 government agency or a private person or agency if the services are not provided at
30 state expense under AS 13.26.112;
31 (4) provide legal representation **in cases involving judicial bypass**

1 **procedures for minors seeking abortions under AS 18.16.030,** in guardianship
2 proceedings to respondents who are financially unable to employ attorneys under
3 AS 13.26.106(b), to indigent parties in cases involving child custody in which the
4 opposing party is represented by counsel provided by a public agency, to indigent
5 parents or guardians of a minor respondent in a commitment proceeding concerning
6 the minor under AS 47.30.775;
7 (5) provide legal representation and guardian ad litem services under
8 AS 25.24.310; in cases arising under AS 47.15 (Uniform Interstate Compact on
9 Juveniles); in cases involving petitions to adopt a minor under AS 25.23.125(b) or
10 petitions for the termination of parental rights on grounds set out in
11 AS 25.23.180(c)(3); in cases involving petitions to remove the disabilities of a minor
12 under AS 09.55.590; in children's proceedings under AS 47.10.050(a) or under
13 AS 47.12.090; in cases involving appointments under AS 18.66.100(a) in petitions for
14 protective orders on behalf of a minor; and in cases involving indigent persons who
15 are entitled to representation under AS 18.85.100 and who cannot be represented by
16 the public defender agency because of a conflict of interests;
17 (6) develop and coordinate a program to recruit, select, train, assign,
18 and supervise volunteer guardians ad litem from local communities to aid in delivering
19 services in cases in which the office of public advocacy is appointed as guardian ad
20 litem;
21 (7) provide guardian ad litem services in proceedings under
22 AS 12.45.046;
23 (8) establish a fee schedule and collect fees for services provided by
24 the office, except as provided in AS 18.85.120 or when imposition or collection of a
25 fee is not in the public interest as defined under regulations adopted by the
26 commissioner of administration;
27 (9) provide visitors and guardians ad litem in proceedings under
28 AS 47.30.839;
29 (10) provide legal representation to indigent parents under
30 AS 14.30.195(e).
31 * **Sec. 6.** AS 18.16.010(d) is repealed.

1 * **Sec. 7.** AS 18.16.030(c), added by sec. 4 of this Act, has the effect of amending Rule
2 40, Alaska Rules of Civil Procedure, by setting a specific timetable for hearing certain cases.
3 * **Sec. 8.** AS 18.16.030(j), added by sec. 4 of this Act, has the effect of amending Rules
4 204, 210, 212, and 213, Alaska Rules of Appellate Procedure, by establishing specific time
5 limits applicable to certain appeals and by instructing the supreme court to modify or dispense
6 with formal requirements applicable to certain briefs.
7 * **Sec. 9.** AS 18.16.030(k), added by sec. 4 of this Act, has the effect of amending Rule
8 512.5, Alaska Rules of Appellate Procedure, by making certain appellate records and papers
9 confidential.
10 * **Sec. 10.** AS 18.16.030(m), added by sec. 4 of this Act, has the effect of amending Rule
11 9, Alaska Administrative Rules; Rule 79, Alaska Rules of Civil Procedure; and Rule 508,
12 Alaska Rules of Appellate Procedure, by prohibiting filing fees and assessment of court costs
13 in certain actions.

SENATE BILL NO. 24

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY SENATORS LEMAN, Halford, Green, Miller, Taylor

Introduced: 1/13/97
Referred: HESS, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to a requirement that a parent, guardian, or custodian consent
2 before certain minors receive an abortion; establishing a judicial bypass procedure
3 by which a minor may petition a court for authorization to consent to an
4 abortion without consent of a parent, guardian, or custodian; amending the
5 definition of 'abortion'; and amending Rules 40 and 79, Alaska Rules of Civil
6 Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate
7 Procedure; and Rule 9, Alaska Administrative Rules."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. PURPOSE; FINDINGS. (a) It is the intent of the legislature in enacting this
10 Act to further the important and compelling state interests of
11 (1) protecting minors against their own immaturity;
12 (2) fostering the family structure and preserving it as a viable social unit;
13 (3) protecting the rights of parents to rear children who are members of their

COMM ... COP

1 household; and

2 (4) protecting the health of minor women.

3 (b) The legislature finds that

4 (1) immature minors often lack the ability to make fully informed choices that

5 take account of both immediate and long-range consequences;

6 (2) the physical, emotional, and psychological consequences of abortion are

7 serious and can be lasting particularly when the patient is immature;

8 (3) the capacity to become pregnant and the capacity for mature judgment

9 concerning the wisdom of an abortion are not necessarily related;

10 (4) parents ordinarily possess information essential to a physician's or surgeon's

11 best medical judgment concerning the child;

12 (5) parents who are aware that their minor daughter has had an abortion may

13 better ensure that the daughter receives adequate medical attention after the abortion;

14 (6) parental consultation is usually desirable and in the best interest of the

15 minor; and

16 (7) parental involvement legislation enacted in other states has shown to have

17 a significant effect in reducing abortion, birth, and pregnancy rates among minors.

18 * Sec. 2. AS 18.16.010(a) is amended to read:

19 (a) An abortion may not be performed in this state unless

20 (1) the abortion is performed by a physician or surgeon licensed by the

21 State Medical Board under AS 08.64.200;

22 (2) the abortion is performed in a hospital or other facility approved for

23 the purpose by the Department of Health and Social Services or a hospital operated by

24 the federal government or an agency of the federal government;

25 (3) **before an abortion is knowingly performed on an unmarried,**

26 **unemancipated woman under 18 years of age, consent has been given as required**

27 **under AS 18.16.020 or a court has authorized the minor to consent to the abortion**

28 **under AS 18.16.030 and the minor consents; for purposes of enforcing this**

29 **paragraph, there is a rebuttable presumption that a woman who is unmarried and**

30 **under 18 years of age is unemancipated** [CONSENT HAS BEEN RECEIVED

31 FROM THE PARENT OR GUARDIAN OF AN UNMARRIED WOMAN LESS

1 THAN 18 YEARS OF AGE]; and
2 (4) the woman is domiciled or physically present in the state for 30
3 days before the abortion.
4 * Sec. 3. AS 18.16.010 is amended by adding new subsections to read:
5 (e) A person who performs or induces an abortion in violation of (a)(3) of this
6 section is civilly liable to the pregnant woman and the woman's parents, guardian, or
7 custodian for compensatory and punitive damages.
8 (f) It is an affirmative defense to a prosecution or claim for a violation of
9 (a)(3) of this section that the pregnant woman provided the person who performed or
10 induced the abortion with false, misleading, or incorrect information about the woman's
11 age, marital status, or emancipation, and the person who performed or induced the
12 abortion did not otherwise have reasonable cause to believe that the pregnant woman
13 was under 18 years of age, unmarried, or unemancipated.
14 (g) It is an affirmative defense to a prosecution or claim for violation of (a)(3)
15 of this section that compliance with the requirements of (a)(3) of this section was not
16 possible because an immediate threat of serious risk to the life or physical health of
17 the pregnant woman from the continuation of the pregnancy created a medical
18 emergency necessitating the immediate performance or inducement of an abortion. In
19 this subsection, "medical emergency" means a condition that, on the basis of the
20 physician's or surgeon's good faith clinical judgment, so complicates the medical
21 condition of a pregnant woman that
22 (1) an immediate abortion of the woman's pregnancy is necessary to
23 avert the woman's death; or
24 (2) a delay in providing an abortion will create serious risk of
25 substantial and irreversible impairment of a major bodily function of the pregnant
26 woman.
27 * Sec. 4. AS 18.16 is amended by adding new sections to read:
28 **Sec. 18.16.020. Consent required before minor's abortion.** A person may
29 not knowingly perform or induce an abortion upon a woman who is known to the
30 person to be pregnant, unmarried, under 18 years of age, and unemancipated unless,
31 before the abortion, at least one of the following applies:

1 (1) one of the woman's parents or the woman's guardian or custodian
2 has consented in writing to the performance or inducement of the abortion;
3 (2) a court issues an order under AS 18.16.030 authorizing the woman
4 to consent to the abortion without consent of a parent, guardian, or custodian, and the
5 woman consents to the abortion; or
6 (3) a court, by its inaction under AS 18.16.030, constructively has
7 authorized the woman to consent to the abortion without consent of a parent, guardian,
8 or custodian, and the woman consents to the abortion.
9 **Sec. 18.16.030. Judicial bypass for minor seeking an abortion.** (a) A
10 woman who is pregnant, unmarried, under 18 years of age, and unemancipated who
11 wishes to have an abortion without the consent of a parent, guardian, or custodian may
12 file a complaint in the superior court requesting the issuance of an order authorizing
13 the woman to consent to the performance or inducement of an abortion without the
14 consent of a parent, guardian, or custodian.
15 (b) The complaint shall be made under oath and must include all of the
16 following:
17 (1) a statement that the complainant is pregnant;
18 (2) a statement that the complainant is unmarried, under 18 years of
19 age, and unemancipated;
20 (3) a statement that the complainant wishes to have an abortion without
21 the consent of a parent, guardian, or custodian;
22 (4) an allegation of either or both of the following:
23 (A) that the complainant is sufficiently mature and well enough
24 informed to decide intelligently whether to have an abortion without the
25 consent of a parent, guardian, or custodian; or
26 (B) that one or both of the woman's parents or the woman's
27 guardian or custodian was engaged in a pattern of physical, sexual, or
28 emotional abuse against the woman, or that the consent of a parent, guardian,
29 or custodian otherwise is not in the woman's best interest;
30 (5) a statement as to whether the complainant has retained an attorney
31 and, if an attorney has been retained, the name, address, and telephone number of the

1 attorney.

2 (c) The court shall fix a time for a hearing on any complaint filed under (a)
3 of this section and shall keep a record of all testimony and other oral proceedings in
4 the action. The hearing shall be held at the earliest possible time, but not later than
5 the fifth business day after the day that the complaint is filed. The court shall enter
6 judgment on the complaint immediately after the hearing is concluded. If the hearing
7 required by this subsection is not held by the fifth business day after the complaint is
8 filed, the failure to hold the hearing shall be considered to be a constructive order of
9 the court authorizing the complainant to consent to the performance or inducement of
10 an abortion without the consent of a parent, guardian, or custodian, and the
11 complainant and any other person may rely on the constructive order to the same
12 extent as if the court actually had issued an order under this section authorizing the
13 complainant to consent to the performance or inducement of an abortion without such
14 consent.

15 (d) If the complainant has not retained an attorney, the court shall appoint an
16 attorney to represent the complainant.

17 (e) If the complainant makes only the allegation set out in (b)(4)(A) of this
18 section and if the court finds by clear and convincing evidence that the complainant
19 is sufficiently mature and well enough informed to decide intelligently whether to have
20 an abortion, the court shall issue an order authorizing the complainant to consent to
21 the performance or inducement of an abortion without the consent of a parent,
22 guardian, or custodian. If the court does not make the finding specified in this
23 subsection, it shall dismiss the complaint.

24 (f) If the complainant makes only the allegation set out in (b)(4)(B) of this
25 section and the court finds by clear and convincing evidence that there is evidence of
26 a pattern of physical, sexual, or emotional abuse of the complainant by one or both of
27 the woman's parents or the woman's guardian or custodian, or that the consent of the
28 parents, guardian, or custodian of the complainant otherwise is not in the best interest
29 of the complainant, the court shall issue an order authorizing the complainant to
30 consent to the performance or inducement of an abortion without the consent of a
31 parent, guardian, or custodian. If the court does not make the finding specified in this

1 subsection, it shall dismiss the complaint.

2 (g) If the complainant makes both of the allegations set out in (b)(4) of this
3 section, the court shall proceed as follows:

4 (1) the court first shall determine whether it can make the finding
5 specified in (e) of this section and, if so, shall issue an order under that subsection;
6 if the court issues an order under this paragraph, it may not proceed under (f) of this
7 section; if the court does not make the finding specified in (e) of this section, it shall
8 proceed under (2) of this subsection;

9 (2) if the court under (1) of this subsection does not make the finding
10 specified in (e) of this section, it shall proceed to determine whether it can make the
11 finding specified in (f) of this section and, if so, shall issue an order under that
12 subsection; if the court does not make the finding specified in (f) of this section, it
13 shall dismiss the complaint.

14 (h) The court may not notify the parents, guardian, or custodian of the
15 complainant that the complainant is pregnant or wants to have an abortion.

16 (i) If the court dismisses the complaint, the complainant has the right to appeal
17 the decision to the supreme court, and the superior court immediately shall notify the
18 complainant that there is a right to appeal.

19 (j) If the complainant files a notice of appeal authorized under this section, the
20 superior court shall deliver a copy of the notice of appeal and the record on appeal to
21 the supreme court within four days after the notice of appeal is filed. Upon receipt of
22 the notice and record, the clerk of the supreme court shall place the appeal on the
23 docket. The appellant shall file a brief within four days after the appeal is docketed.
24 Unless the appellant waives the right to oral argument, the supreme court shall hear
25 oral argument within five days after the appeal is docketed. The supreme court shall
26 enter judgment in the appeal immediately after the oral argument or, if oral argument
27 has been waived, within five days after the appeal is docketed. Upon motion of the
28 appellant and for good cause shown, the supreme court may shorten or extend the
29 maximum times set out in this subsection. However, in any case, if judgment is not
30 entered within five days after the appeal is docketed, the failure to enter the judgment
31 shall be considered to be a constructive order of the court authorizing the appellant to

1 consent to the performance or inducement of an abortion without the consent of a
2 parent, guardian, or custodian, and the appellant and any other person may rely on the
3 constructive order to the same extent as if the court actually had entered a judgment
4 under this subsection authorizing the appellant to consent to the performance or
5 inducement of an abortion without consent of another person. In the interest of justice,
6 the supreme court, in an appeal under this subsection, shall liberally modify or
7 dispense with the formal requirements that normally apply as to the contents and form
8 of an appellant's brief.

9 (k) Each hearing under this section, and all proceedings under (j) of this
10 section, shall be conducted in a manner that will preserve the anonymity of the
11 complainant. The complaint and all other papers and records that pertain to an action
12 commenced under this section, including papers and records that pertain to an appeal
13 under this section, shall be kept confidential and are not public records under
14 AS 09.25.110 - 09.25.120.

15 (l) The supreme court shall prescribe complaint and notice of appeal forms that
16 shall be used by a complainant filing a complaint or appeal under this section. The
17 clerk of each superior court shall furnish blank copies of the forms, without charge,
18 to any person who requests them.

19 (m) A filing fee may not be required of, and court costs may not be assessed
20 against, a complainant filing a complaint under this section or an appellant filing an
21 appeal under this section.

22 **Sec. 18.16.090. Definitions.** In this chapter,

23 (1) "abortion" means the use or prescription of an instrument, medicine,
24 drug, or other substance or device to terminate the pregnancy of a woman known to
25 be pregnant, except that "abortion" does not include the termination of a pregnancy if
26 done with the intent to

27 (A) save the life or preserve the health of the unborn child;
28 (B) deliver the unborn child prematurely to preserve the health
29 of both the pregnant woman and the woman's child; or
30 (C) remove a dead unborn child;
31 (2) "unemancipated" means that a woman who is unmarried and under

1 18 years of age has not done any of the following:
2 (A) entered the armed services of the United States;
3 (B) become employed and self-subsisting;
4 (C) been emancipated under AS 09.55.590; or
5 (D) otherwise become independent from the care and control of
6 the woman's parent, guardian, or custodian.
7 * Sec. 5. AS 44.21.410(a) is amended to read:
8 (a) The office of public advocacy shall
9 (1) perform the duties of the public guardian under AS 13.26.360 -
10 13.26.410;
11 (2) provide visitors and experts in guardianship proceedings under
12 AS 13.26.131;
13 (3) provide guardian ad litem services to children in child protection
14 actions under AS 47.17.030(e) and to wards and respondents in guardianship
15 proceedings who will suffer financial hardship or become dependent upon a
16 government agency or a private person or agency if the services are not provided at
17 state expense under AS 13.26.112;
18 (4) provide legal representation **in cases involving judicial bypass**
19 **procedures for minors seeking abortions under AS 18.16.030,** in guardianship
20 proceedings to respondents who are financially unable to employ attorneys under
21 AS 13.26.106(b), to indigent parties in cases involving child custody in which the
22 opposing party is represented by counsel provided by a public agency, to indigent
23 parents or guardians of a minor respondent in a commitment proceeding concerning
24 the minor under AS 47.30.775;
25 (5) provide legal representation and guardian ad litem services under
26 AS 25.24.310; in cases arising under AS 47.15 (Uniform Interstate Compact on
27 Juveniles); in cases involving petitions to adopt a minor under AS 25.23.125(b) or
28 petitions for the termination of parental rights on grounds set out in
29 AS 25.23.180(c)(3); in cases involving petitions to remove the disabilities of a minor
30 under AS 09.55.590; in children's proceedings under AS 47.10.050(a) or under
31 AS 47.12.090; in cases involving appointments under AS 18.66.100(a) in petitions for

1 protective orders on behalf of a minor; and in cases involving indigent persons who
2 are entitled to representation under AS 18.85.100 and who cannot be represented by
3 the public defender agency because of a conflict of interests;
4 (6) develop and coordinate a program to recruit, select, train, assign,
5 and supervise volunteer guardians ad litem from local communities to aid in delivering
6 services in cases in which the office of public advocacy is appointed as guardian ad
7 litem;
8 (7) provide guardian ad litem services in proceedings under
9 AS 12.45.046;
10 (8) establish a fee schedule and collect fees for services provided by
11 the office, except as provided in AS 18.85.120 or when imposition or collection of a
12 fee is not in the public interest as defined under regulations adopted by the
13 commissioner of administration;
14 (9) provide visitors and guardians ad litem in proceedings under
15 AS 47.30.839;
16 (10) provide legal representation to indigent parents under
17 AS 14.30.195(e).
18 * **Sec. 6.** AS 18.16.010(d) is repealed.
19 * **Sec. 7.** AS 18.16.030(c), added by sec. 4 of this Act, has the effect of amending Rule
20 40, Alaska Rules of Civil Procedure, by setting a specific timetable for hearing certain cases.
21 * **Sec. 8.** AS 18.16.030(j), added by sec. 4 of this Act, has the effect of amending Rules
22 204, 210, 212, and 213, Alaska Rules of Appellate Procedure, by establishing specific time
23 limits applicable to certain appeals and by instructing the supreme court to modify or dispense
24 with formal requirements applicable to certain briefs.
25 * **Sec. 9.** AS 18.16.030(k), added by sec. 4 of this Act, has the effect of amending Rule
26 512.5, Alaska Rules of Appellate Procedure, by making certain appellate records and papers
27 confidential.
28 * **Sec. 10.** AS 18.16.030(m), added by sec. 4 of this Act, has the effect of amending Rule
29 9, Alaska Administrative Rules; Rule 79, Alaska Rules of Civil Procedure; and Rule 508,
30 Alaska Rules of Appellate Procedure, by prohibiting filing fees and assessment of court costs
31 in certain actions.

FISCAL NOTE

No. 1

STATE OF ALASKA
1997 LEGISLATIVE SESSION

Bill Version: SB 24
(S) Publish Date: 2-3-97

Revision Date:		Dept. Affected:	Alaska Court System
Title:	Parental consent before a minor's abortion	BRU:	Trial Courts
		Component:	
Sponsor:	Sen. Leman		
Requestor:	Senate HESS	COMPONENT SERIAL NO.	766

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
PERSONAL SERVICES	10.0	10.0	10.0	10.0	10.0	10.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS & CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	10.0	10.0	10.0	10.0	10.0	10.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

Fund Source (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	10.0	10.0	10.0	10.0	10.0	10.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other						
TOTAL	10.0	10.0	10.0	10.0	10.0	10.0

Estimate of any current year (FY 97) cost: None

Positions

Full-Time						
Part-Time	1.0	1.0	1.0	1.0	1.0	1.0
Temporary						

ANALYSIS: (Attach a separate page if necessary)

See attached fiscal analysis.

Prepared by: C. S. Christensen III, Staff Counsel — Phone: 264-8228
Agency: Alaska Court System — Date: 01/28/97

Approved by: Arthur H. Snowden, II, Administrative Director — Date: 01/28/97
Agency: Alaska Court System

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#1

ALASKA COURT SYSTEM
FISCAL ANALYSIS
SB 24

SB 24 provides that a person may not knowingly perform an abortion upon a woman who is unmarried, under 18 years of age, and unemancipated, unless, before the abortion, one of the woman's parents or the woman's guardian or custodian has consented to the abortion in writing; a court issues an order authorizing the woman to consent to the abortion; or a court, by its inaction, constructively authorizes the woman to consent to the abortion. A woman who seeks a court order authorizing an abortion is required to have an attorney. If she cannot afford an attorney, one must be appointed by the court from the Office of Public Advocacy (OPA). Because we are dealing with unemancipated minors, it must be assumed that all attorneys will be paid for by the state. OPA has estimated that 112 minor females will seek judicial approval for an abortion each year.

SB 24 requires a superior court judge to hold a hearing in these cases on an expedited basis. This note assumes that the review of documents, the hearing, the decision process and the preparation of the order will average two hours of judicial time. This note also reflects clerical costs associated with processing 112 filings which involve expedited hearings and which require court clerks to actively follow cases to make certain that time limits are met and that constructive consent has been given in cases in which a court takes no action within the specified period. This note does not reflect costs for appeals in cases where a court denies permission for an abortion.

Alaska Court System
Fiscal Analysis
SB 24

#1

Personal Services

	Salary	Benefits	Total
Pro tem superior court judge, fully vested, Anchorage, PPT 224 hours	$2,919	$1,595	$4,514
Clerical overtime for 224 hours for range 10A (see note below)			5,473
Total Personal Services			$9,987

Note:

This bill will require clerical (range 8) and legal technician (range 12) services. The average range of the two levels is approximately range 10, which was used for estimating the clerical overtime costs of this legislation.

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

No. 2
Bill Version: SB 24
(S) Publish Date: 2-3-97

Revision Date: 1/28/97 3:30 pm.
Title: "An Act relating to a requirement that a parent, guardian, or custodain consent before certain minors receive an abortion;..."
Sponsor: Senator Leman
Requestor: (S) HESS

Department Affected: Administration
BRU: Office of Public Advocacy
Component: Office of Public Advocacy
COMPONENT SERIAL NO. 43

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	168.0	168.0	168.0	168.0	168.0	168.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	168.0	168.0	168.0	168.0	168.0	168.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

FUND SOURCE	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
1002 Federal Receipts						
1003 GF Match						
1004 GF	168.0	168.0	168.0	168.0	168.0	168.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	168.0	168.0	168.0	168.0	168.0	168.0

Estimate of any current year (FY 97) cost: $ 0

POSITIONS:						
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

The judicial bypass provisions of this bill contemplate a hearing at which an unemancipated minor may seek the court approval of her wish to have an abortion. The bill mandates the appointment of counsel for the minor but does not identify which agency would provide these services. This fiscal note assumes that Office of Public Advocacy (OPA) would be appointed because that agency currently represents children in most other civil cases. The fiscal note is based on the following assumptions: (1) 2,400 abortions per year are performed in Alaska; (2) 12 percent of abortions per year (288) are performed on women aged 17 or younger; (3) 39 percent of young women (112) wishing to obtain an abortion would seek a judicial bypass, based on the fact that 61 percent of parents are informed of abortions in those states which do not require parental notice or consent.

(continued)

Prepared by: Brant McGee, Public Advocate
Division: Office of Public Advocacy
Phone: 274-1684
Date:

Approved by Commissioner: Mark Boyer
Agency: Administration
Date: 1/28/97

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FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. SB 24
#2

ANALYSIS: (continued)

Thus, OPA could be expected to provide attorney representation to 112 young women each year in judicial proceedings in which the minor sought to obtain approval for an abortion. The legal representation in these cases would be short but intense. The Office of Public Advocacy estimates that such services would cost an estimated $1,500 per case for a total of $168.0 per year.

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

No. 3
Bill Version: SB 24
(S) Publish Date: 2-3-97

Revision Date:
Title: "An Act relating to a requirement that a parent, guardian, or custodian consent before certain minors receive an abortion..."

Sponsor: Senator Leman
Requestor: (S)HESS

Department Affected: Administration
BRU: Public Defender Agency
Component: Public Defender Agency

COMPONENT SERIAL NO. 1631

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 97) cost: $ 0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

The bill would require parental, guardian or custodian consent in writing before an abortion for an unmarried, pregnant unemancipated woman under 18 years of age. A judicial process is set up to bypass the consent requirement by the filing of a complaint in superior court. A lawyer shall be appointed to represent the complainant if she has not retained an attorney, but Section 5 of the bill provides those lawyers will be from the Office of Public Advocacy. Therefore, there will be no fiscal impact on the Public Defender Agency.

Prepared by: Barbara K. Brink, Acting Director
Division: Public Defender Agency

Phone: (907) 264-4414
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration

Date: 1/28/97

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FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

No. 4
Bi. .ersion: SB 24
(S) Publish Date: 2-3-97

Revision Date:
Title: Relating to parental consent before certain minors receive an abortion
Sponsor: Leman
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES ... . ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY98	FY99	FY00	FY01	FY02	FY03
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

POSITIONS	FY98	FY99	FY00	FY01	FY02	FY03
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

Enactment of this legislation would have very little impact on the funding of abortions under the General Relief Medical Assistance and Medicaid Programs. Very few abortions funded by these programs are performed on minors.

Prepared by: Nancy Weller
Division: Medical Assistance
Phone: 465-5825
Date: 01/10/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1/24/97

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STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

TONY KNOWLES, GOVERNOR

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(FAX)465-2539

February 26, 1997

The Honorable Robin Taylor, Chair
Senate Judiciary Committee
Alaska State Legislature
Juneau, AK 99801-1182

Re: Responses to Committee Questions re: SB 24

Dear Senator Taylor:

This letter is a response to some of the concerns raised following the Department of Law testimony on SB 24 on February 13, 1997.

1. Concerning other states that have explicit privacy provisions in their state constitutions and the status of provisions relating to parental consent or notification:

There are about nine states, in addition to Alaska, that have specific privacy protections in their constitutions. In five of these states, Arizona, Illinois, Louisiana, South Carolina, and Washington, the privacy provision is attached to the search and seizure provision of the state constitution, so that the constitutional analysis may be more involved with place privacy rights than personal privacy rights. Arizona's and Louisiana's parental consent provisions are subject to permanent injunctions in federal court and the states are appealing the cases to the U.S. Court of Appeals in their respective circuits. Illinois' parental notification provision is subject to permanent injunction in federal court and a Washington parental consent requirement was found unconstitutional in state court in 1975. South Carolina has legislated a parental consent requirement that does not appear to have been challenged in a published decision.

The other states with specific privacy provisions include California, Florida, Hawaii and Montana. In California, a state trial court found a parental consent requirement failed to meet the privacy test under the California constitution because the legislation did not actually further the proclaimed state interests. *American Academy of Pediatrics v. Lungren*, 32 Cal. Rptr. 2d 546 (Cal. App. 1 Dist. 1994). Upon review by the California Supreme Court, however, a divided court upheld the constitutionality of the parental consent requirement with a judicial bypass (*American Academy of Pediatrics v. Lungren*, 912 P.2d 1148 (Cal. 1996)), but enforcement of that provision has been stayed pending a rehearing. In Florida, the state Supreme Court held that the state interests to be advanced by the parental consent statute were not compelling, so that it failed to meet state constitutional scrutiny. *In re: T.W., A Minor*, 551 So. 2d. 1186 (Fla. 1989) (*rehearing denied).* Montana's parental notification provision is not enforceable because the provision has been

determined unconstitutional in federal court. *Wicklund v. Salvagni*, 93 F.3d 567 (Mont. 1996). Montana has petitioned for certification to the U.S. Supreme Court. Hawaii does not appear to have an explicit parental consent or notification requirement.

2. Concerning the enforceability of certain parental consent requirements in Alaska Statutes (responding to a list of references provided in a memorandum from legislative counsel):

First, many of the statutes listed in the memorandum do not exactly require enforcement by the state or the Department of Law. In a number of instances, the listed statutes provide guidance to others who conduct programs involving minors. In the case of the criminal provisions, which are enforceable by the department, a parental consent component appears when an act that involves a minor may be considered criminal unless a parent has provided approval, such as when a minor under 16 possesses a firearm and would be guilty of misconduct involving weapons unless the minor has the consent of a parent or guardian under AS 11.61.220(a)(3). In addition to the provisions listed in law, there may be many instances in which private parties or businesses offering services to minors ask for parental permission, but this is not because of legal requirements.

However, a provision in Missouri state law that required parental consent for an abortion, without providing for a procedure that met constitutional standards to allow a minor to obtain an abortion without parental consent was determined by the U.S. Supreme Court to be unconstitutional in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831, 49 L.Ed.2d 788 (1976). Because the Alaska provision set out at AS 18.10.010(a)(3) imposed a blanket restriction that is even more uncompromising than the Missouri restriction reviewed in *Danforth*, in that the Alaska provision does not make an exception for preserving the life of the mother, the Attorney General's office issued an opinion on October 21, 1976, stating that the parental consent requirement in Alaska law was clearly unconstitutional and that enforcement of that law would be a problem. Consequently, the state has not attempted to enforce a provision that is clearly unconstitutional under U.S. Supreme Court precedent.

Consequently, the major distinction between the consent requirement articulated in Alaska abortion statute and the other parental consent provisions that appear in law is that parental consent requirements in relation to abortion rights have been examined by the U.S. Supreme Court and determined to be unconstitutional. To the extent that other parental consent or permission requirements are set out in statute, they are appropriately applied or enforced unless a court has ruled they are unenforceable.

3. Concerning the requirement that the judicial bypass may be obtained only by clear and convincing evidence:

The clear and convincing burden is a higher burden of persuasion than the more familiar preponderance of the evidence burden that is generally imposed in civil proceedings. The U.S. Supreme Court has held that this standard is required in cases involving state action to deprive individual liberties, such as in a mental commitment or termination of parental rights proceeding.

McCormick on Evidence, §340 (4th ed.1992). It is considered a special standard of persuasion that also has been applied in cases involving fraud or undue influence, claims related to modifying written transactions, or "miscellaneous types of claims and defenses, varying from state to state, where there is thought to be special danger of deception, or where the court considers that the particular type of claim should be disfavored on policy grounds." *Id.*

In certain stages of child protection proceedings, such as when the state agency may be removing children from a home or terminating parental rights, a clear and convincing evidence standard is used in this state. In an emancipation proceeding, a proceeding in which a judge must make a determination of the maturity of a minor, a clear and convincing standard is not specified, so that the usual preponderance of evidence standard is applicable. In judicial bypass for parental consent proceedings in other states, the more customary standard appears to be a preponderance of the evidence, though the U.S. Supreme Court upheld a clear and convincing standard in an Ohio parental notification law in *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 110 S. Ct. 2972, 111 L.Ed.2d. 405 (1990).

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Kristen F. Bomengen
Assistant Attorney General

KFB:ebc

cc: Senate Judiciary Committee Members
Pat Pourchot, Legislative Director
Bruce Botelho, Attorney General
Deborah Behr, Assistant Attorney General
Chrystal Smith, Legal Administrator
Hon. Karen Perdue, Commissioner, Department of Health & Social Services
Elmer Lindstrom, Special Assistant, Department of Health & Social Services

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. CSSB 24

Revision Date:
Title: Parental Consent for Abortion
Sponsor: Leman
Requestor: Senate (JUD)

Dept. Affected: Health and Social Services
BRU: State Health Services
Component: Public Health Admin Services
COMPONENT SERIAL NO. 292
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact.

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 02/25/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/26/97

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FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. CSSB 24 (JUD)

Revision Date:
Title: Relating to parental consent before certain minors receive an abortion
Sponsor: Leman
Requestor: Senate Finance

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY98	FY99	FY00	FY01	FY02	FY03
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

	FY98	FY99	FY00	FY01	FY02	FY03
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

Enactment of this legislation would have very little impact on the funding of abortions under the General Relief Medical Assistance and Medicaid Programs. Very few abortions funded by these programs are performed on minors.

Prepared by: Nancy Weller
Division: Medical Assistance
Phone: 465-5825
Date: 02/24/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/26/97

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DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

February 26, 1997

The Honorable Robin Taylor, Chair
Senate Judiciary Committee
Alaska State Legislature
Juneau, AK 99801-1182

Re: Responses to Committee Questions re: SB 24

Dear Senator Taylor:

This letter is a response to some of the concerns raised following the Department of Law testimony on SB 24 on February 13, 1997.

1. Concerning other states that have explicit privacy provisions in their state constitutions and the status of provisions relating to parental consent or notification:

There are about nine states, in addition to Alaska, that have specific privacy protections in their constitutions. In five of these states, Arizona, Illinois, Louisiana, South Carolina, and Washington, the privacy provision is attached to the search and seizure provision of the state constitution, so that the constitutional analysis may be more involved with place privacy rights than personal privacy rights. Arizona's and Louisiana's parental consent provisions are subject to permanent injunctions in federal court and the states are appealing the cases to the U.S. Court of Appeals in their respective circuits. Illinois' parental notification provision is subject to permanent injunction in federal court and a Washington parental consent requirement was found unconstitutional in state court in 1975. South Carolina has legislated a parental consent requirement that does not appear to have been challenged in a published decision.

The other states with specific privacy provisions include California, Florida, Hawaii and Montana. In California, a state trial court found a parental consent requirement failed to meet the privacy test under the California constitution because the legislation did not actually further the proclaimed state interests. *American Academy of Pediatrics v. Lungren*, 32 Cal. Rptr. 2d 546 (Cal. App. 1 Dist. 1994). Upon review by the California Supreme Court, however, a divided court upheld the constitutionality of the parental consent requirement with a judicial bypass (*American Academy of Pediatrics v. Lungren*, 912 P.2d 1148 (Cal. 1996)), but enforcement of that provision has been stayed pending a rehearing. In Florida, the state Supreme Court held that the state interests to be advanced by the parental consent statute were not compelling, so that it failed to meet state constitutional scrutiny. *In re: T.W., A Minor*, 551 So. 2d. 1186 (Fla. 1989) *(rehearing denied)*. Montana's parental notification provision is not enforceable because the provision has been

determined unconstitutional in federal court. *Wicklund v. Salvagni*, 93 F.3d 567 (Mont. 1996). Montana has petitioned for certification to the U.S. Supreme Court. Hawaii does not appear to have an explicit parental consent or notification requirement.

2. Concerning the enforceability of certain parental consent requirements in Alaska Statutes (responding to a list of references provided in a memorandum from legislative counsel):

First, many of the statutes listed in the memorandum do not exactly require enforcement by the state or the Department of Law. In a number of instances, the listed statutes provide guidance to others who conduct programs involving minors. In the case of the criminal provisions, which are enforceable by the department, a parental consent component appears when an act that involves a minor may be considered criminal unless a parent has provided approval, such as when a minor under 16 possesses a firearm and would be guilty of misconduct involving weapons unless the minor has the consent of a parent or guardian under AS 11.61.220(a)(3). In addition to the provisions listed in law, there may be many instances in which private parties or businesses offering services to minors ask for parental permission, but this is not because of legal requirements.

However, a provision in Missouri state law that required parental consent for an abortion, without providing for a procedure that met constitutional standards to allow a minor to obtain an abortion without parental consent was determined by the U.S. Supreme Court to be unconstitutional in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 96 S. Ct. 2831, 49 L.Ed.2d 788 (1976). Because the Alaska provision set out at AS 18.10.010(a)(3) imposed a blanket restriction that is even more uncompromising than the Missouri restriction reviewed in *Danforth*, in that the Alaska provision does not make an exception for preserving the life of the mother, the Attorney General's office issued an opinion on October 21, 1976, stating that the parental consent requirement in Alaska law was clearly unconstitutional and that enforcement of that law would be a problem. Consequently, the state has not attempted to enforce a provision that is clearly unconstitutional under U.S. Supreme Court precedent.

Consequently, the major distinction between the consent requirement articulated in Alaska abortion statute and the other parental consent provisions that appear in law is that parental consent requirements in relation to abortion rights have been examined by the U.S. Supreme Court and determined to be unconstitutional. To the extent that other parental consent or permission requirements are set out in statute, they are appropriately applied or enforced unless a court has ruled they are unenforceable.

3. Concerning the requirement that the judicial bypass may be obtained only by clear and convincing evidence:

The clear and convincing burden is a higher burden of persuasion than the more familiar preponderance of the evidence burden that is generally imposed in civil proceedings. The U.S. Supreme Court has held that this standard is required in cases involving state action to deprive individual liberties, such as in a mental commitment or termination of parental rights proceeding.

McCormick on Evidence, §340 (4th ed.1992). It is considered a special standard of persuasion that also has been applied in cases involving fraud or undue influence, claims related to modifying written transactions, or "miscellaneous types of claims and defenses, varying from state to state, where there is thought to be special danger of deception, or where the court considers that the particular type of claim should be disfavored on policy grounds." *Id.*

In certain stages of child protection proceedings, such as when the state agency may be removing children from a home or terminating parental rights, a clear and convincing evidence standard is used in this state. In an emancipation proceeding, a proceeding in which a judge must make a determination of the maturity of a minor, a clear and convincing standard is not specified, so that the usual preponderance of evidence standard is applicable. In judicial bypass for parental consent proceedings in other states, the more customary standard appears to be a preponderance of the evidence, though the U.S. Supreme Court upheld a clear and convincing standard in an Ohio parental notification law in *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 110 S. Ct. 2972, 111 L.Ed.2d. 405 (1990).

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Kristen F. Bomengen
Assistant Attorney General

KFB:ebc

cc: Senate Judiciary Committee Members
Pat Pourchot, Legislative Director
Bruce Botelho, Attorney General
Deborah Behr, Assistant Attorney General
Chrystal Smith, Legal Administrator
Hon. Karen Perdue, Commissioner, Department of Health & Social Services
Elmer Lindstrom, Special Assistant, Department of Health & Social Services

RECEIVED
FEB 14 1997
Ans'd............

February 3, 1997

Senator Robin Taylor
716 West 4th Avenue
Anchorage, Alaska 99501

Dear Senator Taylor:

As Medical Director of Alaska Women's Health Services, I am very concerned about SB-24 and HB-37. I would like to tell you the real life implications of this proposed legislation. Both of these bills deal with obtaining parental consent or judicial bypass in order for a person under the age of 18 or 16 years old to have an abortion. This legislation would be bad law for a number of reasons. I have been doing abortions in Alaska for approximately 13 years, and what is clear to me is that teenagers often have a difficult time trying to bring up their pregnancy to their parents and at the time that they choose to have an abortion, they have sometimes reached a relatively advanced gestation. This delay makes the procedure more dangerous to them and, with Valley Hospital's ability to do second trimester abortions being challenged, may place them in a point in gestation when abortion services are not acceptable to them.

In addition to having difficulties bringing these issues up with their parents, teenagers are absolutely intimidated by having to ask for judicial bypass. My experience is that even for parents who have good relationships with their teenagers, bringing up the concept of abortion is quite difficult. This bill will place a significant impediment in front of these teenagers, will prevent them from getting information they need in a timely manner, and ultimately lead to more dangerous abortions in this age group and an increase in unplanned, unintended, and unwanted pregnancies.

If all families were perfect working units and all parents were supportive of their children in issues regarding teenage pregnancy, such laws would make sense. However, the reality of life is that there are many dysfunctional families, and for the teenagers who are in dysfunctional families this impediment may be insurmountable to many of them.

Thank you for taking the time to read this letter. I am available to answer any questions you have about this issue and can supply data from the Centers for Disease Control, which you may find useful. As written, this legislation puts teenagers in our State at unnecessary and increased risk. Thank you for your time.

Sincerely,

Jan Whitefield

Jan Whitefield, M.D., Ph.D.
Medical Director, Alaska Women's Health Services.
JW:FasType.jlb

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Alaska Women's Lobby

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February 16, 1997

Senator Robin Taylor
Chairman, Senate Judiciary Committee
Capital Building,. Room 30
Juneau, Alaska

Dear Senator Taylor:

Here are some statistics you requested at the last hearing on SB 24. According to my sources, after enactment of a parental involvement statute in Massachusetts, court proceedings there delayed the termination of pregnancy by as much as six weeks with no substantial impact on birth rates. In the first month of the law, teens who left the state for abortions increased by 300%; eight months after the law took effect, an average of 91 teens traveled per month.

In Minnesota, the average delay was 1 to 3 weeks, the number of teen births rose sharply and the number of abortions obtained by 15-17 year olds increased by 38.4% between 1980 (pre-law) and 1984 (after the law). The ratio of late to early abortions increased by 26.6%.

Missouri teens apparently got their abortions in Kansas. During the first three years of the Missouri law the percent of abortions obtained in Kansas rose 62%; second trimester abortions increased by 36%.

In Mississippi, a parental consent requirement increased by 19% the ratio of minors to adults who underwent their procedures after 12 weeks gestation; and while there was a small decrease in the proportion of minors who obtained abortions in the state, there was a large increase in the proportion of minors who traveled to other states to have abortions.

New York State saw a 28% increase in abortions after 13 weeks and an 8% increase after 20 weeks for minors from Massachusetts between 1981-1984.

I would also like to make a few additional comments on issues brought up during public discussion of this issue:

1. **FAMILY VALUES:** Many supporters of this legislation cite the need to bolster and reaffirm the parents right to decide what is best for their child. We agree that parents should be in charge. But, as in all things, there are case by case exceptions. In fact, we have learned from testimony that there are many exceptions in Alaska law where parental consent is not required. And what could be more appropriate for an additional exception than the unique, intensely personal experience of pregnancy?

As important, according to the AMA, there is no evidence that legislation mandating parental involvement against the wishes of the adolescent has any added benefit in improving effective family communication or changing the outcome of her decision. In the words of Judge Donald D. Alsop, Federal District Court Judge from Minnesota: "A minor's unplanned pregnancy is a crisis which is not conducive to an attempt to build good family communication."

It is ironic that under this legislation a pregnant teen cannot decide for herself whether or not to have an abortion but will continue to be considered mature enough to make all parental decisions for her newborn baby.

2. **BEST INTERESTS:** While this technically is a parental consent/judicial bypass bill, it is hard to avoid discussion of the underlying issue - abortion. Many supporters of SB 24 argue that any deliberative requirements that slow down the decision are in the best interest of the unborn fetus. This may or may not be the case. But, hasn't the Supreme Court already settled the question of abortion rights so shouldn't government leave well enough alone - directly or indirectly?

Second, what about the teen mother who runs away from home or ends up dead or injured thanks to an illegal back alley abortion because she is not willing or able talk to her parents or a judge? Shouldn't we be even more concerned about what is in her best interests? Like adults, minors have a profound need for privacy. Because this need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. At the very least, this may result in delays in seeking appropriate and timely professional advice and medical care: teenagers are twice as likely to delay the diagnosis of first trimester pregnancy, according to the American Academy of Pediatrics. This substantially increases the risk of emotional and physical harm to the teen mother.

These are never easy questions and many competing concerns must be balanced. In this case, we believe the balance tips in favor of letting the teen mother make this very personal decision, hopefully in cooperation with her parents.

3. **COMMON GROUND:** Senator Miller is right. Both sides appear to agree that society must find ways to reduce the number of abortions. He also suggests that our side never seems to like the other side's proposed solutions. He has asked for

constructive ideas that will lead us to common ground. We suspect that there never will be full agreement on the question of abortion rights and efforts to restrict those rights. But we do believe that there is potential for substantial agreement on ways to deal with the underlying problem - teen pregnancy.

The bottom line is that abortion among teenagers should be made less necessary, not more difficult and dangerous. A comprehensive approach to promoting adolescent reproductive health and reducing teenage pregnancy will require an array of components, including age appropriate health and safety education; access to confidential health services; life options programs that offer teens practical life skills and the motivation to delay sexual activity; and programs for pregnant and parenting teens that teach parenting skills and help ensure that teens finish high school.

While it has been argued by critics of this view that such programs are ineffective, the fact is that this approach has never been implemented on a significant scale in Alaska, or the United States for that matter. As a starting point for future efforts on this question, we urge you to review and initiate public discussion of the report "Three a Day: Children Having Children in Alaska" prepared in 1989 by the Senate Advisory Council.

As for improving SB 24, alternatives to judicial bypass have been adopted in other states that are worth considering. For example:

a) West Virginia allows a doctor - who must be other than the physician who will perform the abortion and who may not have any professional or financial association with that physician - to waive the state's mandatory notification requirement if he or she concludes that a minor is mature enough to make her own decisions, or that notification would not be in her best interests.

b) A 1990 Connecticut statute requires a teenager under 16 to be counseled by a doctor or other qualified professional (a psychiatrist, psychologist, social worker, family therapist, minister, physicians's assistant, nurse or guidance counselor); and,

c) a 1989 Maine statute contains similar counseling provisions. The law gives a teenager two options: obtaining parental consent or judicial authorization for an abortion, or the option of receiving extensive counseling form a qualified professional.

Thanks for your time and willingness to listen, Mr. Chairman.

Yours truly,

David E. Rogers
For the Alaska Women's Lobby

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POSITION PAPER

SB 24: Parental Consent Before Minor's Abortion

The Alaska Women's Lobby is a statewide advocacy organization representing thousands of Alaskans working toward expanded opportunities, equal access, and enhanced representation for women. The Lobby is supported solely by contributions.

The Alaska Women's Lobby opposes Senate Bill 24. We wholeheartedly encourage open and honest communication between parents and their children, and support efforts to prevent teenage pregnancy. We don't believe, however, that SB 24 will accomplish either of those goals.

Responsible parents should be involved when their young daughters face crisis pregnancies. It is the hope of every parent - liberal and conservative- that a child confronting this crisis will seek the advice and counsel of those who care for her most and know her best. In fact, most young women do turn to their parents when they are considering an abortion. We are told that in states that enforce no mandatory consent or notice requirements, more than 75% of minors under 16 involve one or both parents.

Young Women Who Do Not Involve a Parent Often Have Good Cause

Unfortunately, some women cannot or will not because they come from homes where physical violence or emotional abuse are prevalent or because their pregnancy is the result of incest or rape. There were approximately 2.9 million cases of child abuse reported in 1992 in the United States. Among minors who did not tell a parent of their abortion, 30% experienced violence in their family or feared violence or being forced to leave home. And, young women considering abortion are particularly vulnerable because family violence is often at its worst during a family member's pregnancy.

Mandatory Parental Consent and Notice Laws Endanger Health

The government cannot force healthy family communication where it does not already exist. Ironically, laws mandating parental notice or consent can actually harm the young women they are trying to protect by increasing illegal and self-

induced abortion, family violence, suicide, later abortions and unwanted childbirth. For example, In Idaho, a 13 year old sixth grade student named Spring Adams was shot to death by her father after he learned that she was to terminate a pregnancy caused by his acts of incest. In Indiana, Rebecca Bell , a young women who had a very close relationship with her parents died from an illegal abortion because she did not want her parents to know about her pregnancy but Indiana law required parental notice before she could have an legal abortion.

These views are shared by many experts. The American Medical Association takes the position that: "Physicians should not feel or be compelled to require minors to obtain consent of their parents before deciding whether to undergo an abortion...(M)inors should ultimately be allowed to decide whether parental involvement is appropriate. Because the need for privacy may be compelling, minors may be driven to disparate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain back alley abortions or resort to self-induced abortion. The desire to maintain secrecy has been one of the leading reasons for illegal abortion deaths since 1973."

They also concluded in a 1992 study that parental notice and consent laws "increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure. Although a first or second trimester abortion is far safer than childbirth, the risk of death or major complications significantly increases for each week that elapses after eight weeks."

The American Academy of Pediatrics similarly contends that : "Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care...(M)inors should not be compelled or required to involve their parents in their decisions to obtain abortions, although they should be encouraged to discuss their pregnancies with their parents and other responsible adults."

Instead of consent mandates, we believe that it makes more sense to require health practitioners to encourage young women to talk to their parents before making any final decisions.

It is interesting to note that all states have laws permitting minors to receive medical treatment for sexually transmitted diseases without parental consent, recognizing that maintaining confidentiality is essential to a minor's willingness to obtain necessary health care related to sexual activity. It is also interesting to observe that once a teen has a baby she has the right to make all the decisions for her child that her parents have a right to make for her.

Judicial Bypass Provisions Fail to Protect Young Women

Will SB 24 solve these well recognized problems by allowing teens to ask a judge

for permission to terminate their pregnancy as an an alternative to parental consent? We don' t think so. For most adults, going to court for a judicial order for any purpose is difficult. For young women, it can be an overwhelming and at times impossible, especially under these circumstances. Assuming they have reasonable access to a court in the first place, some young women will not go or delay going because they fear that the proceedings are not confidential or that they will be recognized by people at the courthouse. Many will experience general fear and distress and will not want to reveal intimate details of their personal lives to strangers. Others will not be able to attend hearings because they are in school.

Still others, victims of rape or incest, will fear the consequences of possibly having to identify the perpetrators who must under state law then be reported to the proper authorities. And if they do eventually find the courage to go to court, even under the tight deadlines proposed in this bill the time it takes to go to schedule the court proceeding and obtain a decision (not to mention appeals) may result in delays that significantly increase the health risks of the abortion

In its 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey, the U.S. Supreme Court made it clear that states may not veto a woman's decision to terminate her pregnancy, but that states could impose restrictions so long as those restrictions don't have the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion." By requiring young Alaskan women to obtain judicial approval in order to terminate a pregnancy, SB 24 creates just the kind of "substantial obstacle" the U.S. Supreme Court decision prohibits.

Making Abortion Less Necessary Among Teenagers Requires a Comprehensive Effort to Reduce Teen Pregnancy

The bottom line is that abortions among teenage should be made less necessary, not more difficult and dangerous. A comprehensive approach to promoting adolescent reproductive health and reducing teen pregnancy will require an array of components, including age appropriate health and safety education; access to confidential health services ; life options programs that offer teens practical life skills and the motivation to delay sexual activity; and programs for pregnant and parenting teens that teach parenting skills and help ensure that teens finish school. While it has been argued by critics of this view that such programs are ineffective, the fact is that such an approach has never been implemented on a significant scale in Alaska, or the United States for that matter. For more information on this subject, we encourage you to to review a 1989 report by the Senate Advisory Council for Senator Pearce entitled "Three a Day: Children Having Children in Alaska".

Conclusion

SB 24 places an untenable judicial burden on young women who, by virtue of their situation, are already facing difficult decisions. By requiring a teenager to

seek judicial redress, this bill incorrectly assumes that young women in these situations not only have the resources to seek but also the access to obtain such redress.

We understand and sympathize with the goals of SB 24's sponsors and supporters. In a perfect world, all children should talk to their parents before any decisions are made about a teenage pregnancy; and, in fact, most do. But this is not a perfect world. For a wide variety of reasons, many young women will not or cannot talk to their parents or a judge about this unique, very personal and very difficult decision.

Unfortunately, instead of transforming dysfunctional families into stable ones it will force many teens to have their father's or rapist's child, to risk their lives by having illegal or self-induced abortions, or suffer with the results of exacerbating an already troubled or dangerous home life. That is a pretty dear price to pay for a message that will not be heard by its intended audience.

For these reasons, the thousands of Alaskans represented by the Alaska Women's Lobby oppose SB 24.

Cynthia Brooke, MD
A balance of treatment
and prevention

Cynthia Brooke, M.D., F.A.C.O.G
Diplomate of the American Board of Obstetrics and Gynecology

Written testimony regarding House Bill #37 Introduced by Rep. Kelly, Kohring, Vezey and Molder. Senate Bill #24, Robin Taylor.

I would like to thank the members of the legislature for allowing me to testify both verbally and in writing. As a brief introduction, my name is Cynthia Brooke and I am a board certified Obstetrician/Gynecologist practicing in Anchorage. I did my medical school training at the University of Washington and was a WAMI student in Alaska for 3 months in the summer of 1985 and have considered myself lucky to be able to come back to Alaska to practice medicine. I did my specialty training at the University of Texas in San Antonio which is a very busy county hospital serving south Texas and central Mexico. I have been practicing Obstetrics and Gynecology in Alaska since 1992 and have been a solo practitioner in Anchorage since 1995. I am currently on the Board of Trustees of the Alaska State Medical Association and have been asked to review any legislative bills that may impact on my specialty.

Obstetrics and Gynecology is a specialty that deals with pregnancy, pregnancy complications and any medical or surgical diseases associated with female reproduction. Because of this, we also deal with infertility, hormonal disorders, pelvic anatomy dysfunction including bladder and rectal problems and pelvic tumors. Our daily interaction with patients include detailed histories which because of the nature of our specialty impacts on very private issues. We would be of little use to patients if they could not confide such private matters such as sexual dysfunction, unwanted pregnancies, inability to become pregnant, abuse issues including physical, psychological and sexual abuse and anatomical dysfunctions. The privacy of this relationship between the doctor and the patient is absolutely essential to provide appropriate treatment, care and support. Those of us who live in Alaska and understand what a small community this really is, can probably understand the importance of this confidentiality better than persons who live in more urban settings.

I have some significant concerns about this bill and most of them center around the confidentiality issues. We all know that teenage pregnancy is far too common. I deal with this issue on a daily basis. Whether or not one considers teenagers too immature to make decisions about their own health, future and reproduction; as human beings they deserve to expect the same level of confidentiality and professionalism from their health care providers as their parents would expect. I treat many families in my practice. I would never consider breaking the confidence of one of my teenage patients with one of her family members without that teenager's permission any more than I would tell the

3340 Providence Drive • Suite 459 • Anchorage Alaska 99508 • 907-563-8588

teenager of a personal issue that her mother has discussed with me. We actively encourage teenage patients to confide in their parents and the vast majority of them do. However, they do this on their own terms and I think with more honesty than in any artificial scenario I could manipulate. In this way I can keep my relationship with both the mother and daughter intact as confidant and health care provider, giving them unbiased medical facts versus being a policewoman or unwanted arbiter of family tensions.

I think you as a legislature should also know that some teenage pregnancies are the result of extremely harmful, abusive living situations in which it is not in the patient's best interest to inform one or both of her parents. Specifically in the case of incest or abuse by a mother's boyfriend or rape by a close family friend, it is sometimes unrealistic or even unwanted to inform certain family members without the patient's permission. There are some situations where this could even put the patient in harm's way. I think it is absolutely inconceivable to think that a teenager who cannot tell her parents or family members that she is pregnant would be willing to go in front of a judge and a bunch of strangers and tell them of her dysfunctional situation. I know for a fact that there are many teenagers out there who would rather die than confront relatives, friends, parents or strangers who would be disapproving of what they have done and of their situation. Anyone who works with teenage pregnant girls can tell you the risk of suicide, botched abortion attempts (sometimes even conducted by a fellow teenager) and even as evidenced recently in a case in Delaware, attempted infanticide. As you have already stated in your bill, teenagers may not always think clearly. Situations that to many adults may seem tough but not insurmountable can seem insurmountable to a teenager. They may truly feel that their life is not worth living anymore.

In my experience, teenagers with unwanted pregnancies who come from loving households do eventually tell their parents. I cannot imagine the loving parents of a teenage girl not wanting their daughter to get all the medical facts so that she can make the best decision about her own health, body and reproductive future. The fact is, she is five times more likely to die if she carries the pregnancy to term than if she has a legal first trimester termination of pregnancy. I cannot imagine loving parents forcing their daughter to make the decision one way or another that so heavily impacts on her health and her future. In my experience this does not happen. In the opposite situation when teenagers do not come from loving homes, sometimes the situation is so dysfunctional and so bizarre it is not feasible for the parents to participate in the decision making. It is these girls that are at risk with this bill. They are at risk and if this bill passes it is just a matter of time before one of them dies as a result. We have already seen this happen in Ohio. There a couple who spearheaded a similar law in Ohio requiring parental consent for teenagers to receive an abortion lost their own daughter to an illegal, botched abortion. They changed their point of view 180 degrees, but at what cost??

I have included with my testimony some statistics for you, a copy of an oath based on the Hippocratic Oath which has been adopted by the AMA that illustrates succinctly the importance of confidentiality. Whether or not you pass this law, I will not violate this oath with my patients, and I think that you will find a similar response from other physicians in my association. You can call it a misdemeanor, you can call it a felony, you can put me in jail. I need to act in the best interest of my patient. I welcome parents and other interested parties to help me with this commitment to my patients but I am realistic that sometimes relatives including parents do not have the patient's best interests at heart. It is those patients for whom I am the only advocate and if I betray them, who do they have left? We have had many examples in the past where the interference of big government, or legislators and well-meaning community members has resulted in disaster. I cannot support this bill and I have urged all members of the Alaska State Medical Association to do the same.

Sincerely,

Cynthia Brooke, M.D

Cynthia Brooke M.D.

Cynthia Brooke, MD
A balance of treatment and prevention.

Cynthia Brooke, M.D., F.A.C.O.G
Diplomate of the American Board of Obstetrics and Gynecology

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teenager of a personal issue that her mother has discussed with me. We actively encourage teenage patients to confide in their parents and the vast majority of them do. However, they do this on their own terms and I think with more honesty than in any artificial scenario I could manipulate. In this way I can keep my relationship with both the mother and daughter intact as confidant and health care provider, giving them unbiased medical facts versus being a policewoman or unwanted arbiter of family tensions.

I think you as a legislature should also know that some teenage pregnancies are the result of extremely harmful, abusive living situations in which it is not in the patient's best interest to inform one or both of her parents. Specifically in the case of incest or abuse by a mother's boyfriend or rape by a close family friend, it is sometimes unrealistic or even unwanted to inform certain family members without the patient's permission. There are some situations where this could even put the patient in harm's way. I think it is absolutely inconceivable to think that a teenager who cannot tell her parents or family members that she is pregnant would be willing to go in front of a judge and a bunch of strangers and tell them of her dysfunctional situation. I know for a fact that there are many teenagers out there who would rather die than confront relatives, friends, parents or strangers who would be disapproving of what they have done and of their situation. Anyone who works with teenage pregnant girls can tell you the risk of suicide, botched abortion attempts (sometimes even conducted by a fellow teenager) and even as evidenced recently in a case in Delaware, attempted infanticide. As you have already stated in your bill, teenagers may not always think clearly. Situations that to many adults may seem tough but not insurmountable can seem insurmountable to a teenager. They may truly feel that their life is not worth living anymore.

In my experience, teenagers with unwanted pregnancies who come from loving households do eventually tell their parents. I cannot imagine the loving parents of a teenage girl not wanting their daughter to get all the medical facts so that she can make the best decision about her own health, body and reproductive future. The fact is, she is five times more likely to die if she carries the pregnancy to term than if she has a legal first trimester termination of pregnancy. I cannot imagine loving parents forcing their daughter to make the decision one way or another that so heavily impacts on her health and her future. In my experience this does not happen. In the opposite situation when teenagers do not come from loving homes, sometimes the situation is so dysfunctional and so bizarre it is not feasible for the parents to participate in the decision making. It is these girls that are at risk with this bill. They are at risk and if this bill passes it is just a matter of time before one of them dies as a result. We have already seen this happen in Ohio. There a couple who spearheaded a similar law in Ohio requiring parental consent for teenagers to receive an abortion lost their own daughter to an illegal, botched abortion. They changed their point of view 180 degrees, but at what cost??

I have included with my testimony some statistics for you, a copy of an oath based on the Hippocratic Oath which has been adopted by the AMA that illustrates succinctly the importance of confidentiality. Whether or not you pass this law, I will not violate this oath with my patients, and I think that you will find a similar response from other physicians in my association. You can call it a misdemeanor, you can call it a felony, you can put me in jail. I need to act in the best interest of my patient. I welcome parents and other interested parties to help me with this commitment to my patients but I am realistic that sometimes relatives including parents do not have the patient's best interests at heart. It is those patients for whom I am the only advocate and if I betray them, who do they have left? We have had many examples in the past where the interference of big government, or legislators and well-meaning community members has resulted in disaster. I cannot support this bill and I have urged all members of the Alaska State Medical Association to do the same.

Sincerely,

Cynthia Brooke, M.D.

Cynthia Brooke M.D.

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB 24, dated 2/19/97.
bill/subject

Please remember that you can't mandate morality.

Consider that young pregnate mothers will not involve their parents unless they have a good relationship. This leaves them few choices - Remember desperation leads to drastic measures. Please do not close all doors. Please leave this decision to those who are directly involved. Please do not make l.a. long decisions for people you do not know, with out meeting these & treating these people as individuals.

Signed: Cheryl Creek
Testifier

Representing (Optional)

101 Winchester Wy
Address

907-747-3290
Phone No.

97-5807

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB 24, dated Feb 19, 1997.
bill/subject

I strongly urge you not to pass this bill.

1) Parental consent for abortion delays early terminations and increases the incidence of later term abortions.

2) Judicial by pass is very intimidating to young people and would discourage teens from early terminations, increasing the health risk to teenagers choosing to terminate a pregnancy.

3) This is part of a plan to make it harder to have abortion services available in the State of Alaska.

Signed: Jeanneth Chavez
Testifier

Representing (Optional)

PO Box 2122, Sitka AK 99835
Address

747 6127
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary Committee
committee name

committee on SB 24 - Parental Consent for Minor's Abortion, dated 2-19-97.
bill/subject

I am strongly opposed to SB 24 as a woman, mother, mental health counselor, and Advisory Council Chair for Sitka's Planned Parenthood chapter.

Family relationships are not strengthened by parental involvement laws - unhealthy families may actually be hindered by forced breach of confidentiality.

Mandating parental involvement poses health risks to teenagers because they will wait longer to inform anyone of the pregnancy.

This is part of a plan to abolish abortion in Alaska - this is a threat to Alaskans explicit right to privacy as outlined in our state Constitution.

Signed: Jeanette M. Rutherford
Testifier

Representing (Optional)

301 Moller Ave Sitka AK 99835
Address

907 747-5379
Phone No.

9/88 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the SJUD
committee name

committee on SB24, dated 2-19-97.
bill/subject

Please support SB 24. I was once the victim of an unwanted abortion, coerced by the baby's father to accomodate his fears of fatherhood. He was my husband of two months. The public health nurse in Kenai, Alaska also encouraged the abortion after delivering the positive results of the pregnancy test. I was never informed about alternatives or the physical and emotional risks, neither was the surgery explained at all. Of course, my immediate family, my parents included, never knew. Even though I was newly married, given the support of loving parents to help me make my decision, as well as their wisdom about getting accurate medical information, instead of the pressure to hurry and abort from the only two individuals who knew, I probably would not have chosen the abortion. It has taken many years to recover from this devastating experience. The loss of a child, the regret, the guilt are now a permanent part of my life.

A teen should never approach a decision about abortion abruptly and without adult supervision, especially from those who care most about her, i.e., her parents. Many teens have died in this country. Many more are suffering from infertility, breast cancer, self-abuse and thoughts of suicide. Parental consent is not aimed at obstructing privacy or rights, as if abortions were beneficial in some way, but is necessary to protect minors' vulnerability to coercion, unscrupulous doctors and the trauma of a medical procedure that takes a life and threatens the well-being of the patient.

Signed: Rebecca L Perry
Testifier

Kenai-Soldotna Right to Life
Representing (Optional)

PO Box 3623, Soldotna, 99669
Address

260 - 3887

Alaska State Legislature

Please enter into the record my testimony to the SJUD
committee name

committee on SB 24, dated 2-19-97.

I am Elizabeth Barry, 39 y.o. wife + stepmother of 3 teenagers, 2 still living at home. I hold a license as a paraprofessional in the mental Health field.

I support SB 24 This is an issue of parental rights and responsibilities not an issue of abortion rights or privacy rights.

This undoubtedly would not be such a hotly debated topic if the Bill was called SB24 "Parental Consent Before Minor's Surgery".

According to AK. Statutes, parents are legally responsible for their minor children until they reach the age of majority which in Alaska is 18 years old. Parents also have the legal authority and legal responsibility for their minor childrens actions. (There are cases that the responsibility extends beyond 18 y.o.) Parents are held accountable for the misdeeds of their minor children as well and this merely how minors are subject to the authority of his or her parents. As of 1-31-97 we had thirty-one Bills in the State House + Senate pertaining specifically to minors because minors legally come under different authority than adults.

On the issue of minors with abusive parents fearing further parental abuse and the intimidation of facing the judicial bypass procedure on her own being to intimidating: AK Statute 47.10.010 "Delinquent Minors and Children in Need of Aid" is already in place and active. I believe most minors in Jr. High + High School realize that any abuse by parents or guardians reported by a student to a school official must be reported to DFYS. + then must be followed up on. If an abusive situation is discovered and the minor is removed from her home + placed in foster care,

Signed: Elizabeth Barry
Testifier

Representing (Optional)

P.O. Box 3514 Soldotna, AK 99669
Address

262-9790
Phone No.

9/85 Legislative Information Office

she receives a caring, supportive home and all of the legal representation and assistance she could need.

On the issue of emotional and psychological consequences: Even if an abortion has been performed safely the emotional and psychological consequences can be devistating, teens have simply not been on the planet long enough to understand about this aspect of life, long range consequences. Even though it has been stated at these conferences that 98% of women claim they would repeat their abortion, I question if they were asked this during an initial period of relief following a crisis once it was seemingly resolved, or if asked many years later. A ministry called "Open Arms" created specifically to aid women suffering emotional consequences of abortion, states 94% of women they come into contact with said if they were properly informed of the fetal development prior to having their abortions, they would not have carried through with it. In one hour on the telephone on Friday 2-14-97 I contacted fourteen organizations that offer aid or referals to aid to women seeking help with post abortion stress. One was a Crisis Pregnancy Center that offers counseling at all of its 3,000 centers nationwide. There are 16 groups on the internet that offer assistance for this. And yes, I am aware that the A.P.A. and A.M.A. do not officially recognize any such problem. Especially since Dr. C.E. Koop was so grossly misquoted in the 1980'S. Please note what Dr. Koop said in an interview in the "Rutherford Institute Magazine, Spr. 1989:

"Instead of saying 'the Surgeon General could not find sufficient evidence to issue a scientifically statistically accurate report that could not be assailed,' the Associated Press said,

"He could find no evidence.' I know there are detrimental effects [from abortion]. I have counseled women with this problem over the last fifteen years. There is no doubt about it."...
When I got home, my wife was in a frenzy. "You won't believe what they are saying on television," she said. "Rather said it, Brokaw said it, Jennings said it, that you had not been able to find any evidence that there are psychological effects of abortion."

"So that's where it all began. And I spent that entire night on the telephone, until about one o'clock in the morning, doing as much damage control as I could."

I urge you to please vote in favor of parental rights so parents can take their responsibility and continue to do all in their power to protect their children.

A list of Organizations I contacted or was referred to:

Project Rachael - through Catholic Charities 1800-CARE-002
CARE NET - 703-478-5661 - 1800-395-HELP
ABC Crisis Pregnancy Center - Kenai, AK.
Open Arms - 314-449-7672
Post Abortion Ministries - Tenn. 901-837-3343
Last Harvest - 800-422-4542
Institute for Pregnancy Law - 603-431-1904
American Rights Coalition - 904-474-1091
Legal Action for Women - 1145 Candlewood Circle Pensacola, FLA 32514
BirthRight 800550-4900
National Office for Post Abortion Support Services 1800-593-2273
Nurturing Network - 800-TNN-4MOM
Americans United for Life 800-626-6149
Alaska Woman's Resource Center - 276-0528

E. BARRY 3 of 3

Alaska State Legislature

Please enter into the record my testimony to the SJUD committee name

committee on SB24 bill/subject, dated 2-19-97.

I am a fifteen year old boy, and I am in favor of SB#24. I think it will give the parents more of their God given rights back that the parents have so gradually given away. This will promote a more stable and united family. It will make teens more responsible with their sex life knowing that they will have to be accountable to their parents about abortion if that is what the teen wants. This will allow the parents to tell their teens of some abortion risks that teens need to know. Please do not take away the rights of parents, ~~because~~ in doing so you will be taking away my future rights as a parent. Please vote in favor of SB#24.

Signed: Connor Barry
Testifier

Representing (Optional)

P.O.Box 3514 Soldotna, AK 99669
Address

(907)-262-9790
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the SJUD committee name

committee on SB24 bill/subject, dated 2-19-97.

I am a seventeen year old girl in favor of SB24 for many reasons. I believe that parental rights, responsibility, safety, and not abortion are the issues.

I do not see the difference between a surgery and abortion. Parental consent is manditory for a minor to have surgery. What makes abortion so different? It is a medical surgery. Many argue that it is of a different nature and that girls need privacy. If so, then, I believe we have a whole lot of private things to get out of media. Some argue that family communication cannot be legislated. I say what about the laws that require minors to notify their parents about speeding tickets. Is this trying to enforce family communication? Just because the communication might not work the way the state thinks would be prime, the state still knows that it is the responsible thing to do. If it is

Signed: Chelsea Bagoy
Testifier

Representing (Optional)

PO Box 3514
Address

Soldotna, AK 99669 907-262-9700
Phone No.

1 of 3

~~such~~ a different private nature than why do we have illicit sex shown across the country to young and old alike on television? It doesn't take a rocket scientist to figure out the natural progression of things after sex. The girl would get pregnant and do one of three things: have the baby and rear it; have the baby and put it up for adoption (with two million couples waiting to adopt a child in the U.S. I would say that our country is not against adoption), or have an abortion. Abortion is not a new or unknown idea. It still can be private within the family.

Just yesterday a trained counselor from a crisis pregnancy center asked me a few basic questions about my medical history. "Are you allergic to penicillin? When was your last tetanus shot? Do you have Rh?" I had absolutely no idea and immediately turned to my stepmom, who was present for the answers. I am seventeen. Some of these thirteen and fourteen year old girls going in to get abortions without their parents will most likely not know this information that is imperative for the safety of the girl. My great aunt almost died due to an allergic reaction to a dose of penicillin.

We need to take a serious look at the health consequences down the road. The initial response of a girl after the abortion is relief but nobody talks about after that. What about girls who have had abortions having miscarrages because of the torn, damaged ~~mus~~cles of the

cervix caused by the abortions? What about all the infertility caused by scarring inside the uterus after abortions? What about breast cancer? Researchers at Penn State University discovered in an analysis of twentythree studies from around the world of cases dating back to 1957 that women are much more prone to breast cancer in later years after abortions. What about the psychological aspect? There are sixteen support groups on the internet alone for post abortion stress. To me that implies that it does affect a girl after the abortion and not just in a physical way.

Being at the end of the age group that this bill refers to I plead with you to help protect the girls who I am representing. Girls need to have independance, however, we have enough trouble already making small decisions, and do need that loving, holding hand to depend on. Don't leave your daughters alone on this, parental involvement is crucial. Please vote for SB24.

Chelsea Barry 3 of 3

Alaska State Legislature

RECEIVED
FEB 14 1997
Ans'd..........

Please enter into the record my testimony to the JUDICIARY committee name

committee on SB-24 / Parental Consent (Minor Abortion), dated 02-13-97. bill/subject

AT AGE 22, I HAD MY FIRST ABORTION. STATISTICS REPORT A HIGH PERCENTAGE RATE FOR REPEAT ABORTION. IT'S TRUE. SIX MONTHS LATER I HAD A SECOND ABORTION. THESE PROCEDURES MADE A PROFOUND IMPACT ON MY LIFE. NOT ONLY WAS I LEFT EMOTIONALLY NUMB, BUT THIS SET A PATTERN FOR SUBSEQUENT DECISION MAKING IN THE YEARS YET TO COME.

I EXPERIENCED MANY OF THE UNHEALTHY ASPECTS ABORTION BRINGS TO A WOMAN'S LIFE. MY SELF-ESTEEM PLUMMETED. A PROLONGED, DEEP DEPRESSION SETTLED OVER ME. SECRETLY, I WAS ASHAMED OF WHAT I HAD DONE TO MY BABIES. AND, I SOON RECOGNIZED A COMPLETE DISLIKE OF MEN FOR MANY, MANY YEARS I FOUND NO ONE WITH WHOM I COULD DISCUSS THIS INCREDIBLE TURMOIL WITHIN ME. I'D BECOME EMOTIONALLY NUMB AND VOID OF HAPPINESS.

NOW, I AM 45 YEARS OF AGE AND HAVE SUCCESSFULLY MADE MANY GOOD & HEALTHY LIFESTYLE CHANGES. HOWEVER, THERE IS AN ACCOUNTABILITY FOR THOSE DECISIONS MADE IN MY YOUTH. I HAVE NO GRANDCHILDREN IN MY LIFE BECAUSE THERE ARE NO CHILDREN. ALWAYS THERE ARE HOLLOW REMINDERS OF THIS DURING CHRISTMAS AND BIRTHDAY MILESTONES... EVEN HIGH SCHOOL GRADUATIONS.

IF I FIRST MADE THIS DECISION TO ABORT MY BABY (BABIES) ALONE AT AGE 22, AND QUIETLY GRIEVED OVER THIS MOST OF MY ADULT LIFE, HOW CAN WE ASSUME A GIRL OF 13, 14, OR 15 CAN COPE WITH THIS? WOULD YOU HOPE FOR THE SAME SAD LEGACY YOUR YOUNG DAUGHTERS TO REAP? REGARDLESS OF THE DECISION TO KEEP THE CHILD OR END THE LIFE, IT IS OF UTMOST IMPORTANCE THAT THERE IS STRONG PARENTAL INVOLVEMENT HERE.

ABORTION IS A VERY LONELY CALL TO MAKE - IT CAN CAUSE A QUIET DESPERATION DEEP WITHIN... PROTECT YOUR DAUGHTERS, SUPPORT SB-24.

Signed: Teresa Lundy
Testifier

Representing (Optional)

P.O. Box 2975 SITKA AK 99835
Address

907-747-5861 (w) 907-966-2204 (H)
Phone No.

LEGISLATIVE AFFAIRS AGENCY

DIVISION OF PUBLIC SERVICES

DATE: 2-12-97

Please accept the enclosed original(s) of written testimony for the Senate Judiciary teleconference hearing that was scheduled on 2-12-97.

A copy of this testimony was transmitted to your committee via fax on 2-12-97.

Thank you,

LEGISLATIVE AFFAIRS AGENCY
Sitka Legislative Office
210 Lake Street
Sitka, Alaska 99835
747-6276

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB 24, dated 2/12/97.
bill/subject

Signed: ______________________
Testifier

____
Representing (Optional)

____
Address

____
Phone No.

9/95 Legislative Information Office

12 February, 1997

To: Senate Judiciary Committee

Re: SB 24, Parental consent or Judicial Bypass for Minor Women

From: Natasha I. Calvin for Sitkans for Choice

Honorable Senators:

Why require a pregnant 13 year old girl to go to court to get the safest of all alternatives, i.e. a safe, legal abortion? Under former Surgeon General Koop, it was determined that carrying a pregnancy to term is 7 to 24 times as likely to cause a woman's death as a safe first trimester abortion.

Alarms raised about dangers of abortion are true for illegal, unsafe abortions, not for those performed by qualified personnel. Illegal, unsafe abortions require no parental consent or judicial bypass. It is illegal, unsafe abortions that kill women by the thousands. Roe v Wade was promulgated to protect the lives and health of women. Should we in Alaska do less for our children?

Please do not pass SB 24 out of your committee.

Thank you.

Natasha I. Calvin

Natasha I. Calvin for
Sitkans for Choice
PO Box 2966
Sitka, Alaska 99835
(907) 747- 8950

WRITTEN TESTIMONY ON SB 24

I am writing to ask the Legislature to support SB 24 which upholds the requirement of parental consent in the case of a minor seeking an abortion. This bill is necessary to support family unity and protect and support a minor in making this momentous decision. I feel it will allow parents to be more involved in their children's lives by supporting them in this critical time and helping them to make a difficult decision. The family unit and value system is chiseled away enough in our society by the media and externals that parents have no control over. Please support this piece of legislation that strives to uphold the family unit and allow parents to have a say in this vital decision that will follow their children all their lives-no matter what decision is made.

Thank you for your time.

Beverly J. Kokke

Beverly J. Kokke
'31 DeGroff
Sitka, AK 99835
966-2570

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary Committee on S.B. 24, Parental Consent before a minor receives an abortion with a judicial by pass option. dated February 1[2] 1997.

Many years ago five years after the end of the Second World War, I was living in Vienna Austria and became pregnant. My husband was having an affair and became desperate because he had convinced his girl friend that we were only living together for the sake of our three children. My husband forced me to have an abortion. This abortion was performed in a famous women's clinic by the head Doctor. Feel free to ask questions how this all came about. Now for the reasons I am telling you this:

1. I was terrified when I went into the Clinic and was terrified the whole time I was there. Young mothers to day are terrified when they go to have an abortion, they need the protection and comfort of their parents if that is their decision. And parents often want their young daughter who is already a mother, to have an abortion. Make no mistake, the mother has 2 choices, one, that they will give birth to a live baby, or, two, a dead baby.

2. After the abortion I had physical problems because my body like all other women's had naturally been nourishing the baby and preparing for child birth. The physical effects of the abortion reversed all my hormones and other physical systems violently. An abortion is not a "friendly" or a compassionate procedure. There is no way these young mothers will not experience these physical symptoms, because it is the natural progression of events.

3. Emotionally and mentally I "stuffed" the reality of what happened to me because not only did I have three small children to care for but the brutality of the whole situation was to painful to think about. Some of my problems that I have worked through are, fears of being alone in a strange place after dark, but most damaging of all is the inability to trust other people. especially men, and I am still working on that one. Know that young women who receive abortions will have the same and other problems that they will become aware of them sooner or later.

4. How many Abortions preformed in Alaska in a hospital have been bungled and the mother suffered serious injury or death and the Drs. + Hosp. hide this fact behind the privacy rights of the patient?

Finally, do not trust the false words of compassion for young mothers spoken by "experts" who are actually expressing compassion for their bank accounts. If they were truly compassionate they would be performing these services for free.

Please pass SB 24. Thank you.

Signed *Virginia C. Phillips* T
Testifier

Self
Representing(Optional)

404 Lake St., 2-D Sitka, AK 99835
Address

907-747-8024
Phone Number

2/14/97

The Honorable Robin Taylor
Chair, Senate Judiciary

Please include a copy of the following letter in the record for SB 24. Thank You.

Valdez Medical Clinic

Andrew R. Embick, M.D.
Kathleen G. Todd, M.D.
John S. Cullen, M.D.

P.O. Box 1829
Valdez, Alaska 99686

Telephone
(907) 835-4811
Telefax
(907) 835-5162

2/7/97

Pete Kelly, Representative
Alaska House of Representatives

Dear Sir;

I am adamantly opposed to parental consent laws for abortion for two reasons. First, judicial bypass is not a real option. Judges are only available on certain days or certain weeks or at great distance in much of our state. Courts are intimidating to anyone, especially a teenager. In rural Alaska they are anything but confidential, since at least one of your parents' best friends works in the building or is there getting a driver's license or checking out the job service (if not working directly for the judge!). Second, and more important, you are confusing your personal views on abortion with trying to protect children. Abortion is a medically safer procedure than having a baby. For the minor who is pregnant, abortion would be the best option if we focused only on

on abortion with trying to protect children. Abortion is a medically safer procedure than having a baby. For the minor who is pregnant, abortion would be the best option if we focused only on the physical. However, there is also a psychological and belief system focus to consider, as we both know. Some would consider abortion the only reasonable option for a pregnant 14 year old, some would never consider abortion even if the mother's life were at stake. Therefore, we need to honor each other's beliefs and let women choose. If we allow teenagers to choose to be mothers against their parents' will (this happens quite often), we must also allow them to have abortions against their parents' will. If not, fair play demands that you also legislate that all those less than 18 get parental permission to carry to term!

Kathleen A. Todd MD

FAX TRANSMISSION

TO: Senate Judiciary

FAX: 1-907-465-3922

DATE: 2-12-97

MESSAGE:

1 page to follow

T/C # 70249

2/12/97

ROBIN SMITH

February 3, 1997

RE: SB 24 PARENTAL CONSENT

Dear Honorable Senators:

Dealing with an unwanted pregnancy is extremely difficult. Unfortunately in the United States today, if a woman becomes pregnant there is only one acceptable choice, have the child and become a good mother. An abortion is considered heinous and society does not really accept giving up a child as a wonderful, loving act. (We prosecute parents who abandon a child at someone's door.)

What position do we really put women in who have an unwanted pregnancy. If a woman feels cornered and threatened her actions can become extreme. Examples are numerous: The young couple who recently may have killed their new born and Jerry Sander's unwanted grandchild who died of starvation. Abortion was not chosen and the results were deadly. In both cases I am sure the couples' parents wanted to help their (older) children through their desperation. It did not happen. The communication process was not there.

You cannot legislate family interaction. I understand your good intentions. I pray for good family communication. I prefer birth control or abstinence to abortion. But when abortion is not readily accessible, dangerous back alley procedures befall and worse.

The way to reduce abortion is to reduce unwanted pregnancy. I *implore* you to spend your time and effort in this direction. All research shows the vast majority of Americans support more money spent on family planning. Community involvement in a parent/child relation program is another possibility, or required high school community service programs.

We are wasting time, energy, money and losing goodwill in this ongoing debate over abortion. Please use your religious convictions for the common good and address the prevention of unwanted pregnancies not the consequences. After all, women are capable of making their own decisions.

Sincerely,

14100 Jarvi Drive
Anchorage, AK 99515
345-4407

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Sen Taylor	From Anch LIO
Co. (S) Jud	Co.
Dept.	Phone # 258-8111
Fax # 465-3922	Fax #

Written (T) SB 24

Regarding Senate Bill No. 24
Regarding House Bill No. 37

Wednesday, February 12,1997
Thursday, February 13, 1997

"Parental Consent of Minors Seeking Abortion"

My name is Sharylee Zachary,

My husband, Dan, and I have 3 daughters, ages 7, 9, & 11.

We have already sent in written and oral testimony regarding our concerns about this vital issue of parental rights in guiding the health care of our children and medical procedures performed on them, - especially when done without our knowledge. So I will keep this short.

It is important that our Alaskan laws are so designed as to strengthen the family unit and make it possible for the family to work through problems and crisis together. It is neither beneficial to the family nor to Alaska to allow for a situation in which people outside of the family step in-between the parent and child when a child is faced with a situation as serious as a pregnancy. This type of situation allows others to convince the child to keep secrets from their family and allows others to tell the child that they will help them out of the situation, which, - in this case results in the death of a viable baby. This situation, also, does nothing to teach or support the child in taking responsibility for their actions. Our society is breeding a whole generation of people who do not take responsibility for their actions, but take the easy way out.

Minors do not have the maturity to make such decisions on their own. Minors need the wisdom and support of their parents in order to make decisions for life and for taking responsibility for their actions.

We are grateful that this bill is designed to strongly recognize the rights of the family and the parents to support their children through such a crisis and to guide them in making wise decisions for both themselves and their unborn babies.

Very Sincerely and respectfully,

Sharylee M Zachary

Sharylee Zachary
Box 1531
Petersburg, AK 99833
907-772-3681

Question: Does this bill also allow a minor to go to the court to get consent to have the baby - when a parent, guardian, etc., wants to force her to have an abortion?

TOTAL P.02

February 16, 1997

Senator Robyn Taylor
Chair, Sen Judiciary
Capitol Bldg
Juneau AK 99811

Dear Senator Taylor and Members of Senate Judiciary:

I am a voter in House District 26, Senate District M. I am writing this letter to let you know that I am opposed to CSHB37 concerning parental consent for abortion for girls under the age of 18. My reasons are listed below.

1) Apparently the legislature hopes this bill will compel family communication and reduce the numbers of teen pregnancy and abortion. However, statistics from other states make it clear that this type legislation will likely serve no such purpose.

I obtained some information from Planned Parenthood and learned that in Michigan a similar law was passed and the teen pregnancy rates actually increased by over 5%.

As for teen abortion rates, when a similar law was passed in Missouri, the girls went to Kansas to get their abortions. The abortion rate in Kansas rose 62%.

In Massachusetts, after a similar law was passed, the pregnant teens went to another state. During the first month of this Massachusetts law, the number of teens who left the state increased by 300%. Eight months after this law went into effect, Massachusetts teens traveled at an average of 91 a month.

In several states including New York, Missouri and Minnesota, there was a substantial increase (close to 1/3 of the cases) in late (which of course are more dangerous) abortions for teens.

2) This bill will obviously cause a cost burden and case-load burden to the courts. There will be a need to monitor the time lines for the cases and to provide an attorney in most, if not all, cases. I understand there is a fiscal

note with this bill, but I wonder if it will be large enough to cover the costs involved. I keep hearing that the courts are already overburdened with case-load and I wonder what the overall fiscal impact really is. I also wonder if this legislation will effect other peoples rights to a speedy trial.

3) I think this legislation is unnecessary particularly in light of the information provided by the Chicago Attorney, Ms Kohler (spell?) that was presented at the February 11th SA hearing on this matter. She stated that only a very small number of girls who petitioned the court for abortion without consent were denied (I recall it was around 60 out of over 3,600 — I'm not exactly sure of the numbers, but this is close). The rest of them were successful in their petition. It seems that the court expenses involved here are not worth the trouble.

It is also my understanding that the greater majority of young girls in this state already obtain parental consent before they abort a fetus anyway.

This legislation appears to attempt to get teenagers to talk to their parents and this should be handled through good parenting skills that would include dialog about sex before marriage.

4) We have all heard stories about how some girls would literally rather die than to tell their parents they are pregnant and many of them do through suicide and self abortion or they arrange illegal life-threatening abortions performed by incompetent people.

There must be a provision included in this bill to assure protection of the girls who reluctantly come forward to their parents. There should also be some assurance that girls who are emancipated by their parents as a result of the pregnancy or the request for abortion are able to obtain some type of public assistance to assure their survival.

5) The legislation places the entire burden of the episode directly on the shoulders and minds of the girls and their families and the males apparently do not have to take any responsibility for impregnating them.

The boy involved must also be required to notify his parents, and he and his parents must take responsibility (including financial responsibility) in the matter. Keeping in mind, of course, the ultimate decision lies with the one whose body it is that is carrying the fetus.

6) Our bodies are our own and each person should be able to make decisions (especially medical decisions) on his or her own.

7) Shades of discrimination creep up in this bill. Not only toward the female population but perhaps Alaskan Natives and others who live in rural areas and are unable to obtain court petitions and assistance that we enjoy in the larger cities.

In closing, I am sure there are a number of other issues that I have not addressed such as the impact on the medical community, school officials, individual rights of privacy, etc., but I hope the information I have provided will encourage you to withdraw this legislation from the process.

I very much appreciate your consideration of my views on this important legislation.

Sincerely,

Sue Doggett

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February 19, 1997

Kimberly Miller
3320 Nowell Ave., Apt. 4
Juneau, AK 99801
586-1569

Senator Robin Taylor
State Capitol Rm. 30
Juneau, AK 99801

Dear Senator Taylor:

I am writing to express my strong opposition to SB 24 regarding requiring parental consent for minors seeking an abortion. I feel that SB 24 is an attempt to end safe and legal abortions by erecting insurmountable barriers for young women. The argument that SB 24 would enhance teem-parent communication is inaccurate. The following is a list of reasons why I am adamantly opposed to SB 24:

* Studies have shown that nationally the majority (61%) of minors who have abortions do so with at least the knowledge of one parent. The younger the minor the more likely she is to voluntarily discuss the abortion with a parent. The study looked at states without parental consent laws.

* Studies have shown that parental consent laws do not encourage young women to tell their parents. The minority of minors who do not tell their parents come from families where communication is difficult or dangerous due to a variety of circumstances. The belief that telling their parents would result in further abuse, family violence or increased drug/alcohol use for example is real. Thus, SB 24 would act to further victimize these young women.

* The judicial bypass process is not an adequate safety valve for these young women. The judicial process can be a fearful, anxiety and shame producing experience where a young woman who is already in a vulnerable and difficult situation is subjected to further barriers in finding a resolution to her situation. The judicial system is not an appropriate venue for this type of decision to be made.

* Minors in rural Alaska will have to maneuver additional obstacles to receive a safe and legal abortion if SB 24 is enacted. If the young woman's situation was such that she could not tell her parents she would be forced to go to a local judge who more that likely knows her to seek a judicial bypass. The process, coupled with the fact that she already has to travel to a strange place to receive an abortion, makes young women in rural communities even more penalized by SB 24.

The net effect of SB 24 will be to chip away at women's legal right for a safe abortion. After enacting a parental consent law in Minnesota the state had a 18% increase in second-trimester abortions among minors, and the birth rate in Minneapolis for 15-17 year olds increased by 38.4%. These statistics show how detrimental SB 24 will be for Alaskan's. I urge you to take Alaska in a safe, healthy and positive direction rather than cause more hardship for Alaska's children and families.

Thank you,
Kimberly Miller, MSW

Robert G. Thompson, M.D., F.A.C.O.G.
Reproductive Surgeon - Society of Reproductive Surgeons
Diplomate - American Board of Obstetrics and Gynecology

FAX: (907) 465-3973

Catherine A. Thompson, R.N., M.S.N.
Advanced Nurse Practitioner

February 18, 1997

The Honorable Loren Leman
Senator - State of Alaska
Juneau, Alaska 99811

ATTENTION: Mike Pauley

Re: Written Testimony
SB 24 and HB 37

Dear Senator Leman and Judiciary Committee Members:

My name is Robert Thompson. I am a physician and surgeon specializing in obstetrics, gynecology, infertility, and reproductive surgery. I've read numerous other testimonies of other physicians, colleges, societies, and organizations regarding the issue of parental consent for minors before proceeding with an elective surgical procedure, in this case, as an "abortion." There seems to be three major objections physicians and various organizations have in regards to accepting this bill.

First, the legal obligations and consequences of violating this obligation. Being a practicing physician does not exempt physicians of the numerous and extensive responsibilities to the law and the numerous consequences for violations to such responsibility within the practice of medicine. Any argument with regards to criminalization versus aspects of practicing medicine need only to be considered in this light. It is difficult for me to understand why a surgical procedure such as abortion could have ever come to be considered an exempt procedure for parental consent when its consequences can include significant life-threatening and permanent complications which could include death, sterility, infection, and psychological difficulties. While these complications are usually considered to be fairly rare, they exist. The treatment of complications after an abortion is completed would also require parental consent, therefore, I feel it is in the best interest of a physician practicing medicine to involve a responsible guardian or parent in the consent for this surgical procedure.

The second objection involves physician concerns about breach of confidentiality. Again, this is an exceedingly weak argument and continues to be so in all levels of the practice of medicine. It remains the patient's (that is the teenager) responsibility to inform and involve the parents with regards to the diagnosis and treatment of this medical problem.

A Professional Corporation, 4001 Dale Street, Suite 117, Anchorage, Alaska 99508
(907) 562-5328, FAX (907) 562-4363, Fertility (907) 562-3562

As a loving father, I cannot imagine not being able to be there to support and help with my daughter's decisions in this regard. While I recognize that this is not the attitude that all parents take, I have to believe it is the ideal and standard with which society should expect from parents, not an attitude of judgement.

In summary, in no place in this bill does the confidentiality of the physician/patient relationship necessarily have to be abridged by the physician. It remains the minor(s) responsibility to be involved with the parent(s) or legal guardian and the court when such a decision regarding this surgical procedure is deemed necessary.

Finally, the question which has not been completely considered is that of "informed consent." The courts have consistently upheld the right of the parents to be responsible for medical care and decisions regarding their minor child(ren) with regards to surgical procedures. In a large manner, this may be considered to be contributed to by the ability of adults to help assure adequate, informed decisionmaking. Part of becoming an adult is learning to accept the consequences of our decisions. Part of being a parent is to allow our child(ren) to begin to make decisions and to learn to accept the consequences and responsibility for those decisions. Hopefully, this bill will stand on its own merit, continuing to re-inject a balance of responsibility on physicians and parents with regards to the impact of sexuality and teenage pregnancy on our society and to begin to respond accordingly.

I hope this information is helpful and encouraging to the adoption of this bill on the simple premise that parental guidance is desirable in our society.

Very truly yours,

Robert G. Thompson, M.D.

Robert G. Thompson, M.D., FACOG
Reproductive Surgeon

P.S. I've left out all the statistics.

Dr. Ilona J. Hodson Farr, M.D.
3945 Geneva Place
Anchorage AK 99508-5033

February 18, 1997

Senator Loren Leman
Alaska State Capitol Building
Room 115
Juneau AK 99801

Dear Senator Leman:

I am a female family physician, practicing in Anchorage. I have been licensed to practice medicine since 1986. I am writing to offer my professional medical opinion in support of SB 24 and HB 37, which require parental consent for abortions in women under 18 years of age. I think it is very important for parents to be involved in this life changing process.

I think this would deter some teen pregnancies, as abortion could no longer be used as a secret form of birth control behind parent's backs -- often teens are rushed into this procedure because of shock, fear, and time constraints and aren't aware of the true ramifications of this procedure.

Many teens seek abortions because of fear of parental reaction. Yes, parents are often initially shocked, angry, and embarrassed when their teens get pregnant; but most of them end up helping during and after pregnancy, and look forward to their grandchildren. Many teens want to keep their babies, but only choose abortion because of pressure from boyfriends or fear of parental reaction. Often it isn't what they truly want. Many end up pregnant again soon after an abortion because of depression, and guilt feelings about destroying their previous unborn children. This depression often recurs throughout their life.

Some women end up with fertility problems later in life because of problems related to abortions, including scarring from the procedure itself, infections related to the procedure, or cervical incompetence (which causes problems in carrying future pregnancies). Also, the severe emotional trauma associated with the termination of a pregnancy.

I find it hard to believe that parents are not involved in the decision involving a surgical procedure on the children they are legally responsible for. The risk of death from a termination (i.e., an abortion) is 1 to 2 per 100,000 abortions, which can increase to about 115 per 100,000 abortions with termination later in pregnancy, once the baby is more fully developed. The risk of perforations of the uterus, which can result in hemorrhage, injury to the bowel, infections, and may result in hysterectomy or death is 1 per 1,000. Also, patients

can have adverse reactions to anesthetics, ranging from syncopy to convulsions to anaphylaxis with death. Women can bleed severely, often requiring IV fluids blood transfusions which increase the risk of acquiring HIV, hepatitis, CMV, and other blood borne diseases. Abortion is not a benign procedure and parental consent should be required, like it is for all other surgeries.

I am not against all abortions, as there are many medical reasons for them, but I feel strongly that women should have parental consent before undergoing them and counseling from a neutral agency showing what abortion does to a baby, what parental responsibilities they will face caring for a child, and their options regarding adoption. For rural areas, a video could be used to convey this information followed by counseling from maternal child health nurses, public health nurses, or even village health aides. Enforcement of child support laws against teenage males would also force them to take responsibility, and likewise help decrease teenage pregnancy rates.

In summary, I am in favor of parental consent as I feel it would help deter teenage pregnancies; help teens make the wisest choices for themselves and their families; help prevent decisions to have an abortion based upon the shock, fear, and initial panic reactions to pregnancy that teens commonly have; and prevent teenagers from making an uninformed and ill advised decision to undergo a serious medical procedure which can potentially be fatal, or result in life-long medical and/or mental problems. If you have any questions, I can be reached at my work phone number which is (907)562-2070.

Sincerely,

Ilona J. Hodson Farr, M.D.

cc: file

IRENE S. LOHKAMP, M.D.
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February 16, 1997 Reference: S.B. 24

Dear Senator Leman:

I am a physician in private practice specializing in family medicine. I naturally treat many children and adolescents on a daily basis. I need parental consent in order to even evaluate a minor, much less perform a procedure.

It is totally incongruous to me that our State should allow an abortion to be performed upon an adolescent or younger child without parental consent. I have found that children even as old as 18 frequently cannot tell me their drug allergies or other details of their medical history.

Teens and preteens tend to be short sighted in highly stressful situations for many reasons, such as fear of immediate consequences, with less appreciation of long term consequences. I have counseled teens with a crisis pregnancy. Abortion at those times is a quick fix; risks seem unimportant and something that "won't happen to me."

An unemancipated teen requires parental consent to allow me to pierce their ears or take off a mole-very minor procedures which are relatively very low risk. Abortion has serious potential risks that can affect a young girl well into her adulthood. As you know, in addition to the immediate risk of infection, bleeding and perforation, there are long term effects such as the increased risk of ectopic pregnancy and infertility, and possibly even an increased risk of breast cancer-not to mention the possibility of a post traumatic stress type syndrome which frequently occurs as late as 7-12 years after abortion.

Parents must be required to consent to operative procedures performed upon their children-abortion certainly should not be an exception. There is of course judicial bypass for children who are truly endangered by parental disclosure.

There is another effect upon public health which parental consent for abortion has repeatedly caused, that should not be minimized. States which require parental consent have lower teen pregnancy rates. Isn't it time to do something that will lower the teen pregnancy rate for a change.

Sincerely yours,

Irene Lohkamp MD

Irene Lohkamp, M.D.

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Diplomate, American Board of Family Practice

CHARLES E. MANWILLER, M.D.
Diplomate, American Board of Family Practice

Senator Loren Leman
Alaska State Capitol Building
Room 115
Juneau, Alaska 99801

February 18, 1997

Dear Senator Leman:

My name is Charles Manwiller, M.D. I have practiced medicine in Anchorage since 1965; I delivered babies until ten years ago. I am a family doctor.

I am writing to state my position on Senate Bill 24. It is my understanding that this bill will facilitate the involvement of parents in the decision of a teenage girl (under age 18) to have an abortion.
I am in favor of this legislation for the following reasons:

1. An abortion is not without potential complications. A girl's parents have a responsibility to know about and approve a procedure which has medical and emotional impact on a minor daughter.

2. Confidentiality between child and parent, though applicable in the arena of sexually transmitted disease, should be waved in abortion. The parents need to know. Abortion involves the destruction of human life. The unborn baby might have infinite value as a future member of the family.

3. I propose that avoidance of parental involvement at this critical time in a teenager's life, while at the moment seemingly less threatening to the pregnant teen, ultimately is more divisive than constructive in the parent-daughter relationship.

4. Medical personnel are quite concerned about obtaining parental consent before treating a minor in almost every situation. Should an event containing the profound significance of an abortion be any less deserving of parental approval?

Thank you for your concern regarding this important family related issue.

Sincerely yours,

Charles E. Manwiller, M.D.

Charles E. Manwiller, M.D.

SENT BY: LE MAYER+MANWILLER; 2- 8-97 9:54; 9075633732 => 9074653810 99; #1/1

This statement has been sent to members of the House Appropriations Committee in anticipation of an amendment to require parental consent or notification for Title X services.

The undersigned organizations OPPOSE mandatory parental consent or notification requirements for teens receiving services at Title X-funded family planning clinics.

Advocates for Youth
American Academy of Family Physicians
American Academy of Pediatrics
American Association of University Women
American Civil Liberties Union
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American Jewish Committee
American Jewish Congress
American Medical Women's Association
American Nurses Association
American Psychological Association
American Public Health Association
American Social Health Association
American Society for Reproductive Medicine
Association of Maternal and Child Health Programs
Association of Reproductive Health Professionals
Association of Schools of Public Health
Association of State and Territorial Health Officials
Center for Reproductive Law and Policy
Center for Women Policy Studies
Child Welfare League of America
Family Planning Councils of America, Inc.
National Abortion and Reproductive Rights Action League
National Association of Nurse Practitioners in Reproductive Health
National Council of Jewish Women
National Family Planning and Reproductive Health Association
National Latina Institute for Reproductive Health (NLIRH)
National Organization for Women
National Organization for Women Foundation
National Women's Law Center
NOW Legal Defense and Education Fund
People For the American Way Action Fund
Planned Parenthood Federation of America
Sexuality Information and Education Council of the United States
The Alan Guttmacher Institute
Union of American Hebrew Congregations
United Methodist Church, General Board of Church and Society
Voters For Choice
Women's Legal Defense Fund
YWCA of the U.S.A.
Zero Population Growth

June 5, 1996

Nos. 88-1125, 88-1309

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

JANE HODGSON, M.D., *et al.*,
Petitioners, Cross-Respondents,

v.

STATE OF MINNESOTA, *et al.*,
Resondents, Cross-Petitioners.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

---

BRIEF OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (AAPS) AS *AMICUS CURIAE* IN SUPPORT OF STATE OF MINNESOTA

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October 10, 1989

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

Nos. 88-1125, 88-1309

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BRIEF OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (AAPS) AS *AMICUS CURIAE* IN SUPPORT OF STATE OF MINNESOTA

INTEREST OF THE *AMICUS CURIAE* *

The Association of American Physicians and Surgeons, Inc. (AAPS), a not-for-profit corporation, is the largest association of private practicing physicians in the United States. AAPS is comprised of active, practicing physicians and osteopaths of all specialties, from every state and territory in the United States and the District of

---

* This brief is filed with the written consent of the parties, copies of which have been filed with the Clerk of this Court.

Columbia. One purpose of the AAPS is to protect and preserve the private practice of medicine in all of its aspects. AAPS supports the right of patients, both adults and minors, to be provided full and accurate medical information with which to render informed decisions pertaining to their medical treatment. The AAPS recognizes the importance of involving parents in the medical treatment of minors, particularly in the provision of surgical procedures. Many of the members of the AAPS are pediatricians and obstetricians/gynecologists who routinely provide medical services to minors. In addition, many AAPS members are family practitioners whose practices involve working with the family, as a unit, in the provision of medical treatment. For these reasons, the issues involved in this case are of acute interest to the Association.

SUMMARY OF ARGUMENT

In this challenge to the Minnesota parental notice of abortion law, as applied, Minnesota abortion clinics and physicians have launched a selective attack to overturn this Court's decisions in *H.L. v. Matheson*, 450 U.S. 398 (1981), *Bellotti v. Baird*, 443 U.S. 622 (1979), and *Planned Parenthood v. Ashcroft*, 462 U.S. 476 (1983), as well as the constitutional principle that parents have fundamental rights to rear and raise their minor daughters in the area of abortion decision-making. The clinics' record in this case focuses exclusively on a minute subsection of Minnesota teens—those who sought elective abortions through judicial bypass—constituting only 25% of all pregnant teens and never more than .31% of the entire population of Minnesota teens aged 10-17. The clinics attempt to establish the unremarkable proposition that parents and teenagers do not always see eye to eye on teens' activities, that some parents may be abusive, that parents may react with grief, fear, or anger when they suddenly discover that their minor, unwed daughter is unexpectedly pregnant, and that this discovery may

not improve but may harm the parent-teen relationship. The record contains several stories of sad and unfortunate relations between parents and their children. But these conflicts are part and parcel of the parent-child relationship throughout history, and, as part of that relationship, have defined parental authority throughout Anglo-American law. In this sense, adolescent pregnancy is no different than many other serious, adverse events in the lives of teenagers and their families—for example, drug abuse, juvenile delinquency, or failure in school. It is in these very circumstances that parental authority is defined by the law's reaffirmation and support.

If the clinics could show that the notice law resulted in tangible threats to the health of minors generally in Minnesota above and beyond that normally posed by pregnancy and elective abortion themselves—that minors suffered increased abuse from parents, that physicians were prevented from providing prenatal care, or that minors were denied prenatal care, it would then be plausible for the clinics to claim that the notice law was not reasonably related to preserving parental authority or adolescent health. But this is not the case that the clinics have made.

Part of the impact of the notice law that the clinics have either selectively ignored, misconstrued, or incompletely presented is revealed through the official demographic data of the Minnesota Department of Health on adolescent pregnancy, abortion, and childbirth. These data show that teenage pregnancy, abortion, and birth rates declined markedly between 1980-1986; teens who decided to abort were not unusually delayed from having abortions until later times of pregnancy that might increase the risk of abortion; and complications from abortions performed on teens did not increase relative to other age groups. In addition, a comparison of the pregnancy, abortion, and birth rates provides strong support for the conclusion that the notice law effectively caused a

decrease in the pregnancy rate. Between 1980-1986, the birth rate throughout Minnesota fell 12.5% for 10-17 year olds and 28.4% for 18-19 year olds, the abortion rate fell 27.4% for 10-17 year olds and 20.7% for 18-19 year olds, and the pregnancy rate fell 20.5% for 10-17 year olds and 25.4% for 18-19 year olds. Since it seems undisputed that the notice law directly decreased abortion rates, while birth rates simultaneously decreased, this strongly suggests that the law decreased abortion rates by affecting pregnancy rates. This supports the conclusion that the notice law in fact changed adolescent behavior. These data indicate that the notice law is reasonably related to Minnesota's compelling interest in preserving parental authority and adolescent health.

ARGUMENT

I. THE PEOPLE OF MINNESOTA HAVE A COMPELLING INTEREST IN HELPING PARENTS AND FAMILIES TO REDUCE TEENAGE PREGNANCY AND TEENAGE ABORTION.

This Court's decisions in *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), established a constitutional right to elective abortion for adolescent girls of any age that minors had not exercised at any time in the preceding history of this country. *See* Brief Amicus Curiae of the American Academy of Medical Ethics in Support of Cross-Petitioners in *Hodgson v. Minnesota*, No. 88-1125, 88-1309 at 2-23; Brief of Certain American State Legislators in Support of Appellants in *Webster v. Reproductive Health Services, Inc.*, No. 88-605. In the aftermath of those decisions, parents and public officials in every state have sought to adjust public policy on health care to take account of this new constitutional right while preserving other compelling, traditional social values. This Court has recently held that government has a "legitimate secular purpose" in reducing "the social and economic problems caused by

teenage sexuality, pregnancy, and parenthood." *Bowen v. Kendrick*, 108 S.Ct. 2562, 2571 (1988).

In 1985, approximately 26.3% of elective abortions were performed on minors age 18 or younger. Centers for Disease Control, *Abortion Statistics U.S., 1984-1985* (1989) (Table 1.). More than 40 percent of all teenagers who have known pregnancies obtain abortions. Henshaw, et al., *A Portrait of American Women Who Obtain Abortions*, 17 Fam. Plan. Persp. 90, 93 (1985); Russo, *Adolescent Abortion: The Epidemiological Context*, in G. Melton, ed., *Adolescent Abortion: Psychological & Legal Issues* 40, 49 (1986). In 1986, in Minnesota, approximately 49.3% of pregnancies for teens, age 10-17, ended in elective abortion. Table 1, *infra*. Nearly eighty percent (78%) of all abortions performed on teenagers are done in abortion clinics. Henshaw & O'Reilly, *Characteristics of Abortion Patients in the United States 1979-1980*, 15 Fam. Plan. Persp. 5, 11 (1983). One study found that less than half of the abortion clinics require parental notice, even for teenagers 15 years of age or younger; even fewer require parental notification before performing abortions on minors age 16 or older. Torres, et al., *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Fam. Plan. Persp. 284, 285 (1980) (Table 1). Yet, in this study of 1,170 unmarried teenage abortion patients, "[n]inety-one percent were living with their parents, four percent were living with relatives . . . ." *Id.* at 287.

A. Although Many States Have Enacted Parental Consent and Notice Laws, Minnesota Is Unique in Having Had A Parental Law In Effect Which Can Be Evaluated Through Demographic Data Collected By the Department of Health.

The States have sought to address the problem of teenage pregnancy and abortion in many different ways. They have instituted scores of public programs, includ-

ing family planning programs, adoption services, child care, school-based educational programs, and maternal and child health care programs. *See Teen Pregnancy: What is being Done? A State by State Look*, A Report of the House Select Committee on Children, Youth and Families, 99th Cong. 2d Sess. 56 & Appendix IV (Dec. 1986) [hereinafter *Teen Pregnancy*]. The States stress parental involvement in many of these programs. *Id.* at 67-70.

Over 30 states, including Minnesota, have passed parental consent or notice legislation in order to protect the health of minors and to protect parental authority in the area of adolescent health decisionmaking. *See* Appendix I to this Brief. As this Court has said, "parental consent and notice are qualifications that typically may be imposed by the State on a minor's right to make important decisions." *Bellotti v. Baird*, 443 U.S. 622, 640 (1979) (plurality op.). Because this Court's decisions in *Roe v. Wade* and *Danforth* constitutionalized this area of the law, states can ensure parental involvement only through positive legislation.

Very few of these state parental consent and notice statutes have been allowed to go into effect for any meaningful period of time. Many have been declared unconstitutional by federal courts. Statutes in almost a dozen states are currently enjoined in the midst of pending litigation. *See* Appendix I. As the district court below acknowledged, it was the first district court "ever to examine a parental notification or consent substitute statute in actual operation." *Hodgson v. Minnesota*, 648 F.Supp. 756, 774 (D.Minn. 1986). And there is no other currently pending litigation in this country that is examining the effect of parental notice or consent legislation as applied.

Determining the effect of these parental laws has also been frustrated by the absence of state or federal laws

requiring the reporting of statistical data. Data collected from reporting provide demographic statistics that are critical for the study of maternal morbidity and mortality. *See e.g., Teen Pregnancy* at 1-19; Smith, et al., *An Assessment of the Incidence of Maternal Mortality in the United States*, 74 Am. J. Pub. Health 780 (1984). "No federal laws require reporting for abortion." *Teen Pregnancy* at 5. State reporting requirements for abortion are in effect in less than thirty states. Appendix I. Many states do not have reporting for a wide array of demographic factors. *Teen Pregnancy* at 1-19. Many states do not, or cannot, require mandatory reporting of abortion statistics. Illinois, for example, has been prohibited by court order from collecting abortion data since 1984. *Herbst v. Dalen*, No. 84 C 5602 (N.D.Ill. July 1, 1984). Reporting requirements are essential to determine the complete effect of these laws. Minnesota is virtually unique in having had a parental notice law and reporting statute in effect simultaneously for a meaningful period of time.

B. The Plaintiff Clinics Have Failed To Show That the Notice Law Adversely Impacts the Health of Teens, Adversely Impacts the Integrity of the Family, or Fails to Be Consistent With Parents' Rights to Rear and Counsel Their Children.

The clinics' attack on the Minnesota law falls into two broad categories: (1) testimony concerning various burdens imposed on pregnant teens by the notification requirement and the bypass procedure; (2) testimony questioning the necessity and effectiveness of the notification requirement and bypass procedure in furthering the statutory purposes of protecting parental authority and adolescent health. The clinics, and their *amicus*, contend that minors of any age are no less mature and no less capable of making important decisions than their adult parents.[1]

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[1] The American Psychological Association (APA), which has filed an *amicus curiae* brief in this case in support of Hodgson,

The clinics' claim that the notice law had an adverse effect on minors in Minnesota is exclusively focused on those minors who sought abortions. The clinics' challenge reflects a narrow, distorted focus on the impact of the notice law. Minors who sought abortions through the bypass procedure between 1981-1984 constitute less than 25% (23.5%) of the total number of minors (aged 10-17) who became pregnant. *Cf.* Table 1-2, J.A. 60. The clinics' case focuses on only half of the pregnant teens in Minnesota, and that half amounts to only .30% of all Minnesota teens aged 10-17 who were under the influence of the law. *Cf.* J.A. 60, Tables 1-2.[2] The clinics' case thus virtually ignored the impact on the half of the teens who became pregnant and did not abort in Minnesota (and their parents). And the clinics' record says nothing about the drop in the pregnancy rate and how the notice law influenced teens who did not become pregnant. It is, therefore, wholly inaccurate for the clinics to claim that their witnesses had "first-hand knowledge of nearly 100% of the minors who were affected by the statute." Pet.Br.

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has recently been criticized for filing briefs in this Court which overstate the extent to which "developmental theory and data confirm that adolescents and adults have equivalent decision-making capacities." Gardner, et al., *Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights*, American Psychologist 895 (June 1989). One of the Plaintiffs' experts, Lenore Walker, expounded this theory at trial and contributed to the APA brief. APA Brief at n.2.

[2] The 23.5% figure is derived from the estimated number of pregnancies in the 10-17 age group between August 1, 1981 and December 31, 1981 (10,872) compared with the stipulated number of bypass petitions filed during that same period (2,552). J.A. 60. (The 10,872 figure uses 5 mos. of the total number of pregnancies (3,714) in the 10-17 age group in Minnesota in 1981.) *See* Tables 1-2. It appears that 49.6% of the teens that aborted between Aug. 1, 1981 and December 31, 1981 sought judicial bypass. This is based on a comparison of the total of approximately 5,149 abortions for that time period for the 10-17 age group (5 mos. of 1981 total) with the stipulation of 2,552 bypass petitions in that period (J A. 60).

at 29. By their challenge, the clinics would strip all Minnesota parents of the statutory protection of their constitutional rights, as well as all minors of the influence of the law in ensuring parental guidance, in order to remove the requirement of judicial bypass from .30% of Minnesota teens.

There is little, if any, evidence in the record on the experience of the 50% of the pregnant teens, aged 10-17 (or their families), who did not abort—no testimony from those teens or their parents (either custodial or non-custodial) or their doctors, no medical evidence of their pregnancy or current condition, no evidence of their experience in giving birth or caring for their newborn children, no evidence of their past history or future plans or aspirations, no evidence that any minor who carried her child to term later regretted it.

Even the experience of the 50% of the pregnant teens who aborted is presented in the record almost exclusively through the eyes of third parties (*not* parents)—abortion clinic personnel, court or administrative personnel, or experts apparently experienced with only teens who aborted.[3] These teens are "represented" only by three single mothers of pregnant daughters and eight teens as

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[3] The following are the Plaintiffs' witnesses, excluding some of the named Plaintiffs: Paul Wendt, Meadowbrook Clinic; Allen Oleisky, judge, Stanley Henshaw, statistician; Henry Albrecht, juvenile court judge; Edwin G. Widseth, asst. county atty.; Susanne Smith, supervisor, GAD program; Kathrine Welsh, Women's Health Center; Cynthia Daly, asst. public defender; Dr. Lenore Walker, psychologist; Gerald Martin, judge; Charlotte Baker, Midwest Health Center; Maria Hookala, medical asst.; Thomas P. Webber, Planned Parenthood administrator; Heather Sweetland, asst. public defender; Laura Hunter, abortion clinic counselor; Elissa Benedek, psychiatrist; William Sweeney, county judicial officer; Gary B. Melton, psychologist; George Petersen, district judge; Paul Garrity, judge; Steven Butzer, psychiatrist; Neil Riley, judge; Edward Ehlinger, health department administrator; Henry David, Trans. Family Research Inst.; Dr. Arthur Horwitz, Meadowbrook clinic.

named plaintiffs. Pet. Br. at 23 n.49. The experience of certain minors who were deposed is characteristic of the lifestyle of many teens, but there is no evidence that the notice law seriously exacerbated the parent-teen relationship for these teens or for any significant number of Minnesota teens. Most of the Plaintiffs' experts relied on "studies" and "the "literature"—none of which seem to involve Minnesota youth. District Court Transcript (T.) 1137, 1146. The exception seems to be Steven Butzer, who cited two cases of Minnesota adolescents he had counseled, but his experience seems to have been only with girls who sought abortion. J.A. 296-300. There is apparently no evidence of even a single report of child abuse caused by the parental notification, or a single report of medical complications caused by the law, or a single case of parental prevention or coercion of an abortion. Cross Petitioners' Brief (Cross Pet.Br.) at 10-11, 18.

The data collected by the Department of Health tell a broader public health story—not only about those teens who aborted (.60% in 1982) but also about those who never got pregnant (98.7%) and those who carried their children to term (.66%); and it is a story different from the one that the clinics present. The data collected and reported by Minnesota are unique in what they can tell public health researchers about the effect of the notice law. This analysis of the Department's data demonstrates that the notice law is reasonably related to protecting parents' constitutional rights and protecting the health of minors, because it requires parental notice without causing any increased health problems for minors and, in fact, possibly decreases adolescent pregnancy and abortion rates *without* causing increased birth rates. This is an extraordinary benefit for teens and their families in Minnesota—an impact which the clinics virtually ignored.

II. WHILE THE MINNESOTA PARENTAL NOTICE OF ABORTION LAW WAS IN EFFECT AND ENFORCED, TEENAGE ABORTION AND PREGNANCY DECLINED SUBSTANTIALLY AND TEENAGE BIRTHS DID NOT GENERALLY INCREASE COMPARED TO PREVIOUS YEARS.

The Minnesota notice law was only in effect from August 1, 1981 through March 2, 1986, when a preliminary injunction was entered against the entire statute, followed by a permanent injunction on November 6, 1986. Minn. Stat. Ann. 144.343(2)-(7) (West 1989); *Hodgson v. Minnesota*, 648 F.Supp. 756, 760, 781 (D.Minn. 1986), *cert. denied*, 107 S.Ct. 1333 (1987); *Hodgson v. Minnesota*, 853 F.2d 1452, 1455 (8th Cir. 1988); Cross Pet. Br. at 10. That injunction continued in effect throughout the appellate review. After the court of appeals *en banc* reversed the district court's decision on August 8, 1988 and upheld the notice law, the Eighth Circuit issued an order on October 7, 1988, staying the issuance of its mandate pending the filing of a writ of certiorari, or until such time as this Court acted on the petition for certiorari. That stay continues in effect.

During the time that the notice law was in effect, the Minnesota Department of Health, Center for Health Statistics (the Department) collected demographic data from Minnesota abortion providers under mandatory statutory reporting requirements. Minn. Stat. Ann. 145.413 (West 1989); T. 2069, 2076-79 (Dr. Paul Gunderson). The Department began to collect data in 1973. T. 2072. The data collected included:

- the number of teenage pregnancies, abortions, and births,
- complications incurred by teenagers during abortion, and
- the gestational age at which the abortion was performed.

The data relied upon in this brief are the Department's official data. As it has to other researchers (T. 660), the Department provided official data through computer disks and data tables on incidence and population in age specific groupings appropriate for an evaluation of the law—10-17 years, 18-19 years, 20-24 years, 25-54 years.[4] The surveillance of abortion data by the Department begins with age 10. T. 2082. And the Department collects abortion data using a category of 17 years and under. Defendants' Exhibit (D. Exh.) 35; J.A. 481. Official population estimates were also provided by the Department because this analysis was conducted prior to the 1990 census.

In this analysis, it was assumed that any change in the incidence of pregnancy, abortion, and childbirth because of the notice law would most heavily fall on teens 17 and below, who were directly affected by the notice law (Minn.Stat.Ann. 645.451 (West 1989)); less heavily on teens age 18-19 who would have recently been subject to the law; somewhat less on women age 20-24; and least on women age 25-54.[5] The notice law itself does not define "minor" by age, and thus it is quite possible that there was some confusion as to who, among 17-19 year olds, was covered by the law. Moreover, some teens who gave birth at 18 might have been 17 at the time they became pregnant and thus were directly affected by the law. Those who were 18 or 19 in 1983-1986 were subject to the law in 1981 (as, for example, Francis H. (J.A. 68-69)), and the group as a whole could reasonably have been influenced by the law through socialization, including schooling and peer contacts. Similarly, some in the 20-24 age group in later years would have been subject to the law in the earlier years of its enforcement. Women age 25-54 would never have been personally affected by the law. For these reasons, these four groups were considered separately.

[4] The data presented in this brief do not include either teens or adults whose ages were unknown or non-Minnesota residents.

[5] Plaintiffs' witness, Stanley Henshaw, of the Alan Guttmacher Institute, also distinguished between teens age 17 and below and teens age 18-19. J.A. 98. The Director of the Minnesota Center for Health Statistics, Dr. Paul Gunderson, also relied on a category of "17 and below" because the Center collects data for this category. D. Exh. 35; T. 2082-84, 2101-2102, 2104.

This brief presents and analyzes the number and rates of adolescent pregnancies, abortions, and births in Minnesota between 1975 and 1986, the last year for which complete statistics were available.[6] In addition, the study examines the impact of the notice law on medical complications and gestational age at the time of abortion. The examination of rates allows for and takes into account adjustments for changes in the population of Minnesota. The brief also examines the impact on all of these phenomena among women age 25-54, in order to assess law-specific and general population effects. Figures and Tables noted hereafter are included in the Appendix to this Brief.

A. During the Four Years that the Notice Law Was In Effect, Teenage Pregnancies, Abortions, and Births Declined Substantially.

1. *Pregnancies*[7]

The Department's official data show that pregnancies for Minnesota teens, age 10-17, declined between 1981-1986, while the notice law was in effect. Table 1 and Figure 1a show that the number of pregnancies rose from 3,958 in 1975 to 4,315 in 1980 and then decreased to a low of 2,987 in 1983 and to 3,133 in 1986. Thus, the number of pregnancies in this age group grew by 9.0%

[6] At the time of trial in 1986, the State only presented data for years 1980-1983 (D. Exh. 35; J.A. 481) and Planned Parenthood had only data up to 1982 and not beyond. T. 660-61.

[7] Pregnancies equal the sum of abortions, live births, and fetal deaths.

between 1975 and 1980 and fell by 27.4% from 1980 to 1986. In this age group, the highest number of adolescent pregnancies occurred in the year before the notice law went into effect.

Table 1 and Figure 1b show that the number of pregnancies for the 18-19 age group increased from 6,494 in 1975 to a high of 8,301 in 1980 and then declined to a low of 5,493 in 1986. The number of pregnancies in this age group increased by 27.8% between 1975 and 1980 and fell by 33.8% from 1980-1986.

Table 1 and Figure 1c show that the number of pregnancies for the age group 20-24 increased between 1975 and 1980 from 22,001 to 28,093 and then declined between 1980 to 1986 from 28,093 to 22,792—almost to the 1975 figure.

Table 1 and Figure 1d figures show that pregnancies for the 25-54 age group increased between 1975 and 1980 but then continued to increase between 1980 to their highest level in 1986. This group would be the least likely to be affected by the notice law, and the figures show that, in fact, pregnancies in this age group continued to rise throughout the effective period of the notice law.

2. *Abortions*

The Department's data also show that abortions for teenagers, aged 10-17, declined between 1980 and 1986, while the notice law was in effect. Table 1 and Figure 1a show that abortions in this age group rose from 1,507 in 1975 to a high of 2,327 in 1980, the year before the notice law took effect, and then fell to a low of 1,395 in 1981 before rising to 1,545 in 1986. Abortions for this age group increased 54.4% from 1975 through 1980 and fell by 33.6% from 1980 to 1986.

For the 18-19 age group, abortions grew markedly between 1975 and 1980 before decreasing between 1980-1986. Table 1 and Figure 1b show that abortions for this

age group rose substantially from 1,758 in 1975 to a high of 3,380 in 1980, the year before the notice law took effect, and then fell to a low of 2,372 in 1986. Abortions thus rose 92.3% between 1975 and 1980, before falling 29.8% between 1980 and 1986.

In the 20-24 age group, Table 1 and Figure 1c show that abortions grew 124.1% from 2,702 to 6,054 between 1975 and 1980, the last year before enforcement of the notice law, and then remained relatively stable between 1980 and 1986, falling 5.5%.

For the 25-54 age group, abortions did not decline between 1980 and 1986, as Table 1 and Figure 1d show. Abortions in this age group increased 179.3% from 2,161 in 1975 to a high of 6,035 in 1986. Abortions thus rose 118.2% between 1975 and 1980 and rose 28.0% between 1980 and 1986.

3. *Births*

The Department's data show that births for teens age 10-17 declined while the notice law was in effect. In the 10-17 age group, as Table 1 and Figure 1a show, the number of births fell from 2,427 in 1975 to 1,974 in 1980, but continued to decline between 1980-1986, to 1,573 in 1986. Births for teens age 10-17 thus dropped by 18.7% from 1975 to 1980 but dropped 20.3% from 1980 to 1986.

For the 18-19 age group, Table 1 shows that births rose from 4,693 in 1975 to a high of 4,883 in 1980, the year before the notice law went into effect, and then declined to a low of 3,096 in 1986. For this age group, births increased by 4.0% from 1975 to 1980, but decreased by 36.6% from 1980 to 1986. In reviewing this age group, it must be remembered that some girls who became pregnant at 17 would give birth after they were 18. Thus, some girls who gave birth while they were 18 may well have been influenced by the law.

In the 20-24 age group, as Table 1 and Figure 1c show, births increased 14.4% from 1975-1980 but then de-

clined 22.6% between 1980-1986, from 21,899 to 16,959. In the 25-54 age group, as Figure 1d shows, births increased from 1975-1980, increased slightly between 1980-1982, and continued to increase 1982-1986. Births rose from 28,746 in 1975 to a high of 42,269 in 1986.

4. *Migration*

Migration out of Minnesota for abortions was apparently not conducted on any significant scale. Four states border Minnesota: North Dakota, South Dakota, Iowa, and Wisconsin. North Dakota has had a parental consent law in effect since at least 1981. N.D. Cent. Code 14-02.1-03.1 (1981 & 1989 Supp.).[8] South Dakota reports 5, 19, 20, 30, 20, and 17 abortions performed on Minnesota teen residents, 19 years and under, during 1981 through 1986, respectively. *South Dakota Vital Statistics* (1982-1987). Iowa has no parental or reporting law in effect. Wisconsin had no mandated reporting before 1987. One researcher, Robert Blum, concluded that "[i]n contradistinction to the Massachusetts data, there is little evidence to indicate large numbers of Minnesota youth are leaving the state for abortion. . . ." Blum, et al., *The Impact of a Parental Notification Law on Adolescent Abortion Decision-Making*, 77 Am. J. Pub. Health 619, 620 (1987).

One study by Cartoof and Klerman purported to find significant migration out of Massachusetts in their study of the impact of the Massachusetts parental consent law. Cartoof & Klerman, *Parental Consent for Abortion: Impact of the Massachusetts Law*, 76 Am. J. Pub. Health 397 (1986). Nevertheless, as in the case where migration occurs between states with differences in the drinking age

[8] Stanley Henshaw suggested that there was migration to North Dakota based merely on the fact that a clinic opened up in Fargo in 1981. J.A. 99-101; Henshaw T. at 32. But he then chose to exclude North Dakota from his regional assesement of birth rates because of its parental consent law. Henshaw T. at 39-40.

for teenagers, the solution to migration is not to abolish the public health standards of stricter states but to strengthen the standards in the more permissive states. *Cf. South Dakota v. Dole*, 107 S.Ct. 2793 (1987); 23 U.S.C. 158 (1982 ed. and Supp. III). Regardless of the Massachusetts scenario, however, the facts indicate that Minnesota's experience is different. Massachusetts is geographically a small state bordered by several other states without parental involvement legislation that may be more easily reached by car or public transportation (e.g., Maine, New York). Thus, the conclusions of Cartoof and Klerman simply do not apply to Minnesota.

B. During the Four Years that the Notice Law Was In Effect, Teenage Pregnancy, Abortion, and Birth Rates Declined Substantially.

Because raw figures do not take account of possible changes in Minnesota's population for a particular age group from year to year, rates for pregnancies, abortions, and births were also calculated based on the Department's data. Rates, in this study, equal the occurrence (incidence) of a phenomenon per 1000 females. *Cf.* T. 661-65. The numerator is the number reflecting the phenomenon for females in that age category; the denominator is the population number for females in that age category (in thousands). The data in this brief rely on the Department's data for the entire population of Minnesota, not just on a sample. Table 2 contains rates for abortion, births and pregnancy for the various age groups between 1975-1986.

1. *Pregnancy Rate for 10-17 Year Olds*

The pregnancy rate equals the number of pregnancies in the particular age group divided by the population of females in that age group in thousands (pregnancies/population). Table 2 and Figure 2a show that the pregnancy rate for the 10-17 age group rose from 12.7 (12.7

per 1000) in 1975 to a high of 15.6 in 1980, the year before the notice law took effect, and then declined to a low of 11.3 in 1983 and 12.4 in 1986. Thus, even though the population of 10-17 year olds declined between 1975 and 1986, the pregnancy rate declined, as well, by 20.5% between 1980-1986.

2. *Pregnancy Rate for 18-19 Year Olds*

Table 2 and Figure 2b show that the pregnancy rate for the 18-19 age group rose substantially from 75.5 (75.5 per 1000) in 1975 to a high of 98.5 in 1980, the year before the notice law went into effect, but then fell after 1980 to 96.0 in 1981 and to 73.5 in 1986, below the 1975 level. Again, even though the population in Minnesota in the 18-19 age group fell from a high of 86,924 in 1976 to 74,689 in 1986, the pregnancy rate also declined 25.4% between 1980-1986.

3. *Abortion Rate for 10-17 Year Olds*

The abortion rate equals the number of abortions in the selected age group divided by the population of the females in that age group in thousands (abortions/population). Table 2 and Figure 2a show that the abortion rate for the 10-17 age group rose from 4.9 in 1975 to a high of 8.4 in 1980, the year before the notice law became effective, and then fell to 6.8 in 1981, to a low of 5.4 in 1983 and 6.1 in 1986.[9] The abortion rate thus rose 71.4% between 1975-1980 and then fell 27.4% between 1980-1986.

4. *Abortion Rate for 18-19 Year Olds*

The Department's data also show that the abortion rate for the 18-19 age group in Minnesota fell during the time

[9] Stanley Henshaw suggested that the rate of abortions for teens age 15-17 has declined, in part, because they passed themselves off as 18. Henshaw T. 61. This is implausible because it would result in an increase in the abortion rate for 18-19 year olds, which plainly did not occur.

that the notice law was in effect. Table 2 and Figure 2b show that the abortion rate rose from 20.4 in 1975 to a high of 40.1 in 1980, the year before the notice law became effective. The abortion rate then fell 4.8% to 38.20 in 1981 and a further 16.8% to a low of 31.80 in 1986. The abortion rate thus rose 96.6% between 1975-1980 and fell 20.7% between 1980-1986.

5. *Birth Rate for 10-17 Year Olds*

The birth rate equals the number of births in the selected age group divided by the population of females in that age group in thousands (births/population). Figure 2a and Table 2 show that the birth rate for the 10-17 age group in Minnesota fell from 7.8 (7.8 per 1000 teens) in 1975 to 7.2 in 1980, and that it continued to fall to 7.0 in 1981, to a low of 5.8 in 1983 and then to 6.3 in 1986. The birth rate therefore fell 7.7% between 1975-1980 but fell 12.5% between 1980-1986.

6. *Birth Rate for 18-19 Year Olds*

The Department's data show that the birth rate for the 18-19 age group in Minnesota fell during the time the notice law was in effect. Table 2 and Figure 2b show that the birth rate for the 18-19 age group rose from 54.6 in 1975 to 58.0% in 1980 (+6.2%), the last full year before the notice law took effect. The birth rate in this age group then fell to 57.4 in 1981 and to a low of 41.5 in 1986. Thus, the birth rate fell 28.4% between 1980-1986.

In sum, the Department's data refute the clinics' contention that the notice law increased the birth rate for teenagers in Minnesota. Between 1980-1986, the birth rate fell 12.5% for 10-17 year olds, 28.4% for 18-19 year olds, and 23.6% for 20-24 year olds.[10] In contrast,

[10] Stanley Henshaw acknowledged the decline in Minnesota birth rates for 15-17 and 18-19 year olds, but attributed this to a regional decline. J.A. 100.

the birth rate for 25-54 year olds increased 6.1% between 1980-1986. The Minneapolis birth rate data is separately examined in Section III below.

C. The Data Are Strong Evidence that the Notice Law Effectively Reduced Teen Pregnancy Rates in Minnesota During Its Effective Period.

The comparison of the pregnancy, abortion, and birth rates in Minnesota between 1981-1986 strongly supports the conclusion that the notice law effectively caused a decrease in the pregnancy rate in those years. Since the abortion rate fell 27.4% for 10-17 year olds and 20.7% for 18-19 year olds, while the birth rate throughout Minnesota simultaneously fell 12.5% for 10-17 year olds and 28.4% for 18-19 year olds, the pregnancy rate must have declined, as the data confirm, supporting the conclusion that the notice law in fact changed adolescent behavior. In other words, since it seems undisputed that the notice law did directly decrease abortion rates, while birth rates simultaneously decreased, the law must have decreased abortion rates by affecting pregnancy rates.

In addition, the number of teens, aged 10-17, who aborted as a percentage of all pregnant teens (including fetal deaths), aged 10-17, did not decline markedly between 1980-1986. The figures are, respectively, for those years: 53.9%, 49.0%, 47.3%, 47.9%, 46.0%, 50.3%, 49.3%. This is further evidence that the impact of the notice law was to reduce teen pregnancies generally, rather than to compel teens to give birth rather than abort.

On the other hand, it may not be possible, examining the pregnancy and abortion rates in Minnesota alone, to conclude with certainty that the notice law itself caused lower pregnancy rates by inducing minors to change their behavior. But the Department's data at least make clear that the notice law did not cause higher birth rates in Minnesota and was enforced during an unprecedented period when pregnancy and abortion rates declined for teens aged 10-17.

D. Minnesota Teenagers Did Not Have Abortions at Significantly Later Points in Pregnancy Relative to Other Age Groups While the Notice Law Was In Effect.

The plaintiff clinics claim that the notice law delayed minors from having abortions, pushing them into later gestational periods, with the implication that this increased the risk of abortion. Pet. Br. at 13-14; T. 2088; J.A. 347. For this claim, they rely, in part, on a report by the Meadowbrook Women's Clinic, one of the plaintiffs, that "as of December 1985, over 30% of their minor patients seeking abortions were in the second trimester." Pet. Br. at 14 n.29. But this bare statistic from one clinic, presented in isolation, says virtually nothing. Moreover, the Department's data bely these claims generally. *See also* Cross Pet. Br. at 19; J.A. 346-49, 474, 481.

Table 3 and Figure 3a show the number of abortions performed at [greater than] 12 weeks gestational age for all age groups between 1975-1986.[11] For the 10-17 age group, the number of abortions performed after 12 weeks grew from 403 in 1973 to 510 in 1980, jumping substantially between 1979-1980, but *declined* sharply (28.4%) from 1980-1981. Between 1981-1986, the number of abortions performed in this age group after 12 weeks continued to decline 8.8% to 333 in 1986.

Table 3 and Figure 3b show the percentage of abortions performed after 12 weeks. For the 10-17 age group,

[11] The 12-week point was used because 12 weeks is generally used as the line between the first and second trimesters and because the clinics' allegation is that the proportion of minors who had "second trimester abortions increased dramatically." Pet. Br. at 13-14. Dr. Paul Gunderson also used a 12 week cutoff. T. 2103-2104.

the percentage of abortions performed after 12 weeks grew 22.3% from 1975-1980, declined between 1980-1982, increased between 1982-1984 and then declined between 1984 and 1986, with the result that the percentage of abortions performed after 12 weeks in 1985 was nearly the same as the percentage in 1980. For 1980-1986, the percentage of abortions performed at [greater than] 12 weeks for 10-17 year olds dropped 1.4%.

The figures for the 10-17 age group, however, cannot properly be viewed in isolation but must be compared with the figures for the other three age groups in Minnesota between 1975-1986. The percentage of abortions performed after 12 weeks for the 18-19 age group declined from 16.6% in 1980 to 15.2% in 1982, and then increased from 1982 to 1984 before dropping between 1984-86, a total increase between 1980-86 of 10.3%. A similar pattern occurred for the 20-24 and the 25-54 age groups. The 20-24 age group shows a 9.8% increase from 1975-80 in the percentage of abortions performed after 12 weeks. But there is a significant increase in 1981 before a drop to 1986, with a resulting increase of 4.5% between 1980-86. For the 25-54 age group, the percentage of abortions performed after 12 weeks decreased 2.3% between 1975-80 and then increased 1.2% between 1980-86.

Three primary characteristics should be noted for all age groups. First, the percentage of abortions performed after 12 weeks is consistently related to age differences, both before and after the enactment of the notice law. The percentage of abortions after 12 weeks for the 10-17 age group is consistently higher than the 18-19 age group, which is consistently higher than the 20-24 age group, which is consistently higher than the 25-54 age group for all years from 1975-1986. Second, as Figure 3b shows, for all groups there appears to be a cyclical trend with "peaks" every four years, which the notice law has not interrupted. Third, after the notice law became effective

in 1981, the percentage of abortions after 12 weeks dropped for all age groups between 1980-1981, rose slightly from 1981-1982, and rose after 1982. The fact that the number and percentage of abortions performed after 12 weeks in the 10-17 age group dropped between 1980 and 1981, and the fact that the number of abortions for all age groups performed after 12 weeks increased after 1982, provide strong evidence that the notice law did not selectively increase the gestational age at which teens obtained abortion.

E. Minnesota Teenagers Did Not Have Increased Complications From Induced Abortion Relative to Other Age Groups While the Notice Law Was in Effect.

The plaintiff clinics also claim that complications from induced abortions incurred by teens subjected to the notice law increased because of the law. This claim is based entirely on journal publications about general rates of complications and not on any specific medical evidence in the record. *See* Pet. Br. at 11; J.A. 347-48.[12] By relying on general rates of complications, which generally increase with gestational age, the clinics' argument assumes the validity of their claim that the law caused adolescents to have later abortions. But this assumption has been contradicted by the Department's data. Independent of the gestational age data, the Department's data indicate that the claim of increased complications is unfounded. *See* Cross Pet. Br. at 19, 39-40; J.A. 347-48.

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[12] Plaintiffs' counsel told the district court: "In Plaintiffs' Exhibits 1 through 9 and also in Dr. Hodgson's testimony there is a claim that the risk increases through delay, specifically the types of risks such as laminaria due to cervical—lack of laminaria use which relates to cervical injury, but we haven't demonstrated or said on any particular patients those risks have occurred except those who haven't been able to get it, who have gone to childbirth, which of course is much more dangerous." T. 2088; J.A. 347. When asked by the court whether the claim was that the notice law "resulted in an increase in complications to minors" rather than an increase in "risk," counsel for plaintiffs replied, "No." *Id.*

For purposes of this analysis, it must be understood that between 1982-1984, the Department changed and broadened its definition of "complication" for purposes of the reporting statute. T. 2090-2094. This broader definition encompassed more specific instances of morbidity that were required to be reported as complications of abortion. Specifically, the Department changed their reporting form to include more examples of complications (from 8 categories to 12 categories), including a distinction between "minor" complications (not requiring hospitalization) and "major" complications (requiring hospitalization) (e.g., pelvic infection, hemorrhage, and others). In the aftermath, the Department found increased reporting of "minor" complications.

Table 4 and Figures 4a-4b show the number and percentage of abortions with reported complications for all age groups in Minnesota, 1975-1986. The rate of complications is determined by dividing the number of complications by the number of abortions. For the 10-17 age group, the number of complications declined from 16 in 1975 to 6 in 1980, and then declined to 0 in 1981, before jumping to 10 in 1982 and dropping to 8 in 1986, the same as the 1978 figure. Figure 4b shows that, for the 10-17 age group, the percentage of abortions with reported complications increases 56.3% between 1982-1984 but then declines 48.0% between 1984-1986. For the 18-19 age group, the percentage increases 211.1% between 1982-1984 and then declines 43.8% between 1984-1986. For the 20-24 age group, the percentage increases 60.9% between 1982-1984 and then declines 18.4% between 1984-1986. Finally, for the 25-54 age group, the percentage increases 33.7% between 1982-1984 and continues to increase 3.4% between 1984-1986.

In sum, the Department's data show that reported complications increased for all age groups between 1975-1986. This is entirely consistent with the Department's findings after the change in its definition of complications. Between 1982-1984, the percentage of complications *increased more* for the 18-19 and 20-24 age groups than for the 10-17 group. And, between 1984-1986, the percentage of complications *fell less* for all other groups than the 10-17 age group. These facts provide strong evidence that the notice law caused no increased complications for teens age 10-17 who were subject to the law.

III. THE CONTENTION THAT THE NOTICE LAW INCREASED BIRTHS TO TEENS IS BASED ON STATISTICS FOR ONLY THE LIMITED AREA OF THE MINNEAPOLIS CITY LIMITS AND THESE MUST BE VIEWED WITHIN THE CONTEXT OF OTHER DEMOGRAPHIC PHENOMENA IN MINNEAPOLIS AND THROUGHOUT THE STATE.

The plaintiff clinics claim that the notice law caused a 38.4% increase in the birth rate to teens age 15-17 by relying on a 38.4% increase in the birth rate for teens age 15-17 in Minneapolis between 1980-84. Pet.Br. at 12. Plaintiffs, purporting to quote Edward Ehlinger of the Minneapolis Dept. of Health, argue that the notice law "was the only factor that uniquely affected the fifteen to seventeen year old age group which could explain the difference." Pet.Br. at 12. Ehlinger, in fact, did not say that it was the "only" factor; he said merely that it "would be an important factor." T. 2030-31.

As this Court stated recently in *Webster v. Reproductive Health Services, Inc.*, 109 S.Ct. 3040, 3050 (1989), the states may "make a value judgment favoring childbirth over abortion." Thus, the fact that the notice law may have increased births to teens affected by the law is not a constitutional indictment against the law. Such a fact would merely imply that parental influence, as required by the law, had encouraged teens to give birth rather than abort. Such parental guidance is hardly a result which violates the Constitution. But, in fact, the data undermine the claim that the notice law caused in-

creased births to teens either in Minnesota generally or in Minneapolis specifically.

The clinics' assertion rests entirely on data gathered from the Minneapolis Department of Health concerning residents of the City of Minneapolis only. *See* P. Exh. 116; T. 2072 (Dr. Paul Gunderson). The data *do* show an increase of 38.4% between 1980-84 in births to teens between the age of 15-17 who are residents of Minneapolis. *See* Table 5. For 1980-87, the birth rate of Minneapolis teens aged 15-17 is 39.1, 41.2, 42.7, 47.3, 54.1, 58.2, 62.2, 64.5, respectively. When seen within the context of demographic statistics throughout Minnesota and within demographic changes in Minnesota in the 1980's, however, the allegation that the increase is due to the notice law is doubtful.

Initially, it is important to realize that teens who are residents of Minneapolis make up roughly only 6% of the teen population of Minnesota. In 1981, the 15-17 year old female population for Minnesota was 107,784, while the female population in Minneapolis for ages 15-17 was only 6,548. Thus, the 38.4% increase in the birth rate in Minneapolis was limited to 6% of the state's population of 15-17 year olds.

Statistics throughout Minnesota show that the 38.4% increase in the birth rate to Minneapolis residents age 15-17 between 1980 and 1984 was unique to Minneapolis and did not occur in metropolitan Minneapolis or in Minnesota in general, as Table 5 and Figure 5a show. *See also* T. 2073-74 (Dr. Paul Gunderson). The birth rates for ages 15-17 in years 1980-1986 in metropolitan Minneapolis are 17.4, 17.2, 17.2, 15.1, 17.4, 16.5, 17.8. And the birth rate for ages 15-17 between 1980-86 in Minnesota as a whole is 17.5, 17.5, 16.6, 14.6, 16.1, 15.1, 15.6. In addition, Minneapolis differs in birth rate from other geographic regions in Minnesota for other age groups besides 15-17, particularly for ages 10-14, 18-19, and 25-34, as Table 5 and Figures 5b-5e show. Finally, the Minneapolis birth rate for 15-17 year olds continues

to climb throughout 1986 and 1987, even after the notice law was enjoined in March, 1986.

The number of births to teens as a percentage of all births in Minneapolis must also be considered. In Table 7 and Figure 7a, it is apparent that the percentage of births to minors in Minneapolis is lower than that found in the nation generally, but exhibits a remarkably parallel trend to the national trend over time. The selective increase in birth rate in Minneapolis is reflected in the Minneapolis line in Figure 7a, insofar as the percentage of total births to teen births in Minneapolis rises contrary to the national and statewide trend between 1985-1987. But this increase occurs later than we would expect were it a result of a law enacted in 1981. The real increase in the percent of births to minors does not happen until several years later: 1985, 1986, and 1987, when the law was no longer in effect. The increase in the 15-17 year old Minneapolis birth rate during 1981-83 is *not* accompanied by an increase in births to minors as a percentage of total births. This clearly parallels both the Minnesota and national trends in its decline during 1981-83. The opposing trends in Minneapolis in birth rate to minors 15-17 (Figure 5a) and percent of births to minors (Figure 7a) indicate that birth rates must have been increasing in general in Minneapolis from 1981-83, regardless of age. This indicates that the increase in birth rates in Minneapolis to minors during the enactment period of the notice law was merely part of a larger trend effecting all minors and adult women, including those not subject to the law.

Moreover, the increase in births for Minneapolis teens age 15-17 leads to a different conclusion when the Minneapolis population is examined in more detail. When the Minneapolis births are broken down by race, and compared with data from the National Center for Health Statistics, the increase in births to girls under 18 is seen to be largely confined to the minority population, spe-

cifically the population of Asian-Pacifics. Figure 7b is a breakdown by race of the Minneapolis and national trend lines in Figure 7a. The Asian-Pacific Island percentage of births to minors deviates from the national trend and increases dramatically. All other races roughly parallel national trends in their decline, at least until 1986, when the notice law was enjoined. This would suggest that Asian-Pacifics are disproportionately impacting the birth rate for teens age 15-17 in Minneapolis. It is implausible that the notice law would selectively impact Asian-Pacifics more than other races in Minneapolis. Therefore, other explanations for the Minneapolis increase in birth rate should be explored.

Figure 8 suggests one possible explanation—a substantial increase in the population of Asian-Pacific teens. Figure 8 shows the percent of minority enrollment in the Minneapolis Public School District from 1971 to 1987. This Figure shows that the percentage of Asian enrollment sharply increases between 1980-1981 and continues to increase from 1981-1987. It is precisely during this time that the percent of all births to minors for the Asian-Pacific population experienced the greatest increase. These statistics show an unusual increase in both the Asian-Pacific population in Minneapolis and in the percentage of births to minors for this population.

This increase in births to Asian-Pacific minors must be compared with the abortion behavior of this population. The abortion rate is important to consider because the clinics' challenge to the notice law is predicated on the assumption that it keeps minors from getting abortions. The notice law can directly influence only the abortion rate and the birth rate is influenced by a reduction in the number of abortions. This implies that as the influence of the notice law on the abortion rate decreases, its potential influence on the birth rate should also decline. Yet, Dr. Paul Gunderson testified to the virtual nonexistence of abortion to the Asian-Pacific population. *See*

T. 2076 (Dr. Paul Gunderson commenting on the low abortion rate of Asians in Minnesota). It is improbable, therefore, that a group with an extremely low abortion rate before the law went into effect would be the most effected by the law in terms of birth rate. Some other factor(s), and not the notice law, must explain this increase.

In summary, the Minneapolis data do not support the contention that birth rates for teens in Minneapolis increased because of the notice law. When viewed in conjunction with the data from other regions of Minnesota, it appears that the notice law did not increase births to teens in Minneapolis. Together with the marked decrease in pregnancy rates and abortion rates in Minnesota, these data demonstrate that the notice law, as applied, is reasonably related to preserving parental authority and protecting the health of minors.

CONCLUSION

The judgment of the court of appeals should be affirmed in No. 88-1125 and reversed in No. 88-1309.

Respectfully submitted.

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APPENDIX

APPENDIX 1:

STATE REPORTING REQUIREMENTS AND PARENTAL CONSENT OR NOTICE OF ABORTION STATUTES

ALABAMA: Parental consent statute enacted in 1987; in effect and enforced since September 23, 1987. Ala. Code sec. 26-21-3 (Supp. 1988); *Ex parte: State of Alabama* and *Ex parte: Anonymous*, 531 So.2d 901 (Ala. 1988).

No reporting statute.

ALASKA: Parental consent statute enacted in 1970. Alaska Stat. sec. 18.16.010(a)(3) (1987). On October 21, 1976, an opinion of the Attorney General declared that this subsection is "clearly unconstitutional."

No reporting statute.

ARIZONA: Parental notice statute enacted in 1982; Ariz. Rev. Stat. Ann. sec. 36-2152 (1986); enjoined by federal court. New parental consent statute enacted May 22, 1989, with an intended effective date of September 15, 1989; preliminarily enjoined by federal court on September 15, 1989, and injunction extended on September 22, 1989. *Planned Parenthood v. Neeley*, No. CIV 89-489 TUC ACM (D.Ariz. 1989).

Reporting statute in effect from January 1, 1968. Ariz. Rev. Stat. Ann. sec. 36-340 and 341 (1986).

ARKANSAS: Parental consent statute enacted in 1969. Ark. Stat. Ann. sec. 41-2555 (Supp. 1985). Enjoined by federal court in 1980. *Smith v. Bentley*, 493 F.Supp. 916 (E.D. Ark. 1980). New parental notification statute enacted in 1989. Ark. Acts 270.

Reporting statute in effect from February 19, 1981. Ark. Stat. Ann. sec. 20-18-603 (1987).

CALIFORNIA: Parental consent statute enacted in 1987, with intended effective date of January 1, 1988.

Cal. Health & Safety Code sec. 25958 (Supp. 1988). Continuing state court injunction since December 28, 1987, entered on facial challenge to parental consent statute. *American Academy of Pediatrics v. Van de Kamp*, No. 884574 (Cal. Super. Ct. Dec. 28, 1987), *appeal docketed*, No. A040911 (1st Cir. Cal. App. argued August, 1989).

Reporting statute was added by statutes in 1971, amended and effective on June 30, 1973, and operative on July 1, 1973. Cal. Health & Safety Code sec. 25955.5 (1981).

COLORADO: No parental or reporting statute.

CONNECTICUT: No parental or reporting statute.

DELAWARE: Parental notice statute enacted on June 17, 1969, but not presently operative. Del. Code Ann. tit. 24, sec. 1790(b)(3) (1981).

Reporting statute enacted on June 17, 1969. Del. Code Ann. tit. 24, sec. 1790(c) (1981).

DISTRICT OF COLUMBIA: No parental or reporting statute.

FLORIDA: Parental consent statute enacted in 1979. Fla. Stat. Ann. sec. 390.001(4)(a) (West Supp. 1985). Enjoined by federal court on July 10, 1979, and subsequently declared unconstitutional; *Scheinberg v. Smith*, 482 F.Supp. 529 (S.D. Fla. 1979), *aff'd*, 659 F.2d 476 (5th Cir. 1981); parental consent statute enacted on June 15, 1988, with intended effective date of October 1, 1988; enjoined by federal court injunction on facial challenge on October 6, 1988, which was dissolved on February 13, 1989. *Jacksonville Clergy Consultation v. Martinez*, 707 F. Supp. 1301 (M.D. Fla. 1989), *appeal docketed*, No. 89-3127 (11th Cir.). Declared unconstitutional on May 12, 1989. *In re T.W.*, 513 So.2d 837 (Fla. App. 5 Dist. 1989).

Reporting statute in effect as of August 5, 1979. Fla. Stat. Ann. tit. 29, sec. 390.002 (1986).

GEORGIA: Parental notice statute enacted on April 14, 1987, with intended effective date of July 1, 1987. Ga. Code Ann. sec. 24A-4401 (Supp. 1988). Enjoined by federal injunction on June 30, 1987. *Planned Parenthood v. Harris*, 670 F. Supp. 971 (N.D. Ga. 1987). Amended parental notice statute enacted on March 31, 1988, with intended effective date of July 1, 1988; enjoined by continuing federal injunction on July 11, 1988. *Planned Parenthood v. Harris*, 691 F.Supp. 1419 (N.D. Ga. 1988).

There are two reporting statutes in the Georgia Code of 1981, which became effective on November 1, 1982. Ga. Code Ann. sec. 31-10-19, 16-12-141 (1988).

HAWAII: No parental or reporting statute.

IDAHO: Parental notice statute enacted in 1973; Idaho Code sec. 18-609(6) (1985).

No reporting statute.

ILLINOIS: Parental consent statute (Ill. Ann. Stat. ch. 38, para. 81-51 *et seq.* (Smith-Hurd 1989)) enacted in 1977 with an effective date of Jan. 1, 1978; enjoined by federal court in *Wynn v. Scott*, 448 F.Supp. 997 (N.D. Ill. 1978), *aff'd* 582 F.2d 1375 (7th Cir. 1978); *see also Wynn v. Carey*, 559 F.2d 193 (7th Cir. 1979). Parental notice statute enacted on November 2, 1983, with intended effective date of January 31, 1984; Ill. Rev. Stat. ch. 38, para. 81-65 (1988); enjoined by continuing federal court injunction since January 26, 1984. *Hartigan v. Zbaraz*, 584 F.Supp. 1452 (N.D. Ill. 1984), *aff'd*, 763 F.2d 1532 (7th Cir. 1985), *aff'd by equally divided court*, 108 S.Ct. 479 (1989).

Reporting statute amended in 1984. Ill. Rev. Stat. ch. 38, para. 81-30 (1989). Enjoined by continuing federal court temporary restraining order since 1984 from gathering abortion statistics, *Herbst v. Daley*, No. 84 C 5602 (N.D. Ill. July 1, 1984).

INDIANA: Parental consent statute enacted in 1971; enjoined by federal court. *Gary-Northwest Women's Serv. Inc. v. Bowen*, 418 F.Supp. 9 (N.D. Ind. 1976), *aff'd on other grounds*, 429 U.S. 1067 (1977). Parental notification statute enacted in 1982, with intended effective date of Sept. 1, 1982; Ind. Code Ann. sec. 35-1-58.5-2.5 (Burns Supp. 1986). Enjoined by federal court in *Indiana Planned Parenthood v. Pearson*, 716 F.2d 1127 (7th Cir. 1983); New parental consent statute enacted in 1984; enforced since September 1, 1984.

Reporting statutes in effect as of July 26, 1973. Ind. Code Ann. sec. 35-1-58.5-3 and sec. 35-1-58.5-5 (Burns Supp. 1988).

IOWA: No current parental involvement or reporting statute.

KANSAS: No parental involvement statute.

Reporting statute in effect as of July 1, 1975. Kan. Stat. Ann. sec. 65-445 (1985).

KENTUCKY: Parental consent statute enacted in 1982 with intended effective date of July 15, 1982. Ky. Rev. Stat. Ann. sec. 311-732 (1983). A temporary restraining order was entered against Kentucky's entire abortion statute on July 9, 1982, and the entire Act was declared unconstitutional on September 11, 1984. See *Eubanks v. Brown*, 604 F. Supp. 141 (W.D. Ky. 1984). The parental consent statute was amended in 1984 and again in 1986 with an intended effective date of July 15, 1986; temporary restraining order entered on July 10, 1986, on facial challenge and order lifted in approximately March of 1989. On Aug. 23, 1988, the district court partially enjoined the law, but upheld it as modified. See *Eubanks v. Wilkinson*, No. C82-0360-L(A), slip op. at 35-36 (W.D. Ky. Aug. 23, 1988), *appeal docketed*, No. 88-6085 (6th Cir. Sept. 22, 1988), No. 89-5353 (6th Cir. Mar. 21, 1989).

Reporting statute intended to be in effect as of July 15, 1982, but a temporary restraining order was entered against the State's entire abortion Act on July 9, 1982, and then the Act was declared unconstitutional on September 11, 1984. See *Eubanks v. Brown*.

LOUISIANA: Parental consent statute enacted in 1978, amended in 1980 and amended and reenacted in 1981 with this most recent version going into effect on July 23, 1981; La. Rev. Stat. Ann. sec. 40:1299.35.5 (West Supp. 1988); upheld by federal court in *Margaret S. v. Treen*, 597 F. Supp. 636 (E.D. La. 1984).

Reporting statute enacted in 1978. La. Rev. Stat. Ann. sec. 40:1299.35.10, 40:1299.35.11 (1989). Constitutionality upheld except to the extent that the statute requires doctors to provide the zip code or residence of the pregnant woman. *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980). Related reporting statute enacted in 1979. La. Rev. Stat. Ann. sec. 40:48 (1989).

MAINE: Parental notice statute enacted in 1979 with an intended effective date of Sept. 14, 1979, but it was enjoined on Sept. 13, 1979. Me. Rev. Stat. Ann. tit. 22, sec. 1597 (1980 and Supp. 1988); *Women's Community Health Center v. Cohen*, 477 F. Supp. 542 (D.Me. 1979).

Reporting statute in effect as of March 31, 1978. Me. Rev. Stat. Ann. tit. 22, sec. 1596 (1980).

MARYLAND: Parental notice statute enacted in 1982; Md. Health-Gen. Code Ann. sec. 20-103 (1987). Attorney General issued opinion that it is unconstitutional. 70 Op. Atty. Gen. (Dec. 31, 1985).

Reporting statute in effect since 1968. Md. Health-Gen. Code Ann. sec. 20-208(c) (1987).

MASSACHUSETTS: Parental consent statute enacted on August 2, 1974, with intended effective date of October 31, 1974; Mass. Ann. Laws ch. 112, sec. 12 (Michie/Law. Co-op. 1985); enjoined by federal court on October

30, 1974; constitutionality upheld. The Massachusetts statute was enjoined and never enforced until after this Court's decision in 1981. *Bellotti v. Baird*, 443 U.S. 622, 625 n.1 (1979); constitutionality upheld. *Planned Parenthood v. Bellotti*, 641 F.2d 1006 (1st Cir. 1981).

Reporting statute was in effect as of 1974. Mass. Ann. Laws ch. 112, sec. 12R (Michie/Law. Co-op. 1985).

MICHIGAN: No parental statute.

Reporting statute enacted in 1978. Pub. Act 368 of 1978. Mich. Stat. Ann. sec. 14.15 (2835) (Callaghan 1988).

MISSISSIPPI: Parental consent statute enacted in 1986, with intended effective date of July 1, 1986; Miss. Code Ann. sec. 41-41-53 (1988); enjoined by continuing, preliminary federal injunction since July 2, 1986, on facial challenge. *Barnes v. Mississippi*, No. J86-0458 (w) (S.D. Miss. 5/13/87).

No reporting statute.

MISSOURI: Parental consent statute enacted on June 14, 1974, with intended effective date of June 14, 1974; upheld by federal court on January 31, 1975. *Planned Parenthood v. Danforth*, 392 F. Supp. 1362 (1975); parental consent statute enacted in 1979 with intended effective date of June 29, 1979; Mo. Ann. Stat. sec. 188.028 (Vernon Supp. 1989); enjoined by federal court injunction from time of enactment until 1985. *See Planned Parenthood v. Ashcroft*, 483 F. Supp. 679, 683 (W.D. Mo. 1980); constitutionality upheld in *Planned Parenthood v. Ashcroft*, 462 U.S. 476 (1983); subject to renewed challenge; injunction lifted in 1986. *T.L.J. v. Webster*, 792 F.2d 734 (8th Cir. 1986).

Reporting statutes have been in effect since June 29, 1979. Mo.Ann. Stat. sec. 188.052 and 188.055 (Vernon Supp. 1989); upheld in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

MONTANA: Parental notice statute enacted in 1974, but not presently operative. Mont. Code Ann. sec. 50-20-107 (1987).

Reporting statute in effect since 1974. Mont. Code Ann. sec. 50-20-110 (1987).

NEBRASKA: Parental notice statute enacted in 1981 with effective date of May 29, 1981; Neb. Rev. Stat. sec. 28-347 (1985); enjoined on September 16, 1983, in *Orr v. Knowles*, No. 81-0-301 (D.Neb. Sept. 16, 1983).

Reporting statute in effect as of July 1, 1978. Neb. Rev. Stat. sec. 28-343, 344, 345 (1985). Declared unconstitutional and enjoined insofar as statute requires physicians to make an official report of "prescribed" abortions. *Women's Services, P.C. v. Thone*, 483 F. Supp. 1022 (D. Neb. 1979).

NEVADA: Parental notice statute enacted on June 14, 1985, with intended effective date of July 1, 1985; Nev. Rev. Stat. sec. 442.255 (1986 & Supp. 1988); enjoined by continuing federal injunction since June 28, 1985, entered on facial challenge; appeal pending before Ninth Circuit since July 24, 1985. *Glick v. McKay*, 616 F. Supp. 322 (D. Nev. 1985), *appeal docketed*, No. 85-2335 (9th Cir. 1985).

Reporting statute in effect as of 1973. Nev. Rev. Stat. sec. 442.260 (1986).

NEW HAMPSHIRE: No parental or reporting statute.

NEW JERSEY: No parental or reporting statute.

NEW MEXICO: No parental statute.

Reporting statute enacted in 1977. N.M. Stat. Ann. sec. 24-14-18 (1986).

NEW YORK: No parental statute.

Reporting statute enacted in 1953 and most recently amended in 1987, effective Jan. 1, 1988. N.Y. Pub. Health Law sec. 4160, 4161 (McKinney 1989).

NORTH CAROLINA: No parental or reporting statute.

NORTH DAKOTA: Parental consent statute enacted in 1981; N.D. Cent. Code sec. 14-02.1-03.1 (Supp. 1987).

Reporting statute in effect since 1975; N.D. Cent. Code sec. 14-02.1-07; upheld in *Leigh v. Olson*, 497 F. Supp. 1340 (D. N.D. 1980).

OHIO: Parental notice statute enacted on November 20, 1985, with intended effective date of March 24, 1986; Ohio Rev. Code Ann. sec. 2151.85, 2919.12, and 2505.73 (Page Supp. 1985); enjoined by continuing federal injunction on facial challenge since March 31. 1986 (TRO), which became a preliminary injunction on April 22, 1986; *Akron Center for Reproductive Health v. Slaby*, 633 F. Supp. 1123 (N.D. Ohio 1986), *aff'd*, 854 F.2d 852 (6th Cir. 1988), *prob. juris. noted sub nom., Ohio v. Akron Center for Reproductive Health, Inc.*, U.S. No. 88-805.

No reporting statute.

OKLAHOMA: No parental law.

Reporting statute in effect as of October 1, 1978. Okla. Stat. Ann. tit. 63, sec. 1-738, 1-739 (West 1981).

OREGON: No parental law.

Reporting statute enacted in 1983. Or. Rev. Stat. Ann. sec. 435.496 (1987).

PENNSYLVANIA: Parental consent statute enacted in 1982; Pa. Stat. Ann. tit. 18, sec. 3206 (Purdon 1983); parental consent statute amended on March 25, 1988, with intended effective date of April 24, 1988; enjoined by continuing federal injunction since April 21, 1988, on May 23, 1988. *Planned Parenthood v. Casey*, 686 F.Supp. 1089 (E.D. Pa. 1988).

Reporting statute enacted in 1982. Pa. Stat. Ann. tit. 18, sec. 3214 (Purdon 1983). Partially enjoined in

American College of Obstetricians and Gynecologists v. Thornburgh, 613 F.Supp. 656 (E.D. Penn. 1985). The statute was amended on March 3, 1988, with an intended effective date of April 24, 1988. On April 21, 1988, a federal court granted a temporary restraining order and enjoined public disclosure of reports filed pursuant to sec. 3214(f). *Planned Parenthood v. Casey*, 686 F.Supp. at 1092. Then, the court permanently enjoined certain provisions of the reporting statute on May 23, 1988. *Id.* at 1129-1134.

RHODE ISLAND: Parental consent law enacted in 1982; R.I. Gen. Laws sec. 23-4.7-6 (Supp. 1985).

No reporting statute.

SOUTH CAROLINA: Parental consent statute was enacted in 1974; S.C. Code Ann. sec. 44-41-30 (Law. Co-op. 1985); enjoined by federal court; *Floyd v. Anders*, 440 F.Supp. 535 (D.S.C. 1977).

Reporting statute in effect as of 1975. S.C. Code Ann. sec. 44-41-60 (Law. Co-op. 1985).

SOUTH DAKOTA: Parental consent statute was enacted in 1973, but it is not presently operative. S.D. Codified Laws Ann. sec. 34-23A-7 (1986).

Reporting statute in effect as of 1973. S.D. Codified Laws Ann. sec. 34-23A-19 (1986).

TENNESSEE: Parental consent statute enacted in 1978; Tenn. Code Ann. sec. 39-4-202 (1982); enjoined by federal court in 1979; *Planned Parenthood v. Alexander*, No. 79-843 (Tenn. Ch. Ct. Oct. 24, 1979); parental consent statute enacted May 12, 1988, with intended effective date of July 1, 1989; enjoined by continuing federal injunction on facial challenge on June 30, 1989; and ruled unconstitutional on July 24, 1989, in *Planned Parenthood v. McWherter*, 716 F.Supp. 1064 (M.D. Tenn. 1989), *appeal docketed*, No. 89-6026 (6th Cir. Aug. 15, 1989).

Reporting statute in effect as of 1973. Tenn. Code Ann. sec. 39-4-203 (1982).

TEXAS: No parental or reporting statute.

UTAH: Parental notice statute enacted in 1974; Utah Code Ann. sec. 76-7-304 (1978); enjoined by federal court injunction; *L.R. v. Hanson*, No. 80-78 (D. Utah Feb. 8, 1980); constitutionality upheld in *H.L. v. Matheson*, 450 U.S. 398 (1981); subject to renewed challenge in 1986; *H.B. v. Wilkinson*, 639 F.Supp. 952 (D. Utah 1986). Upheld and in effect.

Reporting statute in effect from 1974 and amended in 1981. Utah Code Ann. sec. 76-7-313 (1978).

VERMONT: No parental or reporting statute.

VIRGINIA: No parental or reporting statute.

WASHINGTON: Parental consent statute enacted in 1970 with effective date of May 14, 1970; Wash. Rev. Code sec. 9.02.070 (1974). Enjoined on January 7, 1975, in *State v. Koome*, 84 Wash.2d 901, 530 P.2d 260 (1975).

No reporting statute.

WEST VIRGINIA: Parental notice statute enacted in 1984; W. Va. Code sec. 16-2F-3 (1985).

No reporting statute.

WISCONSIN: No parental statute.

Reporting statute enacted in 1985 and in effect as of Nov. 1, 1986. Wis. Stat. Ann. sec. 69.186 (West 1989).

WYOMING: Parental consent and notice statute enacted in 1989 with an effective date of June 8, 1989. Wyo. Stat. sec. 35-6-118 (1989).

Reporting statute in effect after May 27, 1977. Wyo. Stat. sec. 35-6-107 and 108 (1988).

Table 1
Abortions, Births, and Pregnancies*

YEAR	AGE	ABORTIONS	BIRTHS	(FETAL DEATHS)	PREGNANCIES
1973	10-17	*	2406	24	*
	18-19	*	4509	48	*
	20-24	*	18276	123	*
	25-54	*	27211	277	*
1974	10-17	*	2330	35	*
	18-19	*	4849	37	*
	20-24	*	19098	174	*
	25-54	*	28198	267	*
1975	10-17	1507	2427	24	3958
	18-19	1758	4693	43	6494
	20-24	2702	19137	162	22001
	25-54	2161	28748	238	31145
1976	10-17	2050	2309	22	4391
	18-19	2511	4489	37	7017
	20-24	3643	18630	158	22431
	25-54	2895	29678	264	32837
1977	10-17	2274	2280	19	4573
	18-19	2693	4604	50	7347
	20-24	4528	19863	133	24524
	25-54	3529	32492	261	36282
1978	10-17	2180	2089	18	4271
	18-19	3054	4844	40	7738
	20-24	5066	19851	141	25058
	25-54	3872	33710	267	37849
1979	10-17	2308	2035	21	4364
	18-19	3293	4720	44	8057
	20-24	5083	20938	126	26747
	25-54	4355	35827	245	40423

* Source: Raw data provided by the Minnesota Department of Health. Reported abortions, births, (fetal deaths) and pregnancies are those occurring in Minnesota, with non-residents and women of unknown age excluded. Pregnancies = abortions + births + fetal deaths. Assumes negligible occurrence of abortion to those of age 9 and below and age 55 and above. Abortion data unavailable for 1973 and 1974.

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Table 1 (Continued)
Abortions, Births, and Pregnancies

YEAR	AGE	ABORTIONS	BIRTHS	(FETAL DEATHS)	PREGNANCIES
1980	10-17	2327	1974	14	4315
	18-19	3380	4883	38	8301
	20-24	6054	21899	140	28093
	25-54	4716	37236	246	42198
1981	10-17	1820	1876	18	3714
	18-19	3064	4602	31	7697
	20-24	6047	21638	135	27820
	25-54	4881	38654	269	43804
1982	10-17	1564	1727	16	3307
	18-19	2799	4216	37	7052
	20-24	5963	21161	132	27256
	25-54	5180	39581	242	45003
1983	10-17	1432	1538	17	2987
	18-19	2547	3641	35	6223
	20-24	5487	19319	137	24943
	25-54	5012	39309	260	44581
1984	10-17	1395	1617	19	3031
	18-19	2586	3502	24	6112
	20-24	6032	18864	136	25032
	25-54	5525	40941	282	46748
1985	10-17	1570	1537	15	3122
	18-19	2531	3401	26	5958
	20-24	6067	18409	109	24585
	25-54	5812	42157	281	48250
1986	10-17	1545	1573	15	3133
	18-19	2372	3096	25	5493
	20-24	5724	16959	109	22792
	25-54	6035	42269	240	48544

* Source: Raw data provided by the Minnesota Department of Health. Reported abortions, births, (fetal deaths) and pregnancies are those occurring in Minnesota, with non-residents and women of unknown age excluded. Pregnancies = abortions + births + fetal deaths. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above. Abortion data unavailable for 1973 and 1974.

13a

Figure 1a
Abortions, Births, and Pregnancies
Ages 10-17

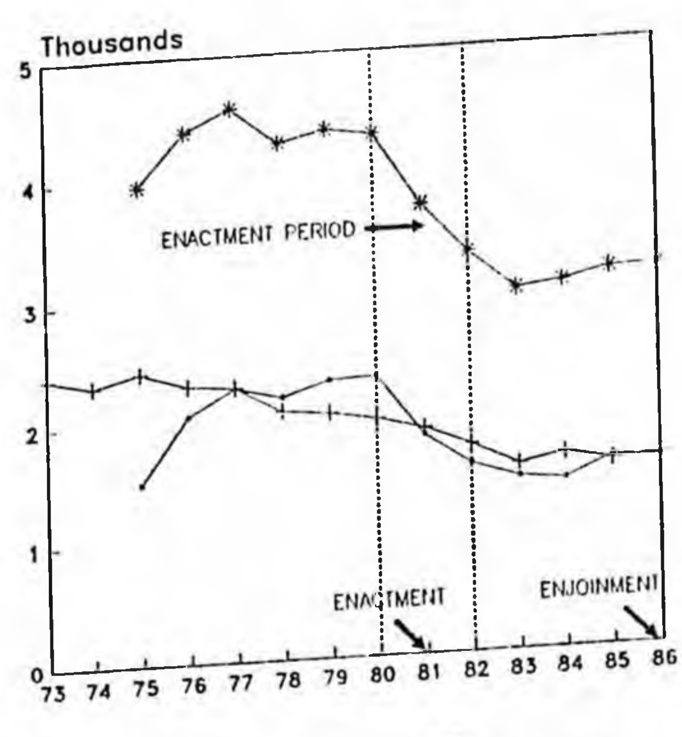
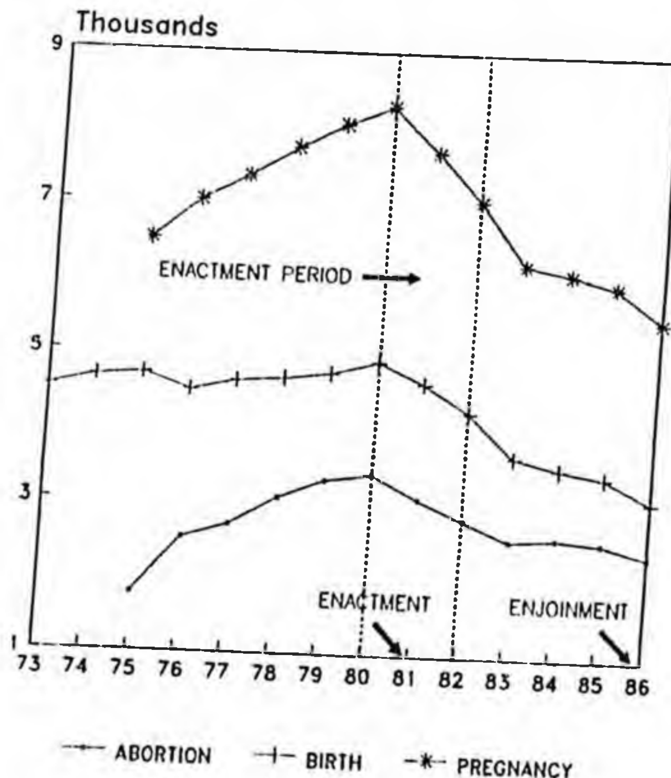


Figure 1b
Abortions, Births, and Pregnancies
Ages 18–19



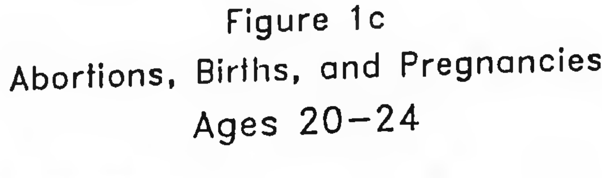


Figure 1c
Abortions, Births, and Pregnancies
Ages 20–24

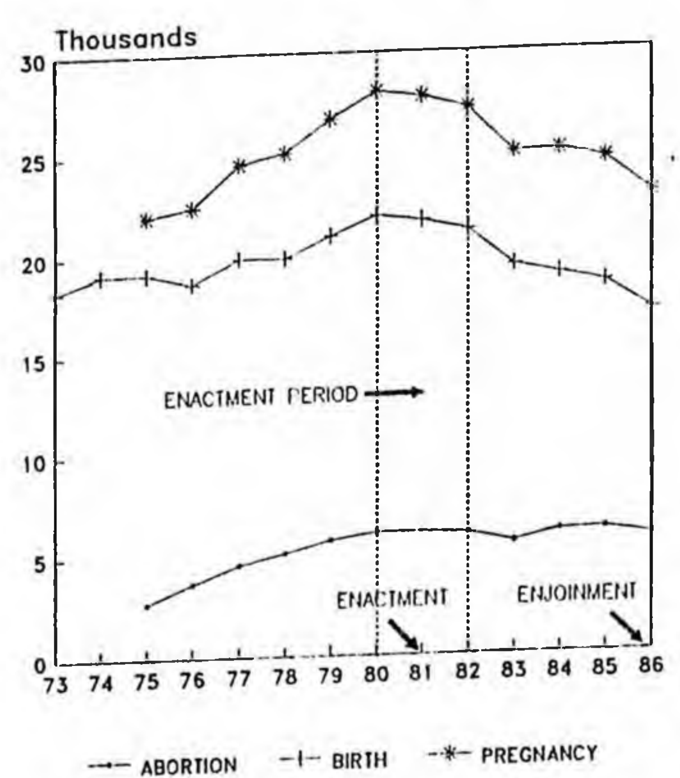


Figure 1d
Abortions, Births, and Pregnancies
Ages 25–54

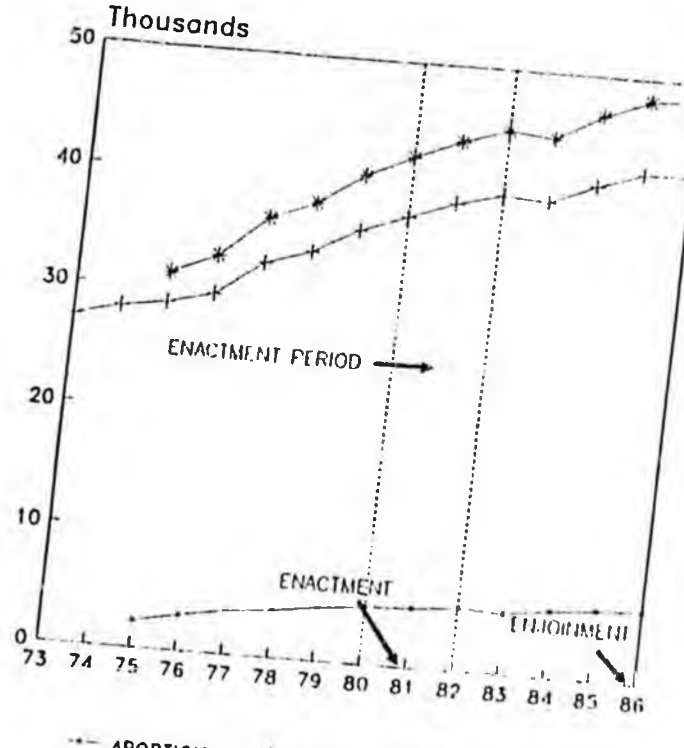


Table 2
Abortion, Birth, and Pregnancy Rates*

YEAR	AGE	POPULATION	ABORTION RATE	BIRTH RATE	PREGNANCY RATE
1973	10-17	319598	.	7.5	.
	18-19	72982	.	61.8	.
	20-24	177400	.	103.0	.
	25-54	652953	.	41.7	.
1974	10-17	318010	.	7.3	.
	18-19	73248	.	63.5	.
	20-24	178011	.	106.7	.
	25-54	659470	.	42.8	.
1975	10-17	310605	4.9	7.8	12.7
	18-19	85997	20.4	54.8	75.5
	20-24	178645	15.1	107.1	123.2
	25-54	683332	3.2	42.1	45.6
1976	10-17	305394	6.8	7.6	14.4
	18-19	86924	28.9	51.4	80.7
	20-24	183437	19.9	101.6	122.3
	25-54	699068	4.1	42.5	47.0
1977	10-17	296203	7.7	7.7	15.4
	18-19	86249	31.2	53.4	85.2
	20-24	187586	24.1	105.9	130.7
	25-54	709131	5.0	45.8	51.2
1978	10-17	288244	7.6	7.2	14.8
	18-19	85898	35.6	54.2	90.3
	20-24	192125	28.4	103.3	130.4
	25-54	724824	5.3	46.5	52.2
1979	10-17	282243	8.2	7.2	15.5
	18-19	85227	38.6	55.4	94.5
	20-24	186312	29.0	106.7	136.3
	25-54	744422	5.9	48.1	54.3

* Rate per 1000 female population. Source: Raw data provided by the Minnesota Department of Health. Rates reflect abortions, births, (fetal deaths), and pregnancies occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above. Abortion data unavailable for 1973 and 1974.

Table 2 (Continued)
Abortion, Birth, and Pregnancy Rates*

YEAR	AGE	POPULATION	ABORTION RATE	BIRTH RATE	PREGNANCY RATE
1980	10-17	278088	8.4	7.2	15.6
	18-19	84247	40.1	58.0	98.5
	20-24	198731	30.5	110.2	141.4
	25-54	754692	6.3	49.3	55.9
1981	10-17	267488	6.8	7.0	13.9
	18-19	80222	38.2	57.4	96.0
	20-24	198269	30.5	109.1	140.3
	25-54	770544	6.3	50.2	56.9
1982	10-17	262199	6.0	6.8	12.8
	18-19	77282	36.2	54.6	91.3
	20-24	197924	30.1	106.9	137.7
	25-54	787094	6.6	50.3	57.2
1983	10-17	263225	5.4	5.8	11.4
	18-19	77508	32.9	47.0	80.3
	20-24	198460	27.7	97.3	125.7
	25-54	789802	6.4	49.8	56.5
1984	10-17	249162	5.6	6.5	12.2
	18-19	74080	34.9	47.3	82.5
	20-24	199312	30.3	94.7	125.6
	25-54	798979	6.9	51.2	58.5
1985	10-17	251107	6.3	6.1	12.4
	18-19	74810	33.9	45.6	79.9
	20-24	200994	30.2	91.6	122.3
	25-54	806028	7.2	52.3	59.9
1986	10-17	251625	6.1	6.3	12.4
	18-19	74689	31.8	41.5	73.5
	20-24	201415	28.4	84.2	113.2
	25-54	808824	7.4	52.3	60.0

* Rate per 1000 female population. Source: Raw data provided by the Minnesota Department of Health. Rates reflect abortions, births, (fetal deaths), and pregnancies occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above. Abortion data unavailable for 1973 and 1974.

Figure 2a
Abortion, Birth, and Pregnancy Rates
Ages 10-17

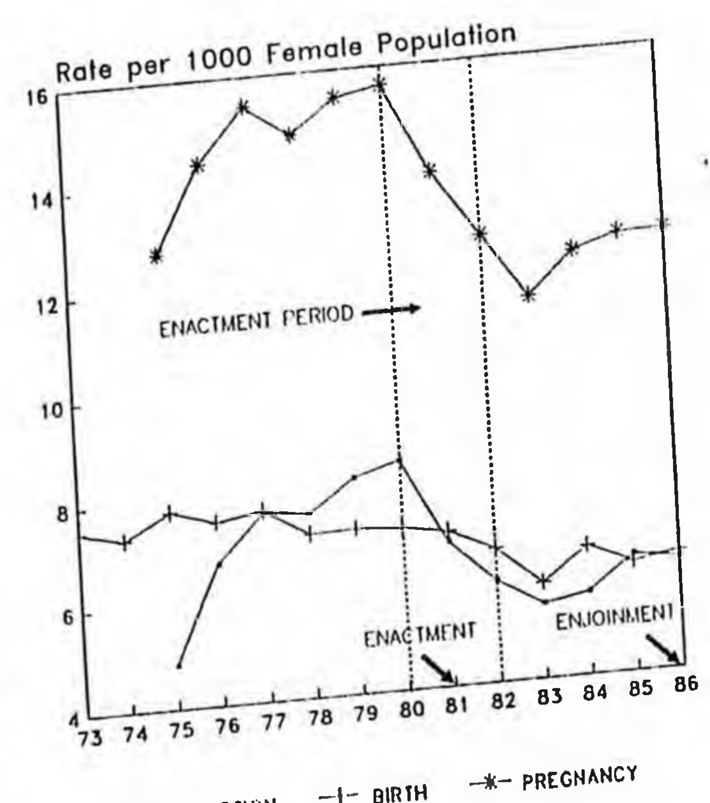
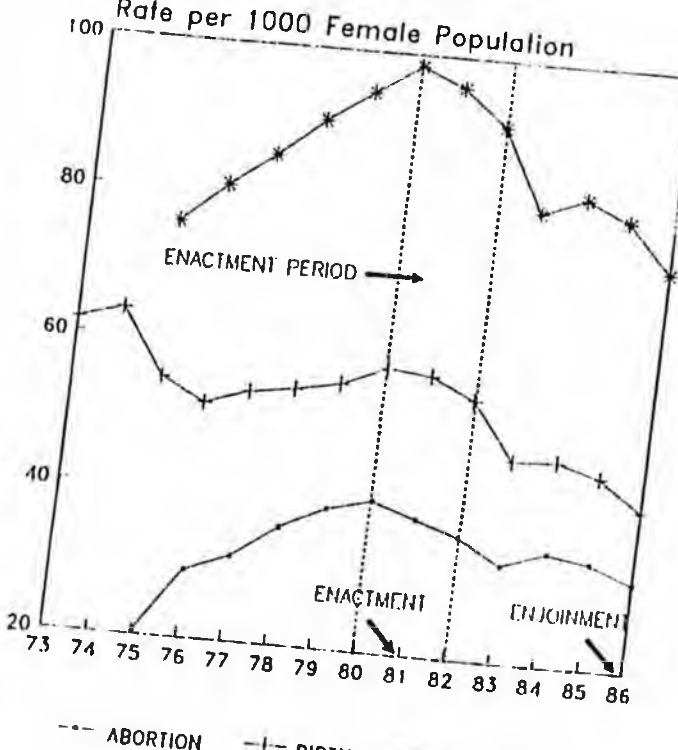


Figure 2b
Abortion, Birth, and Pregnancy Rates
Ages 18–19



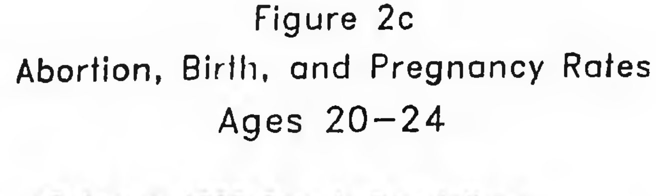


Figure 2c
Abortion, Birth, and Pregnancy Rates
Ages 20–24

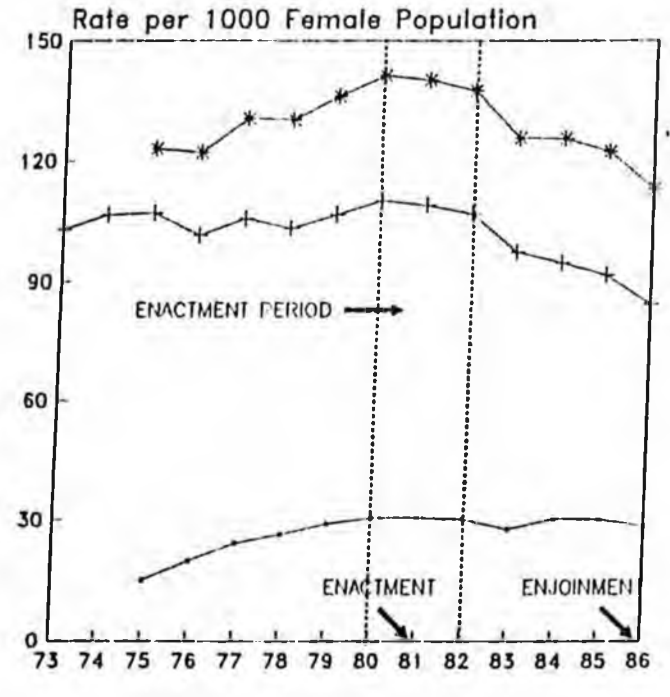


Figure 2d
Abortion, Birth, and Pregnancy Rates
Ages 25–54

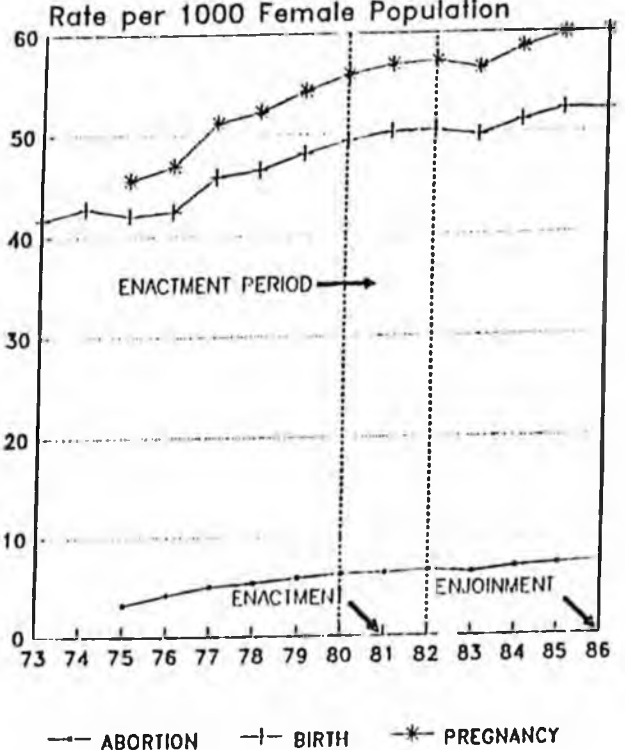


Table 3
Number and Percentage of Abortions with Gestation Age > 12 Weeks*

YEAR	AGE	TOTAL NUMBER OF ABORTIONS	ABORTIONS PERFORMED AT > 12 WKS GESTATION	PERCENTAGE OF ABORTIONS PERFORMED AT > 12 WKS GESTATION
1975	10-17	1507	270	17.9
	18-19	1758	228	13.0
	20-24	2702	275	10.2
	25-54	2181	189	8.7
1976	10-17	2060	470	22.8
	18-19	2511	428	17.0
	20-24	3643	446	12.2
	25-54	2895	308	10.6
1977	10-17	2274	474	20.0
	18-19	2693	464	17.2
	20-24	4528	512	11.3
	25-54	3529	368	10.4
1978	10-17	2186	403	18.4
	18-19	3054	449	14.7
	20-24	5060	505	10.0
	25-54	3872	302	7.8
1979	10-17	2308	432	18.7
	18-19	3293	460	14.0
	20-24	5683	591	10.4
	25-54	4355	327	7.5
1980	10-17	2327	510	21.9
	18-19	3380	562	16.6
	20-24	6054	681	11.2
	25-54	4718	403	8.5

* Source: Raw data provided by the Minnesota Department of Health. Table reflects abortions occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above.

Table 3 (Continued)
Number and Percentage of Abortions with Gestation Age > 12 Weeks*

YEAR	AGE	TOTAL NUMBER OF ABORTIONS	ABORTIONS PERFORMED AT > 12 WKS GESTATION	PERCENTAGE OF ABORTIONS PERFORMED AT > 12 WKS GESTATION
1981	10-17	1820	365	20.1
	18-19	3064	462	15.1
	20-24	6047	625	10.3
	25-54	4881	363	7.4
1982	10-17	1564	322	20.6
	18-19	2799	425	15.2
	20-24	5963	631	10.6
	25-54	5180	412	8.0
1983	10-17	1432	334	23.3
	18-19	2547	419	16.5
	20-24	5487	626	11.4
	25-54	5012	370	7.4
1984	10-17	1395	360	25.8
	18-19	2586	489	18.9
	20-24	6032	786	13.0
	25-54	5525	461	8.3
1985	10-17	1570	361	23.0
	18-19	2531	441	17.4
	20-24	6087	723	11.9
	25-54	5812	450	7.8
1986	10-17	1545	333	21.6
	18-19	2372	435	18.3
	20-24	5724	668	11.7
	25-54	6035	516	8.6

* Source: Raw data provided by the Minnesota Department of Health. Table reflects abortions occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above.

Figure 3a
Number of Abortions with Gestation Age > 12 Weeks

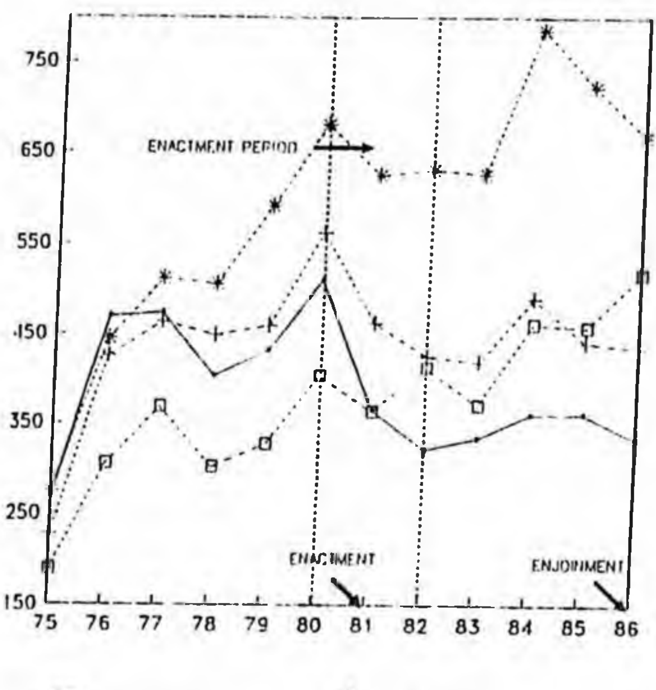


Figure 3b
Percentage of Abortions with Gestation Age > 12 Weeks

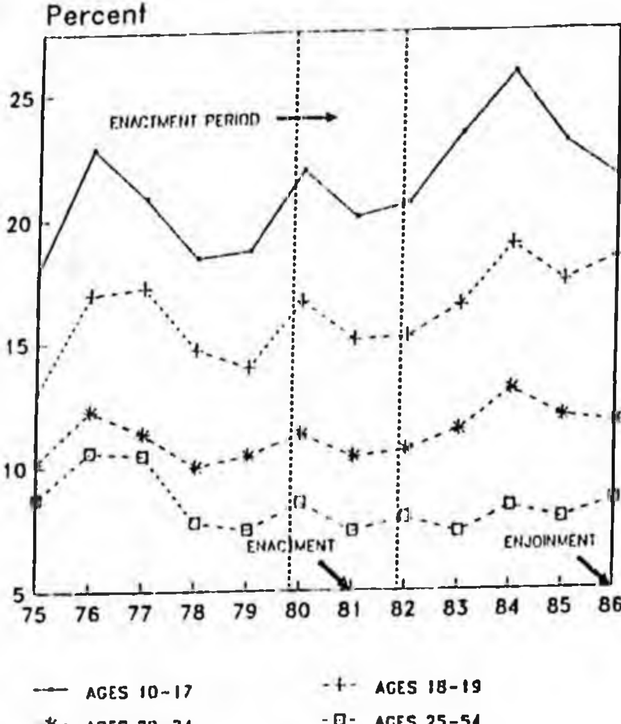


Table 4
Number and Percentage of Abortions with Reported Medical Complications*

YEAR	AGE	TOTAL NUMBER OF ABORTIONS	ABORTIONS WITH MEDICAL COMPLICATIONS	PERCENTAGE OF ABORTIONS WITH MEDICAL COMPLICATIONS
1975	10-17	1507	16	1.06
	18-19	1758	25	1.42
	20-24	2702	32	1.18
	25-54	2161	26	1.20
1976	10-17	2060	11	0.53
	18-19	2511	7	0.28
	20-24	3643	20	0.55
	25-54	2885	21	0.73
1977	10-17	2274	5	0.22
	18-19	2693	6	0.22
	20-24	4528	14	0.31
	25-54	3529	11	0.31
1978	10-17	2136	8	0.37
	18-19	3054	19	0.62
	20-24	5066	26	0.51
	25-54	3872	19	0.49
1979	10-17	2308	3	0.13
	18-19	3293	2	0.06
	20-24	5683	8	0.14
	25-54	4355	5	0.11
1980	10-17	2327	6	0.26
	18-19	3380	10	0.30
	20-24	6054	8	0.13
	25-54	4710	14	0.30

* Source: Raw data provided by the Minnesota Department of Health. Table reflects abortions occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligible occurrence of abortion to those of age 9 and below and age 55 and above.

Table 4 (Continued)
Number and Percentage of Abortions with Reported Medical Complications*

YEAR	AGE	TOTAL NUMBER OF ABORTIONS	ABORTIONS WITH MEDICAL COMPLICATIONS	PERCENTAGE OF ABORTIONS WITH MEDICAL COMPLICATIONS
1981	10-17	1820	0	0.00
	18-19	3064	8	0.26
	20-24	6047	21	0.35
	25-54	4881	11	0.23
1982	10-17	1564	10	0.64
	18-19	2799	10	0.36
	20-24	5963	38	0.64
	25-54	5180	46	0.89
1983	10-17	1432	10	0.70
	18-19	2547	20	0.79
	20-24	5487	49	0.89
	25-54	5012	51	1.02
1984	10-17	1395	14	1.00
	18-19	2588	29	1.12
	20-24	6032	62	1.03
	25-54	5525	66	1.19
1985	10-17	1570	13	0.83
	18-19	2531	12	0.47
	20-24	6067	76	1.25
	25-54	5812	60	1.03
1986	10-17	1545	8	0.52
	18-19	2372	15	0.63
	20-24	5724	48	0.84
	25-54	6035	74	1.23

* Source: Raw data provided by the Minnesota Department of Health. Table reflects abortions occurring in Minnesota, with non-residents and women of unknown age excluded. Assumes negligable occurrence of abortion to those of age 9 and below and age 55 and above.

Figure 4a
Number of Abortions with Reported Medical Complications

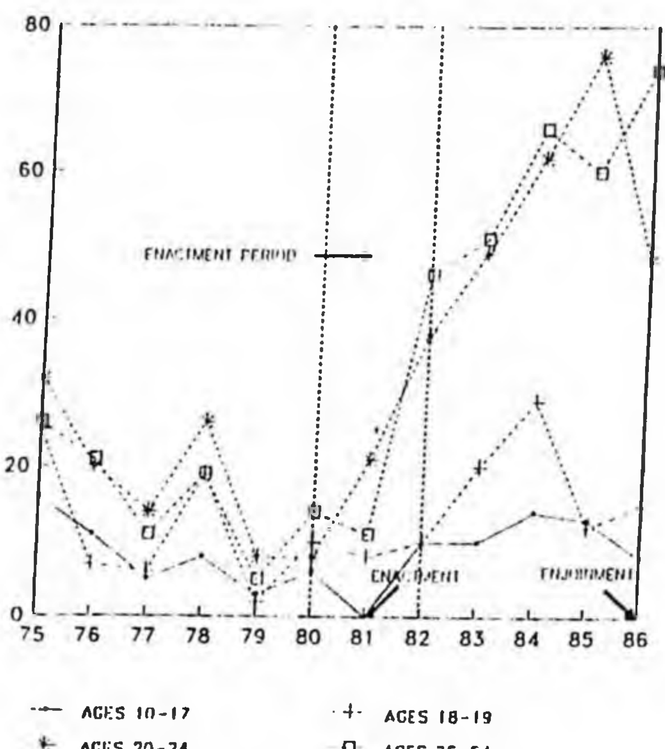


Figure 4b
Percentage of Abortions
with Reported Medical Complications

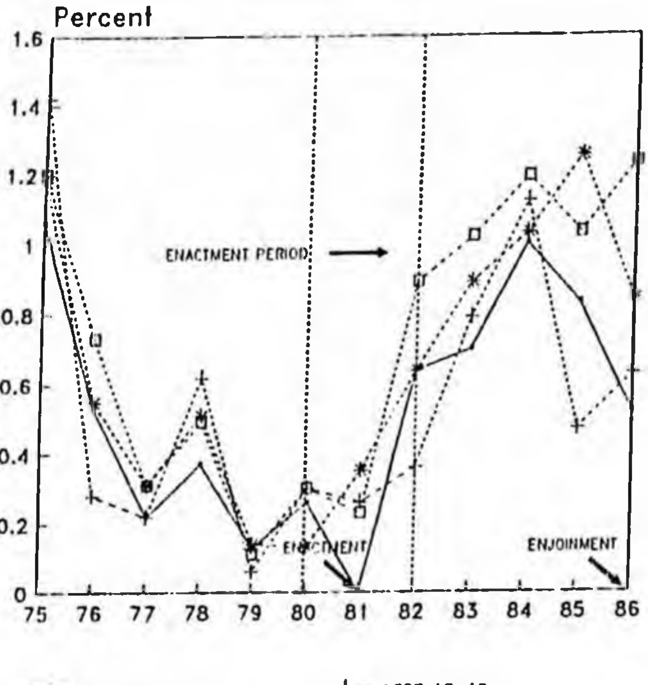


Table 5
Birth Rate
for Different Regions of Minnesota*

YEAR	AGE	MINNESOTA	METROPOLITAN MINNEAPOLIS**	MINNEAPOLIS
1973	10-14	0.4	0.4	.
	15-17	20.4	20.4	.
	18-19	63.7	53.9	.
	20-24	100.0	96.1	.
	25-34	95.4	87.2	.
1974	10-14	0.3	0.3	.
	15-17	19.1	19.1	.
	18-19	64.5	57.4	.
	20-24	109.3	106.0	.
	25-34	97.8	83.3	.
1975	10-14	0.4	0.4	.
	15-17	21.0	18.7	.
	18-19	56.1	48.7	.
	20-24	110.2	91.3	.
	25-34	93.9	88.9	.
1976	10-14	0.4	0.4	1.7
	15-17	19.7	18.2	36.7
	18-19	52.9	47.0	48.8
	20-24	104.5	85.0	82.9
	25-34	93.0	85.8	87.9
1977	10-14	0.3	0.3	1.1
	15-17	19.6	18.3	39.4
	18-19	55.1	48.1	58.1
	20-24	108.1	88.5	84.4
	25-34	90.0	89.6	72.9

* Rate per 1000 female population. Sources: Raw data provided by the Minnesota and Minneapolis Departments of Health. Non residents and women of unknown age are excluded. Minneapolis data were provided in a form unsuitable for figuring rates for ages 35-44 or above.

** Metropolitan Minneapolis is defined as a seven-county region including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Table 5 (Continued)
Birth Rate
for Different Regions of Minnesota*

YEAR	AGE	MINNESOTA	METROPOLITAN MINNEAPOLIS**	MINNEAPOLIS
1978	10-14	0.4	0.4	1.3
	15-17	17.8	16.0	35.4
	18-19	55.6	51.7	61.5
	20-24	106.8	85.3	63.2
	25-34	100.3	90.0	73.7
1979	10-14	0.3	0.4	1.7
	15-17	17.8	17.6	39.7
	18-19	56.9	52.6	56.3
	20-24	110.0	88.4	67.8
	25-34	102.0	91.9	74.0
1980	10-14	0.3	0.4	1.6
	15-17	17.5	17.4	39.1
	18-19	59.3	53.8	62.9
	20-24	113.4	92.3	71.3
	25-34	104.7	95.3	77.5
1981	10-14	0.3	0.4	1.3
	15-17	17.5	17.2	41.2
	18-19	59.1	53.9	65.0
	20-24	112.4	94.0	71.5
	25-34	105.8	98.9	82.7
1982	10-14	0.4	0.5	2.2
	15-17	16.6	17.2	42.7
	18-19	56.2	52.1	65.9
	20-24	109.9	88.8	69.8
	25-34	104.8	97.3	84.6

* Rate per 1000 female population. Sources: Raw data provided by the Minnesota and Minneapolis Departments of Health. Non-residents and women of unknown age are excluded. Minneapolis data were provided in a form unsuitable for figuring rates for ages 35-44 or above.
** Metropolitan Minneapolis is defined as a seven-county region including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Table 5 (Continued)
Birth Rate
for Different Regions of Minnesota*

YEAR	AGE	MINNESOTA	METROPOLITAN MINNEAPOLIS**	MINNEAPOLIS
1983	10-14	0.3	0.5	1.9
	15-17	14.6	15.1	47.3
	18-19	48.5	45.4	58.1
	20-24	100.0	80.1	64.3
	25-34	103.3	97.3	83.2
1984	10-14	0.3	0.5	1.3
	15-17	16.1	17.4	54.1
	18-19	48.7	45.7	63.1
	20-24	97.4	79.5	66.4
	25-34	106.6	102.3	85.9
1985	10-14	0.4	0.6	2.1
	15-17	15.1	16.5	58.2
	18-19	47.0	45.8	73.4
	20-24	94.4	80.1	69.7
	25-34	108.6	106.1	89.8
1986	10-14	0.4	0.5	2.0
	15-17	15.6	17.8	62.2
	18-19	42.6	44.0	81.2
	20-24	86.6	74.2	70.6
	25-34	107.6	100.3	87.5
1987	10-14	.	.	2.2
	15-17	.	.	64.5
	18-19	.	.	92.2
	20-24	.	.	67.5
	25-34	.	.	84.2

* Rate per 1000 female population. Sources: Raw data provided by the Minnesota and Minneapolis Departments of Health. Non-residents and women of unknown age are excluded. Minneapolis data were provided in a form unsuitable for figuring rates for ages 35-44 or above.
** Metropolitan Minneapolis is defined as a seven-county region including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Figure 5a
Birth Rate
for Different Regions of Minnesota
Ages 15-17

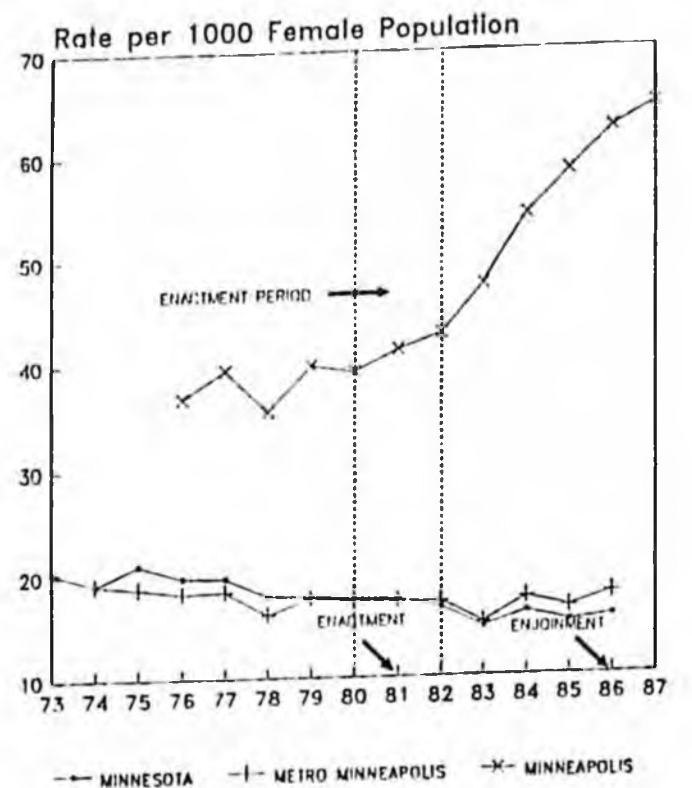


Figure 5b
Birth Rate
for Different Regions of Minnesota
Ages 10-14

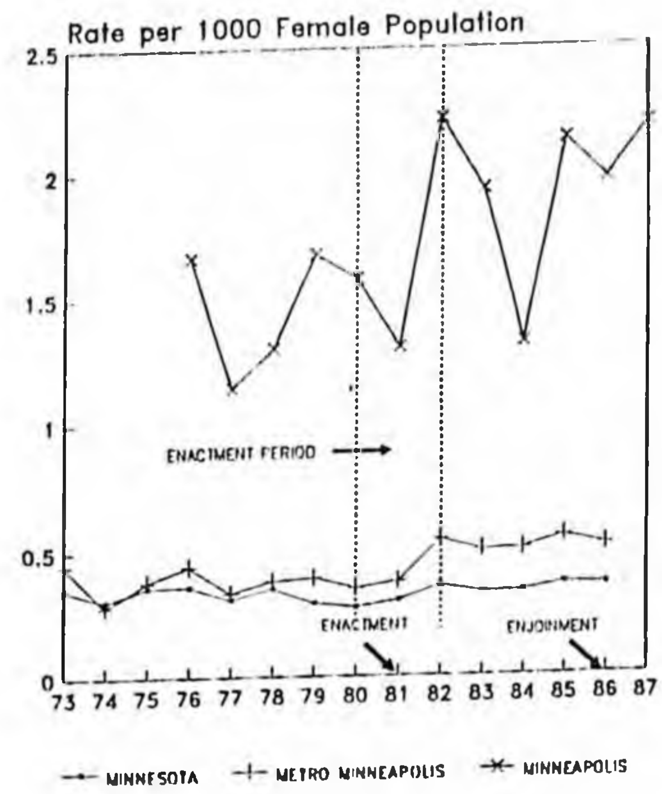


Figure 5c
Birth Rate
for Different Regions of Minnesota
Ages 18–19

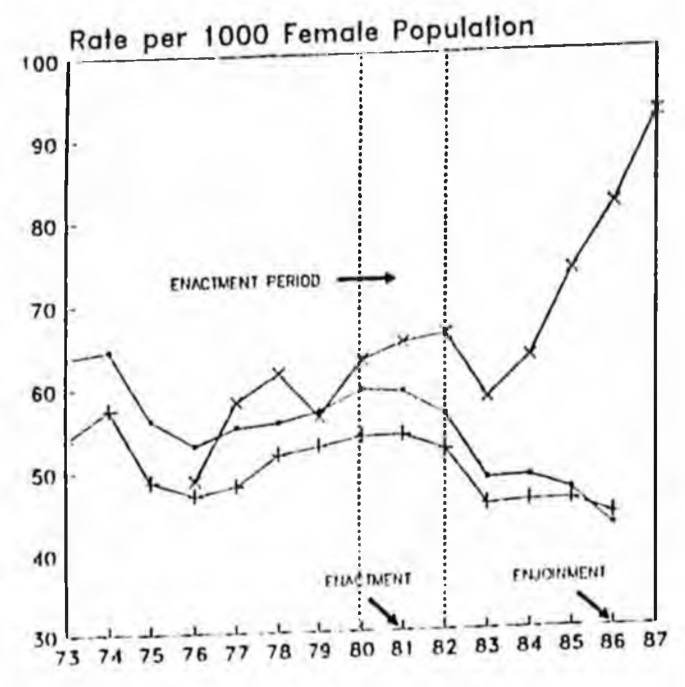


Figure 5d
Birth Rate
for Different Regions of Minnesota
Ages 20–24

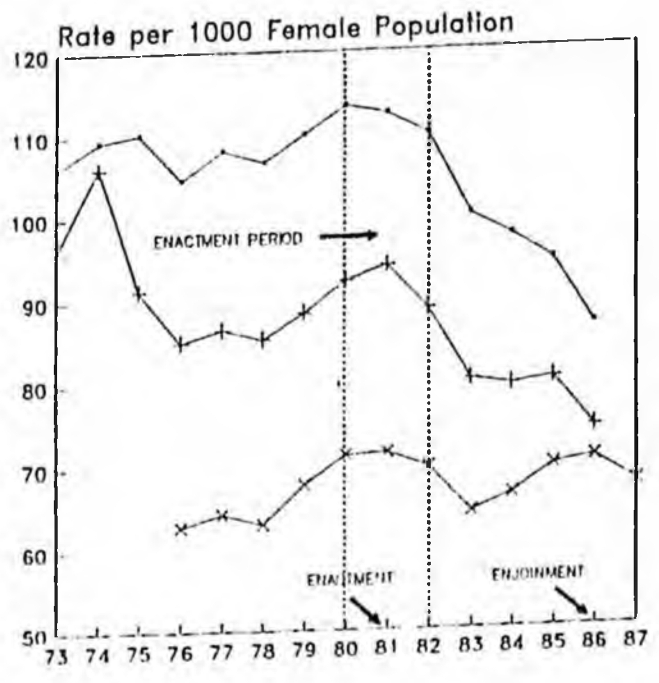


Figure 5e
Birth Rate
for Different Regions of Minnesota
Ages 25–34

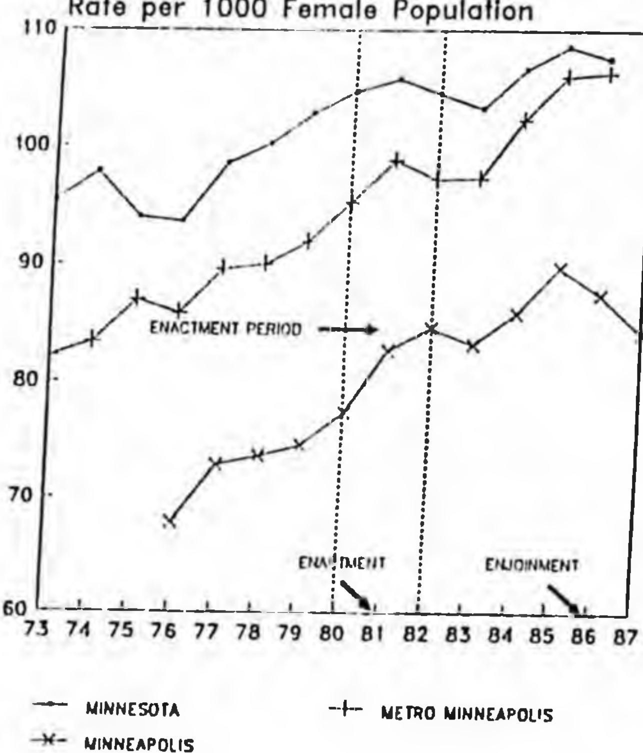


Table 6
Birth Rate for Minneapolis Residents by Age Group*

YEAR	AGES 10-14	AGES 15-17	AGES 18-19
1976	1.7	36.7	48.6
1977	1.1	39.4	56.1
1978	1.3	35.4	61.5
1979	1.7	38.7	56.3
1980	1.6	39.1	62.9
1981	1.3	41.2	65.0
1982	2.2	42.7	65.9
1983	1.9	47.3	56.1
1984	1.3	54.1	63.1
1985	2.1	58.2	73.4
1986	2.0	62.2	81.2
1987	2.2	64.5	92.2

YEAR	AGES 20-24	AGES 25-34
1976	62.9	67.8
1977	64.4	72.9
1978	63.2	73.7
1979	67.6	74.6
1980	71.3	77.5
1981	71.5	82.7
1982	69.6	84.6
1983	64.3	83.2
1984	66.4	85.9
1985	69.7	89.8
1986	70.6	87.5
1987	67.5	84.2

* Rate per 1000 female population. Source: Raw data provided by the Minneapolis Department of Health. Data provided in a from unsuitable for figuring rates for ages 35-44 or above.

Figure 6
Birth Rate for Minneapolis Residents by Age Group

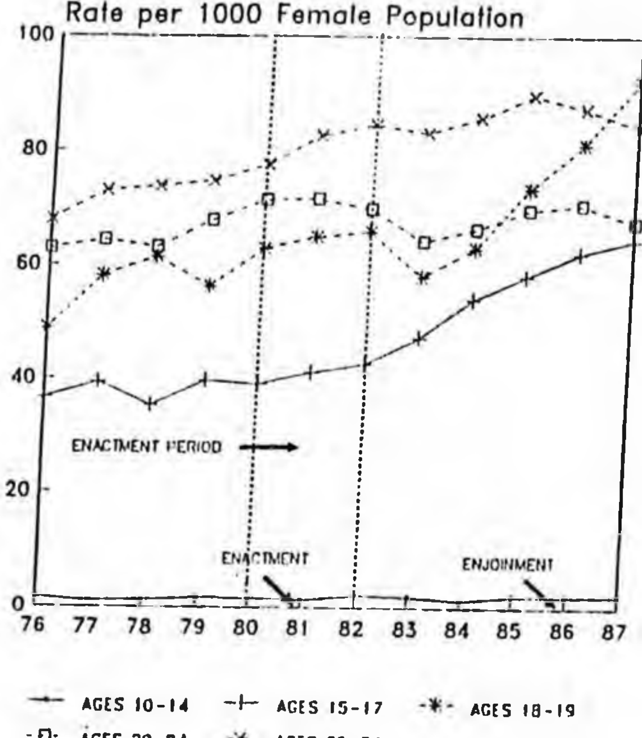


Table 7
Births to Mothers < 18 Years of Age as Percentage of Total Births*

	MINNEAPOLIS	U.S.	MINNESOTA
1970		6.3	
1973			4.6
1974			4.2
1975		7.6	4.4
1976	6.2		4.2
1977	5.9		3.9
1978	5.1		3.4
1979	5.3		3.2
1980	4.7	5.8	3.0
1981	4.5	5.4	2.8
1982	4.3	5.2	2.6
1983	4.4	5.0	2.4
1984	4.4	4.8	2.5
1985	4.5	4.7	2.3
1986	4.8	4.6	2.5
1987	5.1		2.4

MINNEAPOLIS BY RACE

	WHITE	BLACK	ASIAN/PACIFIC ISLAND	AMERICAN INDIAN
1976	4.0	15.3	0.0	18.9
1977	4.1	13.7	1.4	13.9
1978	3.4	11.5	0.0	12.9
1979	2.9	13.5	3.0	15.3
1980	2.9	11.4	1.7	13.3
1981	2.6	11.4	[illegible]	13.0
1982	2.9	11.0	[illegible]	11.0
1983	2.2	11.0	4.9	13.7
1984	2.3	10.6	6.5	11.2
1985	2.2	10.4	7.1	11.1
1986	2.3	[illegible]	5.8	9.3
1987	1.9	[illegible]	6.5	10.6

* Sources: National Center for Health Statistics: *Health, United States, 1988.* DHHS Pub. No. (PHS) 89-1732. Public Health Service. Washington. U.S. Government Printing Office, Mar. 1989. p.47. Minneapolis raw data provided by the Minneapolis Department of Health. Data for some years not available.

Table 7 (Continued)
Births to Mothers < 18 Years of Age
as Percentage of Total Births*

UNITED STATES BY RACE

	WHITE	BLACK	ASIAN/PACIFIC ISLAND	AMERICAN INDIAN
1970	4.8	14.7	3.3	7.5
1975	6.0	16.1	2.7	11.0
1980	4.5	12.2	1.7	8.8
1981	4.3	11.4	1.8	8.5
1982	4.1	11.1	1.8	8.0
1983	3.9	10.9	1.7	7.9
1984	3.7	10.6	1.8	7.4
1985	3.7	10.3	1.8	7.1
1986	3.7	10.4	1.9	7.4

* Sources: National Center for Health Statistics: *Health, United States, 1988* DHHS Pub. No. (PHS) 89-1232. Public Health Service. Washington. U.S. Government Printing Office, Mar. 1989. p.47. Minneapolis raw data provided by the Minneapolis Department of Health. Data for some years not available.

Figure 7a
Births to Mothers < 18 Years of Age
as Percentage of Total Births
Minneapolis, Minnesota, and U.S.

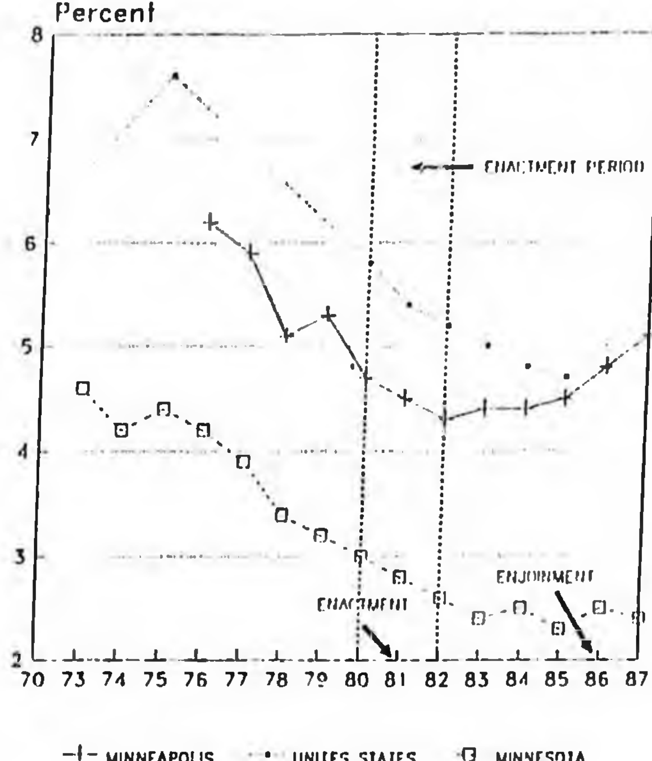


Figure 7b
Births to Mothers < 18 Years of Age
as Percentage of Total Births
by Race/Ethnicity
Minneapolis and U.S.

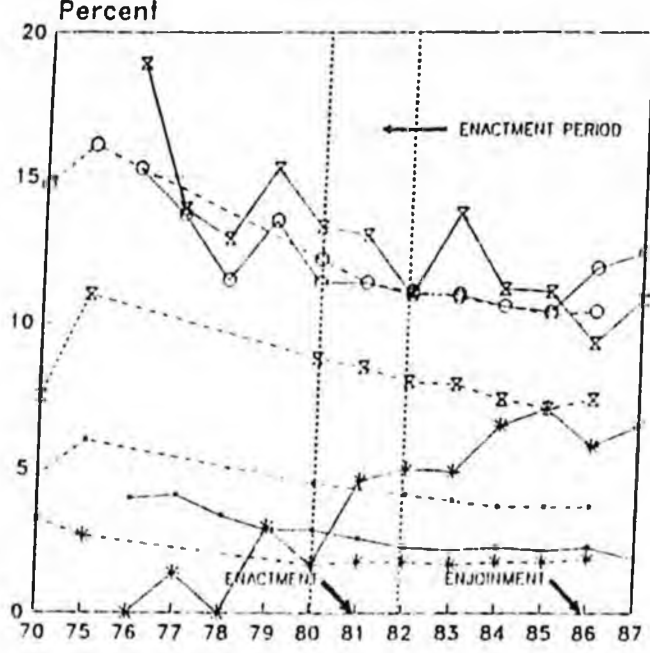
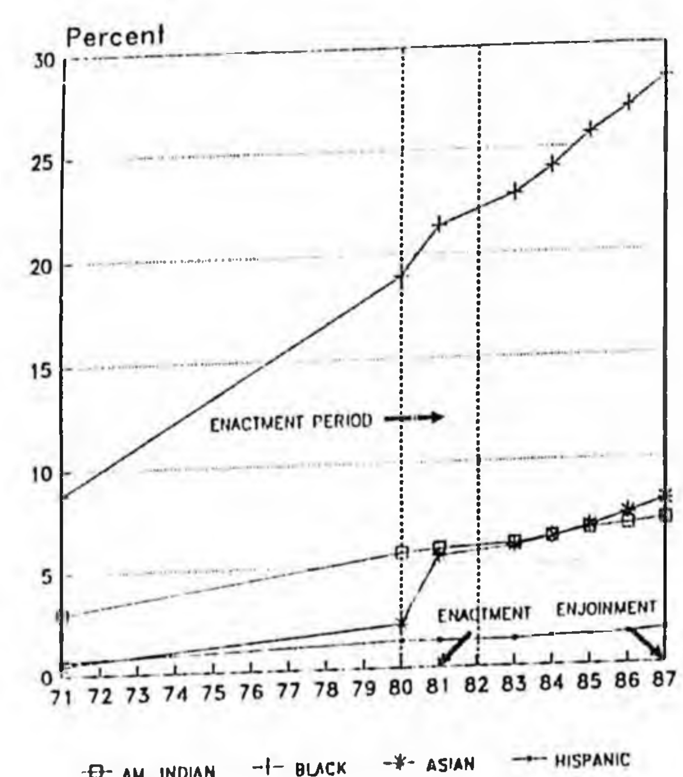


Table 8
Percent Racial/Ethnic Enrollment
Minneapolis Public School District*

	AMERICAN INDIAN	BLACK	ASIAN	HISPANIC
1971	3.0	8.8	0.5	0.7
1980	5.6	19.0	2.1	1.3
1981	5.8	21.3	5.4	1.3
1983	6.0	22.8	5.8	1.3
1984	6.3	24.1	6.2	1.4
1985	6.6	25.7	6.7	1.4
1986	6.8	26.9	7.3	1.5
1987	7.0	28.4	8.0	1.7

* Source: Raw data provided in *Racial-Ethnic Enrollment Trends in Twin Cities Area Schools, 1986-1987*. Pub. No. 620-88-115. Metropolitan Council, St. Paul, Minnesota.

Figure 8
Percent Racial/Ethnic Enrollment
Minneapolis Public School District



ARTICLES

Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion

*Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White, Noel S. Weiss**

Background: Certain events of reproductive life, especially completed pregnancies, have been found to influence a woman's risk of breast cancer. Prior studies of the relationship between breast cancer and a history of incomplete pregnancies have provided inconsistent results. Most of these studies included women beyond the early part of their reproductive years at the time induced abortion became legal in the United States. *Purpose:* We conducted a case-control study of breast cancer in young women born recently enough so that some or most of their reproductive years were after the legalization of induced abortion to determine if certain aspects of a woman's experience with abortion might be associated with risk of breast cancer. *Methods:* Female residents of three counties in western Washington State, who were diagnosed with breast cancer (n = 845) from January 1983 through April 1990, and who were born after 1944, were interviewed in detail about their reproductive histories, including the occurrence of induced abortion. Case patients were obtained through our population-based tumor registry (part of the Surveillance, Epidemiology, and End Results Program of the National Cancer Institute). Similar information was obtained from 961 control women identified through random digit dialing within these same counties. Logistic regression analysis was used to estimate odds ratios and confidence intervals (CIs). *Results:* Among women who had been pregnant at least once, the risk of breast cancer in those who had experienced an induced abortion was 50% higher than among other women (95% CI = 1.2-1.9). While this increased risk did not vary by the number of induced abortions or by the history of a completed pregnancy, it did vary according to the age at which the abortion occurred and the duration of that pregnancy. Highest risks were observed when the abortion was done at ages younger than 18 years—particularly if it took place after 8 weeks' gestation—or at 30 years of age or older. No increased risk of breast cancer was associated with a spontaneous abortion (RR = 0.9; 95% CI = 0.7-1.2). *Conclusion:* Our data support the hypothesis that an induced abortion can adversely influence a woman's subsequent risk of breast cancer. However, the results across all epidemiologic studies of this premise are inconsistent—both overall and within specific subgroups. The risk of breast cancer should be reexamined in future studies of women who have had legal abortion available to them throughout the majority of their reproductive years, with particular attention to the potential influence of induced abortion early in life. [J Natl Cancer Inst 86:1584-1592, 1994]

In 1973, the Supreme Court legalized induced abortion in the United States. Since that time, this procedure has been used by many women to terminate unwanted pregnancies. The Alan Guttmacher Institute estimates that as of 1990, one in four U.S. women younger than 45 years of age had had at least one induced abortion (Henshaw SK: personal communication). Since the timing and number of completed pregnancies are known to affect a woman's risk of breast cancer (*1*), it is possible that a history of terminated pregnancies may have an effect as well.

In 1981, Pike et al. (*2*) reported a 2.4-fold increase in the risk of breast cancer among young women (aged younger than 33 years) that was associated with a first-trimester induced abortion prior to a full-term pregnancy. While additional studies have examined the general question of induced abortion as a risk factor for breast cancer (*3-10*), they primarily included women who, by the early 1970s, already were beyond the early part of their reproductive lives. Thus, the studies have been limited, to some extent, in their ability to evaluate the impact of an abortion at a relatively young age or prior to a first pregnancy.

We conducted a case-control study of breast cancer in young women born recently enough to have had some or most of their reproductive years after the legalization of induced abortion to determine if there were certain aspects of a woman's experience

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See "Notes" section following "References."

cancer.

Patients and Methods

All white women diagnosed with a first invasive or in situ breast cancer between January 1, 1983, and April 30, 1990, who were residents of King, Pierce, or Snohomish County in Washington State and who were born after 1944, were eligible for the study. We restricted our study to white women, since approximately 85% of this population is white and no minority group makes up more than 5% of the population. These women were identified through the Cancer Surveillance System, a population-based tumor registry that serves 13 counties in western Washington State and is part of the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI). Of the 1011 eligible cases, 845 (83.6%) were successfully interviewed. Reasons for not obtaining an interview for case patients included the following: deceased (n = 58; 5.7%), patient refusal (n = 71; 7.0%), and physician refusal to give permission (n = 37; 3.7%). Ninety-eight of the case patients interviewed had been diagnosed as having an in situ lesion.

Controls were recruited by random digit dialing, using the method described by Waksberg (11). To minimize geographic clustering of controls that can occur using the Waksberg-Mitofsky method of random digit dialing, we used a clustering factor of two residences per sampling unit (denoted "k" by Waksberg). Use of a "k" of 2 resulted in no more than two controls per sampling unit, although the majority of sampling units yielded either one or no controls. All telephone numbers were called at least nine times at different times of the week during a 2- to 6-week period before they were abandoned. Telephone numbers that resulted in refusals to answer the screening questions were called again by a different interviewer 4-6 months later. One half of the initial refusers were successfully screened on the second attempt. One-step recruitment was used, with a stratified sampling design that recruited controls into age strata evenly throughout the control ascertainment period (12,13). The King County controls were shared by another study, therefore age stratification requirements were determined by the study needing the largest number of controls. Eligible women who agreed to receive a letter about the study were contacted within 3 weeks of the initial random digit dialing contact by an interviewer to schedule a personal interview. We were unable to determine residential status after nine or more attempts for 4% of the telephone numbers dialed (3%: "no answer," 0.2%: "slow busy" [tone repeated 60 times per minute], and 0.5%: "fast busy" [tone repeated 120 times per minute]). In the past, we found the majority of these numbers to be nonresidential. We were able to obtain a household census for 97% of the known private residences. Of the 1239 respondents who met the study's residence and age requirements, 961 (78%) were successfully interviewed for a final overall response rate of 75.5%.

All but 1.8% of the interviews were conducted in person. To aid the women's recall, trained interviewers used a calendar on which major life events were identified. Only events that took place before each woman's reference date (month and year of diagnosis for the case patients and a comparable date for controls) were recorded. Demographic, lifestyle, and medical-history data were obtained, as well as data on family history of breast and other cancers. We also obtained a detailed history of birth-control methods used by each woman. A complete menstrual and pregnancy history was obtained for all women. For each induced or spontaneous abortion reported, questions were asked regarding the gestational age (number of weeks or 1-8, 9-12, 13-16, or >16 weeks) and method of birth control (if any) at the time of conception. In addition, the type of procedure was ascertained for each induced abortion.

Logistic regression analysis using EGRET (Statistics and Epidemiology Research Corp., Seattle, Wash.) statistical software was used to estimate odds ratios (ORs) and confidence intervals (CIs) associated with induced abortion. The primary focus of the analysis was on the difference in the subsequent risk of breast cancer between pregnant women who did and did not choose to terminate that pregnancy but who, based on their demographic characteristics and childbearing histories, were otherwise at similar risk. Thus, all analyses presented are adjusted for age (continuous), family history of breast cancer (none, mother or full sister, or grandmother, aunt, or half sister), religion (none/Jewish/other, Catholic/Mormon/Seventh-day Adventist, or other Christian), and age at first pregnancy (11-17, 18-19, 20-29, or 30-41 years). Adjustment for age at first birth was done in analyses that were restricted to parous women (women who ever had a live birth or stillbirth). Further adjustment for residence, alcohol use, cigarette smoking history, age at menarche, income, education, and marital status. Analyses relating to gestational length were restricted to the categories 1-8, 9-12, and 13 or more weeks, since the women who did not know the exact number of weeks of gestation were asked to report which of the above gestational categories best represented their experience. Analyses for spontaneous abortion were adjusted for age, marital status (never married, currently or formerly married, or living as married), family history of breast cancer, age at first live birth, and body mass index (quartiles). The term relative risk (RR) is used hereafter instead of odds ratio, since the two have similar values in case-control studies of other than very common diseases.

Results

On the average, controls in our study were somewhat younger than the breast cancer case patients (Table 1). Adjusting for age, an increased risk of breast cancer was associated with early age at menarche, nulliparity, and having a first- or second-degree relative who had breast cancer. In contrast, parous case patients and controls were similar with respect to age at first birth and number of children. Women in the highest quartile of body mass index had a 20% reduction in breast cancer risk. The proportion of control participants with a history of induced abortion decreased with increasing age and increasing parity and differed by religious affiliation (Table 2). However, that proportion varied little by other characteristics.

Among women who had been pregnant at least once, a history of induced abortion was associated with an increased risk of breast cancer (RR = 1.5; 95% CI = 1.2-1.9) (Table 3). The RR was also 1.5 (95% CI = 1.2-2.0) in women who had given birth at least once, adjusting for age at first full-term pregnancy. When we confined this analysis to parous women whose only pregnancies were live births and/or induced abortions, the RR was 1.6 (95% CI = 1.2-2.3). The magnitude of the association did not vary substantially by whether the induced abortion preceded or followed a first birth or by the interval from first abortion to cancer diagnosis. The magnitude of the increase in risk of breast cancer was similar between women who had one or more than one induced abortion. The RR associated with having an induced abortion was 1.8 (95% CI = 1.2-2.9) in women younger than 35 years at diagnosis and/or reference date; it was 1.4 (95% CI = 1.0-1.9) in 35- to 44-year-old women. While pregnancies terminated by an induced abortion at 9-12 weeks' gestation were associated with a somewhat higher risk than those terminated earlier, that trend was not continued in the small number of abortions that took place beyond 12 weeks. The elevation in risk associated with induced abortion was greater in women who underwent their first induced abortion either before 18 years of age (RR = 2.5; 95% CI = 1.1-5.7) or at age 30 years and older (RR = 2.1; 95% CI = 1.2-3.5) (Table 3). The risk associated with abortion did not vary by early or late stage of disease at diagnosis. Among women who had an induced abortion as a teenager, there was no variation in risk by age at menarche (data not shown).

We examined the combined influence of age at first induced abortion and the gestational length at the time the abortion occurred. Fifteen case patients, but only five controls, had terminated a pregnancy when younger than 18 years of age that had lasted more than 8 weeks (adjusted RR = 9.0; 95% CI = 2.0-

Characteristic	Case patients (n = 845)		Controls (n = 961)		Age-adjusted RR (95% CI)
	No.	%	No.	%	
Age, y					
21-30	71	8	163	17	Not applicable
31-35	197	23	246	26	
36-40	380	45	388	40	
41-45	197	23	164	17	
Birth year					
1945-1949	495	59	469	49	Not applicable
1950-1954	235	28	283	29	
1955-1959	95	11	139	15	
1960+	20	2	70	7	
Marital status					
Never married	89	10	102	11	1
Married	581	69	658	68	0.8 (0.6-1.1)
Widowed, divorced, or separated	115	14	152	16	0.7 (0.4-1.0)
Living as married	60	7	49	5	1.3 (0.8-2.2)
Education, years completed					
≤12	255	30	278	29	1
13-15	284	34	353	37	0.9 (0.7-1.1)
16	193	23	215	22	1.0 (0.8-1.3)
≥17	113	13	115	12	1.0 (0.7-1.3)
Religion*					
None/Jewish/other	204	24	250	26	1
Catholic/Mormon/Seventh-day Adventist	158	19	168	17	1.1 (0.8-1.5)
Other Christian	481	57	542	57	1.0 (0.8-1.3)
Family history of breast cancer					
None	533	63	770	80	1
Second degree only	176	21	142	15	1.8 (1.4-2.2)
First degree	136	16	49	5	3.9 (2.7-5.5)
Age at menarche, y†					
7-12	442	52	435	45	1
≥13	402	48	525	55	0.8 (0.6-0.9)
Parous					
No	240	28	258	27	1
Yes	605	72	703	73	0.7 (0.6-0.9)
Age at first birth, y					
Never	240	28	258	27	1
13-17	38	5	46	5	0.7 (0.5-1.2)
18-19	78	9	99	10	0.6 (0.4-0.9)
20-24	245	29	278	29	0.8 (0.6-1.0)
25-29	158	19	183	19	0.7 (0.6-1.0)
≥30	86	10	97	10	0.7 (0.5-1.0)
No. of births					
None	240	28	258	27	1
1	147	17	184	19	0.7 (0.6-1.0)
2	285	34	347	36	0.7 (0.5-0.9)
≥3	173	21	172	18	0.8 (0.6-1.1)
Duration of breast feeding‡					
Never	183	30	177	25	1
<1 y	265	44	322	46	0.9 (0.7-1.1)
≥1 y	157	26	204	29	0.8 (0.6-1.1)
No. of spontaneous abortions					
None	652	77	732	76	1
1	148	18	169	18	0.9 (0.7-1.2)
≥2	45	5	60	6	0.8 (0.5-1.2)
Body mass index§					
13.31-20.26	214	25	241	25	1
20.27-22.01	228	27	242	25	1.0 (0.8-1.3)
22.02-25.56	221	26	238	25	1.0 (0.8-1.3)
25.57-52.57	182	22	239	25	0.8 (0.6-1.0)

*Missing for two case patients and one control.
†One control with bilateral oophorectomy in early childhood excluded. Data missing for one case patient and one control.
‡Among parous women.
§Missing for one control; quartiles of quetelet index, calculated as weight in kilograms divided by height in meters squared.

Characteristic	No. controls	Induced abortion		Spontaneous abortion	
		% never had*	% ever had*	% never had*	% ever had*
Age, y					
21-30	163	75.5	24.5	86.5	13.5
31-35	246	72.8	27.2	76.8	23.2
36-40	388	81.4	18.6	73.7	26.3
41-45	164	86.6	13.4	70.7	29.3
Birth year					
1945-1949	469	83.8	16.2	72.9	27.1
1950-1954	283	73.5	26.5	74.6	25.4
1955-1959	139	75.5	24.5	82.7	17.3
1960+	70	77.1	22.9	91.4	8.6
Marital status					
Never married	102	69.6	30.4	96.1	3.9
Married	658	82.5	17.5	74.5	25.5
Widowed, divorced, or separated	152	75.7	24.3	77.6	22.4
Living as married	49	63.3	36.7	53.1	46.9
Education, years completed					
≤12	278	80.2	19.8	74.1	25.9
13-15	353	75.9	24.1	73.7	26.3
16	215	80.5	19.5	81.9	18.1
≥17	115	83.5	16.5	78.3	21.7
Religion†					
None/Jewish/other	250	72.4	27.6	75.6	24.4
Catholic/Mormon/Seventh-day Adventist	168	87.5	12.5	75.0	25.0
Other Christian	542	79.5	20.5	76.8	23.2
Family history of breast cancer					
None	770	78.1	21.9	75.7	24.3
Second degree only	142	87.8	12.2	73.5	26.5
First degree	49	81.7	18.3	79.6	20.4
Age at menarche, y†					
7-12	435	79.5	20.5	76.7	23.3
≥13	525	78.7	21.3	75.6	24.4
Parous					
No	258	76.0	24.0	93.0	7.0
Yes	703	80.2	19.8	70.0	30.0
Age at first birth, y					
Never	258	76.0	24.0	93.0	7.0
13-17	46	76.1	23.9	58.7	41.3
18-19	99	77.8	22.2	74.7	25.3
20-24	278	84.2	15.8	66.9	33.1
25-29	183	77.6	22.4	74.3	25.7
≥30	97	78.4	21.6	71.1	28.9
No. of births					
None	258	76.0	24.0	93.0	7.0
1	184	69.6	30.4	74.5	25.5
2	347	81.3	18.7	73.2	26.8
3	172	89.5	10.5	58.7	41.3
Duration of breast feeding‡					
Never	177	79.7	20.3	67.2	32.8
<1 y	322	79.5	20.5	72.7	27.3
≥1 y	204	81.9	18.1	68.1	31.9
No. of spontaneous abortions					
None	732	79.5	20.5	—	—
1	169	76.9	23.1	—	—
≥2	60	80.0	20.0	—	—
Body mass index†,§					
13.31-20.26	241	78.4	21.6	80.1	19.9
20.27-22.01	242	72.7	27.3	78.1	21.9
22.02-25.56	238	84.9	15.1	75.2	24.8
25.57-52.57	239	80.3	19.7	71.1	28.9
Oral contraceptive use					
Never or <1 y	228	80.3	19.7	71.1	28.9
≥1 y	733	78.7	21.3	77.8	22.2

*% is of those with this factor.
†Missing for one control.
‡Among parous women.
§Quantiles of quetelet index, calculated as weight in kilograms divided by height in meters squared.

Induced abortion history	Case patients (n = 689)		Controls (n = 781)		RR (95% CI)*
	No.	%	No.	%	
Never had induced abortion	479	69.5	580	74.3	1.0 —
Induced abortion, ever	210	30.5	201	25.7	1.5 (1.2-1.9)
1 only	150	21.8	142	18.2	1.5 (1.1-2.0)
2 or more	60	8.7	59	7.6	1.6 (1.0-2.4)
Age at first abortion, y					
<18	20	2.9	15	1.9	2.5 (1.1-5.7)
18-19	34	4.9	36	4.6	1.7 (1.0-3.0)
20-29	115	16.7	123	15.7	1.3 (1.0-1.7)
≥30	41	6.0	27	3.5	2.1 (1.2-3.5)
Gestational length of first aborted pregnancy					
1-8 weeks	129	18.7	136	17.4	1.4 (1.0-1.8)
9-12 weeks	64	9.3	48	6.1	1.9 (1.3-2.9)
≥13 weeks	16	2.3	17	2.2	1.4 (0.7-2.8)
Unknown	1	0.1			
Timing of first induced abortion					
Before first birth	69	10.0	76	9.7	1.4 (1.0-2.0)
After first birth	74	10.7	63	8.1	1.5 (1.0-2.2)
Never gave birth	67	9.7	62	7.9	1.7 (1.2-2.6)
Interval between first abortion and reference date, y					
0-9	69	10.0	83	10.6	1.4 (1.0-2.0)
10-14	82	11.9	69	8.8	1.7 (1.2-2.5)
≥15	59	8.6	49	6.3	1.4 (0.9-2.2)
Stage of disease at diagnosis†					
In situ and local	119	28.2	201	25.7	1.5 (1.1-2.0)
Regional and distant	88	33.7	201	25.7	1.6 (1.2-2.2)

*Risk relative to that of women with at least one pregnancy who never had an abortion; adjusted for age, family history of breast cancer, religion, and age at first pregnancy.

†Three case patients who had an induced abortion did not have stage of disease available.

41.2) (Table 4). Abortions at ages younger than 18 years that occurred earlier in gestation were associated with a far smaller increase in risk (RR = 1.3; 95% CI = 0.3-7.0) (Table 4). There was little variation in risk associated with the gestational timing of an abortion during a given pregnancy if the first abortion took place at 18 years of age or older. We obtained similar results when we analyzed the timing and duration of a woman's last induced abortion (for most women, the first abortion was also the last abortion).

In women with no family history of breast cancer, the overall size of the increased risk associated with a history of induced abortion was 1.4 (95% CI = 1.0-1.9) and varied little by the age at which the first induced abortion occurred (data not shown). In women with a positive family history (defined as a sister, mother, aunt, or grandmother with breast cancer), the overall risk was 1.8 (95% CI = 1.1-1.3) and was particularly strong for a first abortion that occurred prior to age 18 years (12 case patients and zero controls; RR = ∞; lower 95% CI of RR = 1.8) and at age 30 years or older (14 case patients and three controls; RR = 3.7; 95% CI = 1.0-13.4).

Among parous women who never nursed a child or had nursed less than 1 month, there were similar risks associated with a history of induced abortion whether or not it preceded their first delivery (Table 5). There was a suggestion that, among women who later nursed a child, the association with induced abortion was stronger the longer the interval from the time of the first abortion until the initiation of lactation. The association of induced abortion with breast cancer was also present if the first abortion did not occur until after a woman already had nursed a child (RR = 1.9; 95% CI = 1.1-3.1) (Table 5).

Since some women may view induced abortion as an alternative to contraception, and may not consider having a full-term pregnancy at all, we performed one analysis comparing women who never had a pregnancy with women whose only pregnancy ended in an induced abortion. Sixty-three case patients and 53 controls in this subgroup had undergone an induced abortion, corresponding to an RR of 1.4 (95% CI = 0.9-2.2).

We also evaluated the relationship of spontaneous abortion to risk of breast cancer. Women who had a history of spontaneous abortion were older and were more likely to be currently married, to be living as married, or to have been married in the past than women who had not had a spontaneous abortion (Table 2). They were more likely to have had a first birth at a young age, to have had three or more live births, and to be heavier.

Among women who were parous (more than 90% of the case patients and controls with a history of spontaneous abortion), there was no overall increase in risk for breast cancer (Table 6); however, there was some indication that women whose first spontaneous abortion occurred at age 18 or 19 years might be at increased risk. In addition, among women who had a spontaneous abortion, those with breast cancer were more likely to have had the first spontaneous abortion occur at 9-12 weeks' gestation than at 1-8 weeks' gestation. Among women who had never delivered a child or had any other pregnancy outcome, there was no increase in breast cancer risk related to a history of

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Age at birth or first induced abortion, y	Outcome of pregnancy	Case patients (n = 672)*		Controls (n = [illegible])*		RR (95% CI)†
		No.	%	No.	%	
<18	Induced abortion at 1-8 wk	5	8.8	10	16.4	1.3 (0.3-7.0)
	Induced abortion at 9-24 wk	15	26.3	5	8.2	9.0 (2.0-41.2)
	Completed pregnancy	37	64.9	46	75.4	1
18-19‡	Induced abortion at 1-8 wk	16	12.3	16	10.5	1.4 (0.6-3.3)
	Induced abortion at 9-24 wk	17	13.1	20	13.2	1.3 (0.6-2.8)
	Completed pregnancy§	97	74.6	116	76.3	1
20-29	Induced abortion at 1-8 wk	77	14.5	88	14.6	1.2 (0.8-1.7)
	Induced abortion at 9-24 wk	38	7.2	35	5.8	1.4 (0.8-2.2)
	Completed pregnancy§	415	78.3	479	79.6	1
≥30	Induced abortion at 1-8 wk	31	15.0	22	9.2	2.1 (1.2-4.0)
	Induced abortion at 9-24 wk	10	4.9	5	2.1	3.3 (1.1-10.2)
	Completed pregnancy§	165	80.1	211	88.7	1

*Excludes women who were never pregnant or only had a pregnancy in the indicated time frame that did not result in either an induced abortion or a birth. The sum of the number exceeds the total, since a woman could have had a birth in an earlier age category and so could be included in more than one category

†Referent category is women who had a birth in the age category in question. RR adjusted for age, family history of breast cancer, religion, and age at first pregnancy.

‡One case patient who had an induced abortion of unknown gestational length excluded.

§Excludes women who had an induced abortion at an earlier age.

Table 5. Risk of in situ and invasive breast cancer in relation to history of lactation and induced abortion among parous women

Lactation, ≥1 mo	History of induced abortion	Case patients (n = 605)		Controls (n = 703)		RR (95% CI)*	RR (95% CI)†
		No.	%	No.	%		
Never	No	166	78.7	163	80.3	1	—
	Yes, before first birth	15	7.1	12	5.9	1.4 (0.7-3.2)	—
	Yes, not until after first birth	30	14.2	28	13.8	1.2 (0.7-2.2)	—
Ever‡	No	296	75.7	401	80.7	0.8 (0.6-1.0)	1
	Yes, first abortion ≤5 y before lactating for first time	22	5.6	32	6.4	—	1.1 (0.6-2.1)
	Yes, first abortion 6-10 y before lactating for first time	17	4.3	24	4.8	—	1.5 (0.7-2.9)
	Yes, first abortion >10 y before lactating for first time	15	3.8	8	1.6	—	3.2 (1.3-8.0)
	Yes, not until after lactating for first time	41	10.5	32	6.4	—	1.9 (1.1-3.1)

*Risk relative to women without abortion and lactation, adjusted for age, family history, age at first full-term pregnancy, and religion.

†Risk relative to women without abortion who ever lactated, adjusted for age, family history, age at first full-term pregnancy, and religion.

‡Excludes three case patients and three controls who lactated after an abortion that followed a first birth without lactation.

spontaneous abortion (RR = 1.1; 95% CI = 0.4-2.6), based on 14 case patients and 12 controls who had a spontaneous abortion.

None of the foregoing results were materially influenced when we excluded from the analyses the 98 women with an in situ lesion only.

Discussion

We were able to interview only 83.6% of the breast cancer case patients and 78% of the controls. If those not interviewed differ from the interviewed women regarding history of induced abortion, our results would be biased. Olsson et al. (*14*) found that the breast tumors of women who had a spontaneous or induced abortion at a young age had a higher rate of cell proliferation and a higher frequency of aneuploid tumors compared with the tumors of other young women with breast cancer. These same investigators also found that early abortion was related to INT2 amplification (*15*). Since these tumor characteristics are related to a poor prognosis (*16*), it could be that those women with breast cancer whom we were unable to interview because of serious illness or death may have been more likely to have had an induced abortion than the women we did interview. If this bias were present, we would have underestimated the risk of breast cancer that is associated with induced abortion.

A second concern is the accuracy of reporting of induced abortion by case patients and controls. Our interviews took place from the mid 1980s through the early 1990s, a time when induced abortion was common and well accepted among U.S. women. We designed the study to focus largely on legal induced abortion by restricting our study subjects to women born after 1944, i.e., by including women in whom most or all of their reproductive years occurred after 1970 (the year in which induced abortion was legalized in Washington State). Of the 411 induced abortions reported by study participants, 371 (90.3%) took place in 1970 or later. Thirty of the 35 abortions (85.7%) reported as having occurred in women younger than 18 years of age were during the era of legalized abortion.

Spontaneous abortion history	No.	%	No.	%	RR (95% CI)*
Never had spontaneous abortion	432	71.4	492	70.0	
Spontaneous abortion	173	28.6	211	30.0	0.9 (0.7-1.2)
One only	133	22.0	154	21.9	1.0 (0.7-1.3)
Two or more	40	6.6	57	8.1	0.8 (0.5-1.3)
Age at first spontaneous abortion, y					
<18	7	1.2	13	1.8	0.7 (0.3-1.9)
18-19	26	4.3	19	2.7	1.6 (0.9-3.0)
20-29	106	17.5	139	19.8	0.9 (0.7-1.2)
≥30	34	5.6	40	5.7	0.8 (0.5-1.4)
Gestational length of first spontaneous abortion, wk					
1-8	85	14.1	127	18.1	0.7 (0.5-1.0)
9-12	55	9.1	51	7.3	1.2 (0.8-1.9)
≥13	30	5.0	33	4.7	1.1 (0.6-1.8)
Unknown	3		0		
Timing of first spontaneous abortion					
Before first birth	80	13.2	101	14.4	0.9 (0.6-1.3)
After first birth	93	15.4	110	15.6	1.0 (0.7-1.3)
Interval between first spontaneous abortion and reference date, y					
1-9	55	9.1	74	10.5	1.0 (0.7-1.5)
10-14	50	8.3	56	8.0	1.1 (0.7-1.6)
≥15	68	11.2	81	11.5	0.8 (0.6-1.2)

*Risk relative to that of women with at least one birth who never had a spontaneous abortion; adjusted for age, family history of breast cancer, age at first full-term pregnancy, marital status, and body mass index.

It is possible that a woman diagnosed with a life-threatening disease such as breast cancer might report a history of induced abortion more completely than a healthy control woman contacted at random. Lindefors-Harris et al. (*17*) evaluated this hypothesis by linking responses to interview questions on induced abortion from Swedish case patients and controls in a study of breast cancer to national registry data on abortions occurring in 1966-1974. Nineteen (79.2%) of 24 case patients listed in the national registry as having had an induced abortion reported it during the interview, in contrast to 42 (71.2%) of 59 controls. Complicating the interpretation of this difference was the fact that no national registry record of an abortion could be located for seven other case patients, but only one other control, who claimed to have had an abortion during 1966-1974. Lindefors-Harris et al. compared ORs for an induced abortion–breast cancer association using interview data alone and then data from the national registry alone and concluded that a spurious 50% increase in risk could be obtained from interviews. However, we believe it is reasonable to assume that virtually no women who truly did not have an abortion would claim to have had one, and thus to assume those study participants whose reported abortion could not be documented (*a*) were incorrect when stating that the year of their abortion was within the period 1966-1974 or (*b*) had undergone the abortion outside of Sweden. If these assumptions are correct, it is possible to calculate ORs obtained from interview data alone with those obtained using a positive statement of an induced abortion in either interview or registry data as the standard. When we calculate this OR, the size of the spurious increase in risk that arises from reporting differences between case patients and controls is only 16%.

To further examine the possibility of differential reporting, we assessed the risk of invasive cervical cancer associated with a history of induced abortion among 214 case patients in western Washington State who were younger than 45 years of age and 321 controls obtained through random digit dialing (unpublished data from a population-based case–control study). After adjusting for age at reference date, age at first intercourse, number of lifetime sexual partners, income, and smoking history, the RR of cervical cancer in relation to an induced abortion was 1.0 (95% CI = 0.7-1.6). Unless a history of an induced abortion were truly negatively associated with the incidence of invasive cervical cancer, this result argues against there being differential reporting of prior induced abortions by cancer case patients and controls among reproductive-age women in western Washington State.

We were not able to validate the histories of induced abortion and had to rely solely on the respondents to provide information regarding the gestational length of incomplete pregnancies. However, we believe it is likely that the reporting of gestational length would be neither more nor less accurate for controls than for case patients. We were also unable to validate the histories of spontaneous abortion. We did ask at interview if the pregnancy that resulted in the spontaneous abortion was verified by a physician and/or a pregnancy test. Ninety percent of the case patients and 87% of the controls indicated the pregnancy had been so verified. Our results did not change when we restricted our analyses to verified spontaneous abortion.

The results of some epidemiologic studies (*2-4*), including this study, support the hypothesis that women who have undergone an induced abortion are at a 40%-90% increased risk of developing breast cancer later in life. However, other studies

mixed pattern of results is present whether the studies ascertained abortion status on the basis nterview or through records that documented the procedure.

We addressed the possibility that an elevated risk of breast cancer might be associated with only some induced abortions, perhaps those that occurred at a certain time in life, in a certain relationship to other events of reproductive life, or after a minimum gestational length. In doing so, we paid particular attention to the hypothesis that reproductive events occurring at the time of development of the breast affect the proliferation and hormonal regulation of the breast decades later (*19*). This hypothesis is supported, in part, by studies on experimental animals (*20*), indicating that chemically induced carcinogenesis is directly related to the rate of cell proliferation of the gland at the time of exposure to the carcinogen and that the rate of cell proliferation is highest in young nulliparous animals.

Russo et al. (*21*) have studied the effect of pregnancy interruption in the young rat. In the 7,12-dimethylbenz[*a*]anthracene (DMBA) model system, the hormonal changes of pregnancy accelerated tumor development in rats that mated after administration of DMBA, whereas a single pregnancy prior to feeding the carcinogen to the rat was protective against tumor development. However, when the rat's pregnancy was interrupted (by hysterectomy at midpregnancy), the differentiation of the mammary gland was not completed and these animals had nearly the same tumor response to subsequent DMBA administration as did virgin animals. They hypothesized that the incomplete differentiation of mammary gland cells during the first trimester may increase the subsequent susceptibility of breast tissue to carcinogenic agents (*22*).

The results of epidemiologic studies are in only partial accord with predictions based on these animal models. Our data suggest that abortions performed at a very early age are associated with an increased risk of breast cancer: women who underwent an induced abortion when younger than 18 years of age had a subsequent 2.5-fold increase in risk compared with women who have been pregnant and never had an induced abortion. While the only other study to examine the possible effect of early abortion (defined as occurring at younger than age 20 years and confined to nulliparous women) (*6*) found no increase in risk, the authors did not further divide this category to consider abortions done very early in reproductive life. Nonetheless, even in our own results, the association with induced abortion was not restricted to procedures performed during the teenage years, since we observed a 2.1-fold increase in risk among women whose first abortion did not occur until age 30 years or older.

A possible explanation for our observation of a variation in risk of breast cancer associated with induced abortion according to age at first induced abortion could involve the change in the distribution of breast lobule types with age. Russo et al. (*23*), using mammoplasty specimens from the breasts of women with various reproductive histories, characterized four different lobular structures in the breast. Lobules type 1 are the most undifferentiated ones and are the site of origin of preneoplastic lesions that evolve to ductal carcinoma in situ, with progression to invasive carcinoma. Lobules types 2, 3, and 4 are less likely to be the site of tumor development. The proportion by age of in women younger than 19 years, lowest in women aged 24-28 years, and thereafte reasing in frequency with age.

There are considerably more epidemiologic data to evaluate the possible influence of an induced abortion prior to a first pregnancy on the incidence of breast cancer, and here, too, the results are not completely in accord with the results in experimental animals. In our study, there was no appreciable difference in risk with regard to whether the first induced abortion occurred in the absence of a subsequent term pregnancy or prior to or following a term pregnancy. In this regard (although not necessarily in terms of the overall relationship of induced abortion to breast cancer), our results were similar to those obtained by Adami et al. (*7*), Yuan et al. (*9*), Harris et al. (*18*), and Parazzini et al. (*5*). Ewertz and Duffy (*4*) and Brinton et al. (*10*) observed a several-fold increase in breast cancer risk (based on a modest number of subjects) in nulliparous women who had undergone an induced abortion but no increase in risk in those whose abortion preceded or followed a subsequent term pregnancy. Finally, Pike et al. (*2*) found a several-fold increased risk associated with abortion (induced or spontaneous) in nulliparous women, a 1.8-fold increase if the abortion preceded a term pregnancy, and no increase if the abortion was followed by a term pregnancy.

Some epidemiologic studies of breast cancer in young women (*1,24,25*), as well as animal studies (*21,22,26*), indicate that breast-feeding protects against the development of breast cancer. If pregnancy interruption leaves undifferentiated structures in the breast, we hypothesized that a full-term pregnancy followed by lactation relatively soon after an induced abortion may push those cells to full differentiation. Our results offer some support for this hypothesis (Table 5) in that induced abortion was not associated with an altered risk of breast cancer in women who nursed a child during the 5 years following the abortion. However, the relatively small number of women with this history argues for a cautious interpretation.

During the first trimester of pregnancy, the breast is characterized by high mitotic activity and proliferation: only in midpregnancy to late pregnancy does cellular differentiation predominate (*27*). Therefore, it is plausible that those pregnancies that are not interrupted until the end of the first trimester could result in the breast containing a high number of undifferentiated cells, relative to the breasts of women whose abortion was induced early in pregnancy (or who had no abortion at all). Conceivably, these morphologic differences could be related to differences in the subsequent incidence of breast cancer as well. Unfortunately, there is but limited information from epidemiologic studies on breast cancer risk in relation to when during pregnancy an induced abortion had been performed. Neither Ewertz and Duffy (*4*) nor Pike et al. (*2*) observed any increased risk of breast cancer associated with a prior second-trimester abortion, but they did not address the issue of the impact of late first-trimester abortion. In the study of Howe et al. (*3*), the authors reported that prior abortions in breast cancer case patients occurred on average at 9.6 weeks' gestation, as opposed to 11.5 weeks in controls. While the difference is in the opposite direction of that predicted, the very short duration of

follow-up after the induced abortions in that study (1-10 years) severely limits its interpretation.

Prior studies of breast cancer in relation to spontaneous abortion have not yielded consistent results (*1*). We did not observe an increased risk of breast cancer among women who had a history of a spontaneous abortion. We can only speculate on why this result did not parallel that for induced abortion. We did observe that only 14.3% of women who had had an induced abortion nursed a child during the 5 years following the abortion compared with 46.3% of women with a spontaneous abortion. However, when we excluded from the analysis those case patients and controls who had experienced a spontaneous abortion and then nursed during the next 5 years, no excess risk of breast cancer associated with spontaneous abortion was seen (RR = 1.1; 95% CI = 0.8-1.5). Another possible explanation may be the relatively short gestational length of many pregnancies that end in spontaneous abortion. In their study of tissue from abortuses, Fantel and Shepard (*28*) estimated that, on the average, the majority of the fetuses that had spontaneously aborted had spent approximately 24 days in utero following the cessation of fetal growth.

The data from the present study suggest that induced abortion in the last month of the first trimester is associated with nearly a doubling of subsequent breast cancer risk (Table 3). While the difference in risk associated with an abortion prior to and following 2 months of gestation was particularly great when the abortion occurred at a very young age (Table 4), the relatively small number of subjects in that subgroup and the lack of a corroborating study argue against a firm conclusion at this time. For the same reasons, the particularly large case–control differences regarding very young or older age at first induced abortion in women with a positive family history of breast cancer should be viewed only as hypotheses worthy of subsequent testing.

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Notes

[1]*Editor's note:* SEER is a set of geographically defined, population-based central tumor registries in the United States, operated by local nonprofit organizations under contract to the NCI. Each registry annually submits its cases to the NCI on a computer tape. These computer tapes are then edited by the NCI and made available for analysis.

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"The Psycho social Outcome of Induced Abortion." J.R. Ashton, Department of Community Health, London School of Hygiene. British Journal of Obstetrics and Gynecology, December 1980, pp. 115-1122.

This study focused on the psycho-social outcome on women who had an induced abortion. About five percent of the women in the study had enduring, severe psychiatric disturbance following abortion. Nearly half of all abortion patients were affected by short-lived disturbances. Initial guilt and regrets and sensitivity to the comments of people around them which relate to abortion were among the symptoms of the short-lived disturbances.

"Ectopic Pregnancy and Prior Induced Abortion." Ann Aschengrau Levin, MS, Stephen C. Schoenbaum, MD, MPH, Phillip G. Stubblefield, MD, Susan Zimicki, MS, Richard R. Monson, MD, ScD, and Kenneth J. Ryan, MD. American Journal of Pubic Health, March 1982 p. 253.

An ectopic pregnancy can threaten a woman's life and future fertility. A relationship was found between the number of prior induced abortions and the risk of ectopic pregnancy. Induced abortion may be one of several risk factors for ectopic pregnancy, particularly for women who have had multiple abortions plus pelvic inflammatory disease.

"Associations of Induced Abortion with Subsequent Pregnancy Loss." Ann Aschengrau Levin, MS, The Journal of the American Medical Association, June 1980, pp. 2495-2499.

This study suggests that there is a direct relationship between number of prior induced abortions and subsequent risk of having pregnancy loss. Women who have had two or more prior induced abortions have a progressively greater risk of subsequent pregnancy

loss. Prior induced abortions may cause cervical trauma that result in cervical incompetence. Cervical incompetence could explain the increased risk of mid-trimester missed abortion and first-trimester incomplete abortion.

"Does Abortion Increase the Risk of Breast Cancer?" Scott W. Somerville Journal of the Medical Association of Georgia. April 1994 pp. 209-210.

Numerous studies in this article suggest that abortions before the first live birth increase the risk of breast cancer. A study in 1989 at the New York State Department of Health found that women who had induced abortions were 1.9 times more likely to get breast cancer than were those with no abortion history.

More research in the areas of biology, epidemiology, and demographics is pointing to abortion as the missing link to the mystery of breast cancer. This research supports the hypothesis that abortion before the first live birth increases the risk of breast cancer.

"Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion." Janet R. Daling, Ph.D.. (Fred Hutchinson Cancer Research Center) Journal of the National Cancer Institute. Vol. 86. No. 21 November 2. 1994. pp. 1044-1592.

Among women who had been pregnant at least once, the risk of breast cancer in those who had experienced an induced abortion was 50% higher than among other women. This increased risk did vary according to the age at which the abortion occurred and the duration of that pregnancy. Highest risks were observed when the abortion was done at ages younger than 18 years -- particularly if it took place 8 weeks' gestation.

The data from this study supports the hypothesis that an induced abortion can adversely influence a woman's subsequent risk of breast cancer.

"Induced Abortion As An Independent Risk Factor for Breast Cancer: a Comprehensive Review and Meta-Analysis." Joel Brind, Department of Natural Sciences, Vernon M. Chinchilli, Center for Biostatistics and Epidemiology, Walter B. Severs, Department of Pharmacology, Joan Summy-Long, The Milton S Hershey Medical Center. Journal of Epidemiology and Community Health, 1996 vol. 50 pp. 481-496.

The results of this study support the inclusion of induced abortion among significant independent risk factors for breast cancer.

"The Relationship Between Induced Abortion and Outcome of Subsequent Pregnancies," Shai Linn, MD, American Journal of Obstetrics & Gynecology. May 1983 pp. 136-140.

This article analyzes the relationship between prior history of induced abortion and subsequent late pregnancy outcomes. Women with a history of two or more induced abortions are more likely to have complications such as bleeding in the first and third trimesters, abnormal presentations and premature rupture of the membranes, fetal distress, low birth weight, short gestation, and major malformations.

"A Study on the Effects of Induced Abortion on Subsequent Pregnancy Outcome," Carol Madore, MA, American Journal of Obstetrics & Gynecology, March 1981, pp. 516-521.

In this study, Dr. Madore concludes that women with a history of previous induced abortion have a statistically significant increase of subsequent pregnancy failure.

A scientific perspective on the Danish abortion study published in the 1/9/97 New England Journal of Medicine (NEJM)

MYTHS AND FACTS. Prepared by Joel Brind, Ph.D., Professor of endocrinology, Department of Natural Sciences, Baruch College, City University of NY, 1/13/97

Myth 1

The Danish study's lead author, Dr. Mads Melbye, told the Wall Street Journal (1/9/97):

"I think this settles it. Definitely—there is no overall increased risk of breast cancer for the average woman who has had an abortion."

Dr. Patricia Hartge of the National Cancer Institute, in a NEJM Editorial accompanying the Danish study, echoed "the clear central finding that there is no overall risk", and concluded: "In short, a woman need not worry about the risk of breast cancer when facing the difficult decision of whether to terminate a pregnancy."

Fact

Said Dr. Karin Michels of Harvard Medical School, as quoted in the 1/9/97 Wall Street Journal: "You should never end a debate with one study and say this is the definitive study"

In fact, this one study from Denmark is the 30th separate study published since 1957 to report specific data on induced abortion and breast cancer. It is only the sixth one not to show an overall increased risk, compared to 24 that do show an increased risk, 18 of which are statistically significant on their own.

Contrary the implication of most current media reports, the Brind study, the comprehensive review and meta-analysis, published in the October, 1996 Journal of Epidemiology and Community Health the epidemiology journal of the British Medical Association, is not one of the 30 studies: It is a compilation of the entire worldwide literature, which pooled the results of the 23 separate studies available at the time of its preparation. This study of studies found a statistically significant, 30% overall risk increase.

Myth 2

The Danish study is different. One reason it is definitive is its enormous size, including over 1.5 million women (most Danish women), over 280,000 of whom had one or more induced abortions. Moreover, the study includes over 10,000 women with breast cancer.

Fact

The enormous size of the Danish study is enormously misleading, because this is a cohort study, in which an entire population (or cohort) of women is followed for many years, to track exposures to the alleged risk factor (induced abortion) and the incidence of the disease in question (breast cancer). Consequently, most of the women in the cohort (over 1.2 million of the 1.5 million) have neither the exposure nor the disease in question, but their presence in the cohort inflates the size of the study.

Myth 3

Even so, the number of women with abortion and breast cancer is very large, which gives this study unusually large statistical power. According to Dr. Hartge, in her NEJM editorial:

"In this cohort of 1.5 million women, 1338 cases of breast cancer were diagnosed in women who had

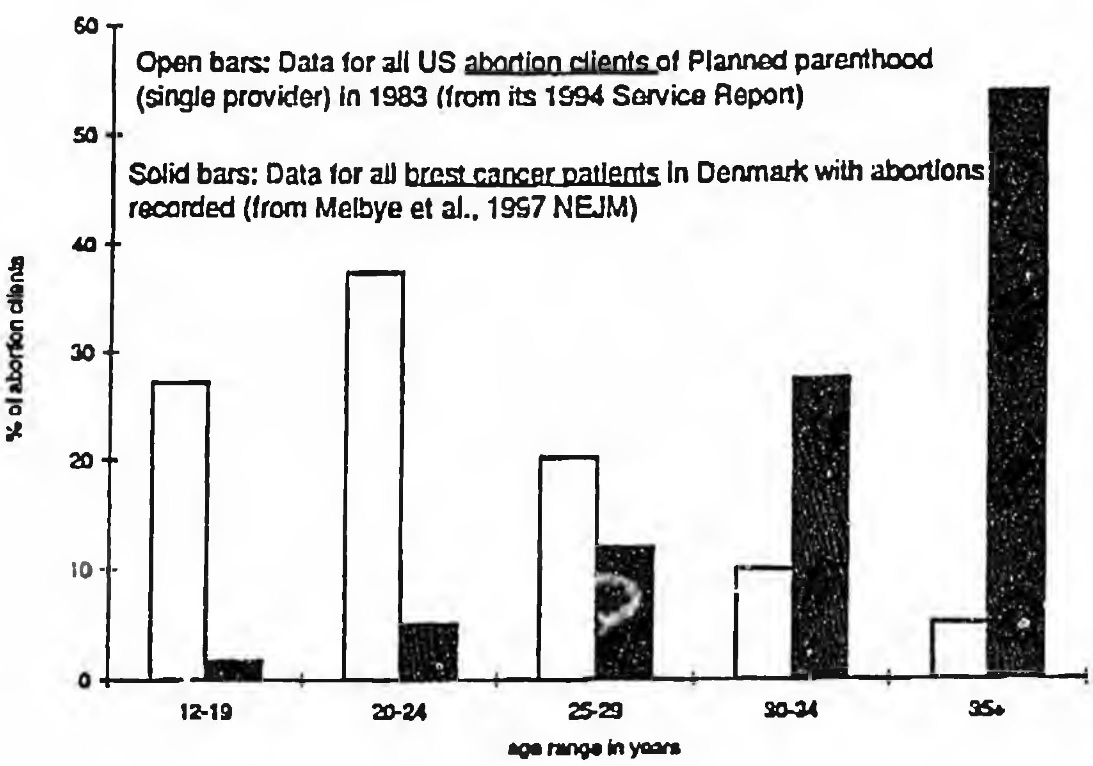
terminated pregnancies. By comparison, large case-control studies in the United States each have included 200 to 300 cases of breast cancer in women who had abortions."

Fact

The selection of such a large part of the Danish population (i.e., women born back to 1935), yields a data base which is very distorted because only abortions occurring since 1973 are on record. Consequently, the majority of breast cancer patients in the Danish study who are on record as not having had any abortions (8,908 women) were in their 30's when abortion data were first collected. Consequently, their abortion history is largely unknown. Keep in mind that we are speaking of a very small proportion of the entire cohort— but the majority of breast cancer victims—since breast cancer is found overwhelmingly among the oldest members of the cohort.

Among the 1338 breast cancer patients whose abortions are on record, the majority of them are on record as having had abortions only at age 35 or over. In fact, over 81% of them have abortions recorded only at age 30 or over!

The egregious distortion of the age distribution of abortion clients is best illustrated by a graphic comparison with US data for the average year (1983) for which the abortions are recorded:



From the above graph, it is easily seen that the Danish (Melbye) study is therefore considerably weaker than its authors and proponents indicate: The statistical power of the study relies largely on a database which is questionable for three reasons:

1) It consists mostly of women too young for cancer to develop (those who had abortions and did get breast cancer having had their abortions when they were atypically old);

2) The abortion histories of the oldest women in the cohort (which includes most of the women who did get breast cancer) before their fourth decade of life are largely unknown.

3) Concerning the fate of women who have abortions at younger ages—particularly in their teens—the study has almost no statistical power. That is why, even though it shows a 29% risk increase for women who had any abortions as teenagers (the same magnitude of the overall risk increase calculated for women in the Brind meta-analysis), the figure is not statistically significant:

The database only contains a total of 23 cases of breast cancer among women with teenage abortions, and a grand total of only 252 cases of breast cancer for all women who had abortions before the age of 30. That puts the study's real statistical power in the same range as the American studies Dr. Hartge refers to in her editorial.

Unfortunately, the effect of including all the older women (who have most of the breast cancer, but a relatively small portion of the recorded abortions) and all the younger women (who have most of the abortions, but almost none of the breast cancer), is to dilute the statistics, making the calculated relative risk appear lower and at the same time, more precise than it really is. (The summary finding of the Melbye study is an overall relative risk of 1.00 [i.e., no risk increase with induced abortion], and a 95% confidence interval of 0.94-1.06.)

Myth 4

Even though the sample size for women with abortion at younger ages is limited, the Danish data should show some sort of trend, if there were a real risk increase due to abortion. But there is no trend, Dr. Melbye arguing "the oldest women have exactly the same (relative) risk as the younger women."

Fact

As noted above, women who got abortions in their teens showed a 29% higher risk of breast cancer. This was, in fact, noted in the text of the results section (but interestingly, not in the discussion or the abstract):

"Age at the time of the induced abortion did not significantly influence the overall risk, but there was a tendency toward a higher risk of breast cancer among women in the lowest age category—between 12 and 19 years of age (relative risk, 1.29; 95% confidence interval, 0.80 to 2.08)." The lack of significance and lack of effect on observed overall risk is a direct consequence of the lack of statistical power of this supposedly definitive study.

Myth 5

The credibility of the overall finding of no increased risk in the Melbye study is supported by previous research. According to the first paragraph of the authors' Discussion section: "This result is very much in line with the results of previous retrospective cohort studies 9,10,15,16".

Fact

This statement is a flat-out misrepresentation of the medical literature: Three of the four studies cited (as footnotes) to back it up are entirely irrelevant. Two concern spontaneous abortion (miscarriage) exclusively 9,16 and one concerns spontaneous abortion mostly, and does not present any data relating specifically to induced abortion.10

Myth 6 (The "Loch Ness Monster")

It isn't just the statistical power of the study that's important, but the fact that the data are collected

prospectively (i.e., at time of abortion) means they do not depend on the accuracy of study subjects' own reporting of past, personally sensitive events. According to Dr. Hartge, in her NEJM editorial:

"By relying on uniformly collected data on abortion in Danish registries, Melbye et al. avoided the major problem that has plagued case-control interview studies: differential reporting of abortions (response bias)".

Melbye et al. used this argument to attack the Brind meta-analysis directly: "However, since almost all 23 studies included in the analysis were case-control studies, it is not unreasonable to assume that many of them were inherently biased, making the pooled conclusions biased as well."

Fact

Many scientists insist that this potential source of error is responsible for the result whenever a study shows that abortion is associated with increased breast cancer risk. In fact, this is the third time in a little over two years that the National Cancer Institute has used the response bias argument, via medical journal editorials, to attack such research. Like the famous mythological Loch Ness Monster, they insist that it is there. But every time a study actually looks for evidence of its presence, the only credible evidence they can ever find is against it.

When comparing the abortion histories of breast cancer patients with those of healthy women, a finding of more abortions among the patients will show up statistically as an increased risk. The argument is essentially this: If the cancer patients report more of their abortions than the healthy women do, then their breast cancer risk will appear artificially increased, due to this response bias (bias meaning difference between the two groups).

Melbye et al. are less than forthright in their Danish study in their attack on the Brind meta-analysis: One could hardly tell from their discussion that the meta-analysis spent over 1,000 words of text meticulously analyzing the alleged evidence of such bias. Yet still, they hark back to a 1991 Swedish study which compared computer prospective cohort data with case control interview-based data on the same population of Swedish women. That study claimed statistically significant evidence of underreporting of previous induced abortions among controls relative to overreporting among cases. In other words, the significance of the finding was largely dependent upon the belief that the seven breast cancer patients who reported having had abortions of which the computer registry had no record, had overreported them, i.e., had made them up!

Until the Danish study's appearance in the 1/9/97 NEJM, the most recent citing of the monster was in the 12/4/96 Journal of the National Cancer Institute (JNCI). That issue of the JNCI contained a Dutch case-control study which attributed the 90% increased risk it found among women with abortions to response bias. However, a careful reading of the study reveals the authors found significant evidence of response bias between healthy women from different regions of Holland, but no bias between breast cancer patients and healthy women at all. That didn't stop NCI editorialists from hyping these results and unleashing the monster: . . . a Swedish study . . . show(ed) that healthy women consistently and widely underreport their history of induced abortion.

Meanwhile, strong evidence against the response bias argument has surfaced repeatedly: 1) A 1989 New York State computerized registry study found a 90% increased breast cancer risk among women with induced abortions; 2) A 1994 Seattle, Washington study found a 50% increased risk and used cervical cancer data to test specifically for response bias among these women—and found none; 3) A 1995 study among Greek women found a 51% increased risk, and cited other studies among Greek women in drawing their conclusion that healthy women in Greece report reliably their history of induced abortion.

Myth 7

According to a 1/10/97 New York Times editorial: The only uncertainty in the Melbye study) was a suggestion that women who had abortions in the second or third trimester did have an increased risk of breast cancer, but the number of women in this category was too small to warrant firm conclusions.

The falsehood of the first phrase is obvious to anyone familiar with any epidemiological study: All findings are subject to varying degrees of uncertainty. The rest of the statement is a masterpiece of under statement. Consider the actual relevant part of the Results section of the paper: With each one-week increase in the gestational age of the fetus, however, there was a three percent increase in the risk of breast cancer. In fact, the relative risk rose from a 19% (non-significant) risk decrease for women whose abortions occurred at less than seven weeks gestational age, to a significant 89% risk increase for women with post 18-week abortions. Moreover, a risk elevated above the norm started showing up for women with late first trimester abortions (11-12 weeks).

In fairness to the New York Times, however, the authors themselves de-emphasized the finding, failing even to mention it among the "Conclusions" in the paper's abstract. Thankfully, this error of omission did not go unnoticed, drawing sharp criticism from Dr. George Bonney, Chairman of Biostatistics at the Fox Chase Cancer Center in Philadelphia, who told the Washington Post: "This is a powerful group (Melbye et al.), that should know better".

Yet the most important aspect of this finding of significantly increased risk with increasing gestational age at abortion is that Melbye et al. acknowledged it as supporting the biological basis of abortion as a breast cancer risk factor. That is, growth promotion of primitive (and potentially cancer forming) breast cells by surging estrogens during pregnancy may increase breast cancer risk if the pregnancy is aborted. Theoretically, the longer the exposure to this hormonal stimulus, the greater the risk increase. Although other studies have not found a consistent difference in early v. late first trimester abortions, this one did, and the authors call this finding to be "in line with the hypothesis".

Concluding Remarks

Ample evidence has been presented above to show that the authors' "Conclusions: Induced abortions have no overall effect on the risk of breast cancer." is, to say the least, a gross oversimplification. But there are additional concerns: First, a great deal of information about the effects of other variables is missing from the paper, as well as the unadjusted relative risk calculations. In fact, the unadjusted overall relative risk can be calculated at 1.44—a 44% risk increase. Of course, this figure doesn't mean much without adjustment, but how it manages to decrease to 0% increased risk is a disturbing mystery. Dr. Melbye (personal communication) says that they had to shorten the paper considerably for publication, but then one wonders why there is then so much redundancy in it: most of the data in the paper's only table is repeated in the text.

Second, it must be noted that one of the variables adjusted for in this (and most other) studies, is age at first full term pregnancy. That's because delaying the first full term pregnancy is universally recognized to increase breast cancer risk. Induced abortion surely increases risk when performed on young childless women, since it delays the full term delivery that would otherwise naturally have occurred. This increase, being specifically subtracted out, does not show up in any study (including the Brind meta-analysis) that is looking for the specific effect of induced abortion on breast cancer risk.

Finally, it must be acknowledged that computerized cohort data are generally of better quality than interview-based data, all other things being equal. The difficulty with computerized data on the risk of a disease like breast cancer is that it takes years—perhaps 5 to 50 years— for cancer to show up in exposed women. And abortion registries are not generally that old. Computerized registry data are most useful when the outcome in question does not require such a long follow up period. A perfect example is a 1996 study using the Finnish abortion registry. In this British Medical Journal paper, Dr. Mika Gissler et al. found a very reliable, almost sixfold (4888) increase in the rate of suicide by women who had had an induced abortion in the previous year, compared to women who had a baby.

STATISTICS FOR PARENTAL INVOLVEMENT INFLUENCE IN THE STATE OF NEBRASKA

The State of Nebraska, during the year 1991, enacted a protective parental involvement law. This law required that one parent, of a minor girl seeking an abortion, <u>MUST</u> be notified or the minor must obtain a judicial bypass. The most recent evidence shows the effects of passing just such protective legislation.

I. Number of abortions of those aged 17 and under:

1990 708
1991 596
1992 459
1993 427

* This is a decrease of 39.7% from 1990 to 1993. Bear in mind that Parental Notification became effective in 1991.

II. **Estimate** of the number of live births in Nebraska for given year:

1987 ...... 24,087.17
1988 ...... 24,266.67
1989 ...... 24,513.57
1990 ...... 24,625.53
1991 ...... 24,195.31
1992 ...... 23,707.79
1993 ...... 23,196.--

These tables not only show a reduction in abortions after protective parental involvement legislation is enforced, but they also give witness to the reduction in live births. This is evidence that with protective laws in place, minors not only seek fewer abortions, but that they avoid becoming pregnant in the first place.

These statistics have been compiled
by Michael Hussey, B.A. in Mathematics
rec'd of St. Louis University
from the data prepared by
Nebraska Department of Health
Division of Health Data Systems

Impact of the Minnesota Parental Notification Law on Abortion and Birth

James L. Rogers, PhD, Robert F. Boruch, PhD, George B. Stoms, BA, and Dorothy DeMoya, DNSc

ABSTRACT

Background. The impact of the Minnesota Parental Notification Law on abortion and birth was examined.

Methods. Using linear models, outcome parameters were compared before and after enactment of the law. Time by age group interactions also were examined.

Results. The pre-enactment to post-enactment change in the Minnesota abortion rate reflected a greater decline for minors (≤17 years old) than for 18–19 year-olds (who were not under the law). An increase in abortion rate occurred for women ages 20–44. The law appeared to have had no impact on birth rate in minors. Following the enactment of the law, the rate of early abortions (≤12 weeks) declined among minors more than the rate of late abortions (>12 weeks). This resulted in a pre-enactment to post-enactment increase in the ratio of late-to-early abortions among minors.

Conclusions. These data suggest that parental notification facilitated pregnancy avoidance in 15–17 year-old Minnesota women. Abortion rates declined unexpectedly while birth rates continued to decline in accordance with a long-term trend. (*Am J Public Health* 1991;81:294–298)

Introduction

Laws requiring parental consent or parental notification prior to legal induced abortion for minor women, collectively called parental involvement laws, exist or have been proposed in numerous states. As of July 1990, laws in the United States requiring parental consent were in effect in Alabama, Indiana, Louisiana, Massachusetts, Missouri, North Dakota, and Rhode Island. Laws requiring parental notice were in effect in Arkansas, Idaho, Utah, and West Virginia; and parental involvement statutes were under challenge in Arizona, California, Georgia, Illinois, Kentucky, Mississippi, Nevada, Pennsylvania, and Tennessee. National attention focused on these laws when statutes from Minnesota and Ohio were heard by the US Supreme Court during its October 1989 term resulting in a decision largely supporting these laws. The present paper concerns the Minnesota law, enacted in August 1981 and enjoined in March 1986. This law required a minor woman to notify both parents at least 48 hours prior to an abortion or else seek court approval.

Few empirical studies have evaluated the impact of parental involvement statutes on minor women. Cartoof and Klerman[1] determined that abortions to minors in Massachusetts declined dramatically (43 percent) following the enactment of a parental consent law. However, during this time an approximately equal number of women migrated to surrounding states to obtain abortions. Blum[2] found that under parental notification in Minnesota, communication with parents about a minor's planned abortion occurred more often than had been reported by Clary[3] in a Minneapolis/St. Paul study predating the law. But Blum found that patterns of communication differed little from those among teenagers simultaneously surveyed in the neighboring state of Wisconsin (without such a law).

Common negative claims about parental involvement laws are that they force minors to leave the state to obtain abortions (as in Massachusetts), and that they result in increased birth rates, late abortions and medical complications. These effects are presumably related to a minor's reluctance to discuss her pregnancy with parents.[4] Positive claims about these laws are that they promote responsibility (by encouraging teenagers to "think before they act"), foster parent-child communication, facilitate mature decision making, and may reveal medical history information that would otherwise remain unknown to the physician.[5,6]

Empirical evaluation of assertions like these will necessitate multiple studies under a variety of circumstances and localities. The Cartoof and Klerman study[1] was conducted in Massachusetts, located in close proximity to states without parental involvement laws. This made it possible for minors to avoid the law altogether by crossing state lines. In Minnesota, the distance from out-of-state abortion facilities appears to have worked against mi-

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gration. Blum determined that "[i]n counterdistinction to the Massachusetts data, there is little evidence to indicate large numbers of Minnesota youths are leaving the state for abortion (data available on request to author)."[2] It cannot be assumed that findings characterized by one set of background factors, such as proximity to out-of-state abortion facilities, will generalize to other settings.

In this study, the statewide impact of the Minnesota Parental Notification Law upon the incidence rate of abortion and birth, as well as upon the ratio of abortions to births and the ratio of early to late abortions, is examined.

Methods

Data

Abortion and birth incidence data were provided by the Minnesota Center for Health Statistics (MCHS). The data exclude all observations of unknown age and are restricted to residents of Minnesota. Live births to Minnesota residents are included regardless of whether the birth occurred inside or outside of Minnesota. Induced abortions reflect only those occurring in Minnesota.

Population estimates by age and gender are provided by the Minnesota Center for Health Statistics that computed them using a modified version of the cohort-component method for all years following the 1980 census.[7]

Throughout this report "birth(s)" and "abortion(s)" will refer to live birth(s) and induced abortions(s), respectively.

Outcome Measurements

The report utilizes six outcome measurements: four rates and two ratios.

- The abortion rate, the late abortion rate (>12 weeks), the early abortion rate (≤12 weeks) and the birth rate refer to the number of reported abortions (or births) in one year divided by the population estimate of females, in thousands, for that same year.
- The abortion-to-birth ratio refers to the number of abortions in a year divided by the number of births. Alternatively, this may be thought of as the abortion rate divided by the birth rate for a given year.
- The late-to-early abortion ratio refers to the number of late abortions in a year divided by the number of early abortions. Again, this may be thought of as the late abortion rate divided by the early abortion rate for a given year.

Measures of Effect

Each rate and ratio was examined using a linear model.[8,9] Serving as a dependent variable, the rate (or ratio) was modeled as a function of age category (≤17, 18–19 or 20–44 years old), the year of occurrence (1975 through 1987), and the age by year interaction.

First, each model was employed to determine whether a given rate (or ratio) three years before and four years after enactment of the Minnesota Parental Notification Law differed within each age category. Because the modeling was performed in the log scale, the pre-enactment (1978 to 1980) and post-enactment (1982 to 1985) values represent the geometric mean of the individual values comprising the pre-enactment and post-enactment periods. (The antilog of the arithmetic mean of log values corresponds to the geometric mean of the same measurement in the original scale. That is, anti-ln $[\ln a + \ln b]/2 = \sqrt{[ab]}$.)

Second, three additional contrasts were constructed to detect the presence of any age group by time interaction that might exist for a given rate or ratio. These contrasts reflect whether the pre-enactment to post-enactment *change* was different among minors than among 18–19 year-olds, or 20–44 year-olds, or among 18–19 year-olds than women 20–44 years old. It was assumed that a change due to the law, rather than to general factors operating in all age groups, would be most pronounced among women 17 years of age or younger; less evident among 18 and 19 year-old women who would have recently been, but would not presently be under the law (pregnancy at age 17 may mean birth at age 18); and least present among older women not subject to the law for at least two years.

Models

The mechanics underlying the linear models[8,9] used to construct the six contrasts described above were as follows. The model parameters, representing age category (two parameters capturing three age classifications), year (12 parameters capturing 13 years), and the age by year interaction (24 parameters reflecting the cross-product of age and year), were regressed against the *natural log* of the rate or ratio under question. Rows of each model's design matrix were combined to form the six contrasts. When the abortion rate, late abortion rate, early abortion rate, or birth rate served as the dependent variable, weighted least squares estimates and asymptotic variances for the estimates were obtained. When the abortion-to-birth ratio or late-to-early abortion ratio served as the dependent variable, maximum likelihood was used to obtain estimates and asymptotic variances. PROC CATMOD of Version 6.03 of the Statistical Analysis Software (SAS)[10] was employed to fit the models.

For ease of interpretation, the authors elected to display each contrast effect as a quotient (contrast ratio) in the original scale rather than a difference in the log scale. For any given contrast, this means that rather than presenting in tables the difference between two natural log values, it is the antilog of this difference that has been presented. It is evident that the difference between two identical log values will be "zero" while the corresponding contrast ratio will be unity (one). That is, $(\ln A) - (\ln A) = 0$ implies that the antilog is unity. Thus, contrast ratios equal to unity imply equivalence between the contrasted values.

Results

Table 1 contains the outcome measures examined in this study. For each outcome measure, Table 2 contains the contrast ratios that compare the pre-enactment and post-enactment periods. Contrast ratios greater than unity imply an increase in the outcome measure (abortion rate, birth rate, etc.) after enactment of the law and contrast ratios less than unity imply a decrease. Similarly, Table 3 contains ratios that reflect the age by time interactions. Here, a contrast ratio less than unity indicates a greater pre-enactment to post-enactment decline in the younger age group of the two being compared; a contrast ratio greater than unity indicates a greater increase.

Abortion Rate

Deviations from unity for the contrast ratios that compare pre-enactment and post-enactment periods (Table 2) are substantial in all age groups. Whereas the yearly abortion rates after the law's enactment increased for women 20–44 years old (who were substantially removed from its impact), abortion rates declined in both 15–17 and 18–19 year-olds during this same period. The pre-enactment to post-enactment decline was substantially greater for 15–17 than 18–19 year-old women, and for 18–19 year-old women than 20–44 year-old women (Table 3).

TABLE 1—Outcome Measures and Population Estimates for Minnesota Women, 1975 to 1987*

Outcome Measure	Age (years)	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
Abortion Rate†	15–17	12.38	16.50	18.60	18.25	19.24	19.57	16.06	14.25	12.80	13.03	14.54	14.42	15.46
	18–19	20.47	28.92	31.27	35.71	38.72	40.26	38.37	36.45	33.06	35.05	34.07	31.89	30.83
	20–44	7.32	9.55	11.48	12.36	13.41	14.13	14.00	13.96	13.11	14.21	14.48	14.29	14.17
Birth Rate†	15–17	20.94	19.64	19.62	17.80	17.71	17.48	17.36	16.54	14.56	16.00	15.01	15.52	15.03
	18–19	56.11	52.98	55.10	55.80	57.00	59.46	59.33	56.57	48.76	48.85	47.18	42.65	43.68
	20–44	74.0?	72.48	75.79	76.14	78.05	79.80	79.43	78.13	75.18	75.57	75.92	74.00	72.67
Abortions/ Births	15–17	0.59	0.84	0.96	1.03	1.09	1.12	0.93	0.86	0.88	0.81	0.97	0.93	1.03
	18–19	0.36	0.55	0.57	0.64	0.68	0.68	0.65	0.64	0.68	0.72	0.72	0.75	0.71
	20–44	0.10	0.13	0.15	0.16	0.17	0.18	0.18	0.18	0.17	0.19	0.19	0.19	0.19
Early Abortion Rate†	15–17	10.22	12.81	14.73	14.97	15.73	15.34	12.93	11.37	9.86	9.68	11.24	11.38	12.65
	18–19	17.81	24.01	25.89	30.46	33.31	33.56	32.58	30.92	27.63	28.42	28.13	26.04	26.23
	20–44	6.62	8.45	10.23	11.24	12.19	12.71	12.74	12.65	11.87	12.89	13.04	12.86	12.84
Late Abortion Rate†	15–17	2.16	3.09	3.88	3.28	3.51	4.23	3.13	2.89	2.94	3.36	3.30	3.04	2.80
	18–19	2.66	4.91	5.39	5.25	5.41	6.69	5.78	5.53	5.44	6.63	5.94	5.85	4.56
	20–44	0.70	1.10	1.25	1.11	1.23	1.42	1.27	1.31	1.24	1.53	1.44	1.44	1.31
Late/Early Abortions	15–17	0.21	0.29	0.26	0.22	0.22	0.28	0.24	0.25	0.30	0.35	0.29	0.27	0.22
	18–19	0.15	0.20	0.21	0.17	0.16	0.20	0.18	0.18	0.20	0.23	0.21	0.22	0.17
	20–44	0.11	0.13	0.12	0.10	0.10	0.11	0.10	0.10	0.10	0.12	0.11	0.11	0.10
Population	15–17	115684	117102	116317	115722	115202	113600	108143	103961	104371	100131	100912	101172	101646
	18–19	8558?	86828	86110	85525	85047	83964	79663	76786	77004	73784	74296	74375	74768
	20–44	662309	683069	700327	722162	747058	761209	779081	797136	799812	811693	819042	821954	828167

*Raw data provided by the Minnesota Center for Health Statistics.
†Abortion, birth, early abortion and late abortion rates are expressed as the number of abortions or births per 1000 women.
NOTE: Early abortions: ≤12 weeks; Late abortions: >12 weeks.

Birth Rate

Birth rates decreased in all age categories following enactment of the law (Table 2). However, the decline was most pronounced in 15–17 and 18–19 year-old women. Table 3 reveals that the pre-enactment to post-enactment change among 15–17 and 18–19 year-old women was similar, with both age groups evidencing a substantially greater decline than found among women ages 20–44.

Ratio of Abortions to Births

A marked drop in the abortion-to-birth ratio occurred after the law in 15–17 year-old women when compared to both 18–19 year-old women and 20–44 year-old women (see Tables 2 and 3). In Figure 1, the abortion rate and birth rate are plotted separately for 15–17 year-old women along with the abortion-to-birth ratio (abortion rate/birth rate) in order to examine the relative importance of abortions and births to the markedly declining abortion-to-birth ratio in this age group. It is evident that birth rates continue a modest and nearly linear decline, apparently unaffected by the law ($r = -0.89$ between birth rate and year). On the other hand, the abortion rate falls dramatically after the enactment of the law in August 1981. Together, these facts indicate that the drop in the 15–17 year-old abortion-to-birth ratio is due to a disproportionately greater decrease in the abortion rate (numerator).

Early and Late Abortions

The early abortion rate closely tracks the overall abortion rate (Tables 2 and 3). The pre-enactment to post-enactment late abortion rate substantially declines for women of 15–17 years, increases for women of 20–44 years, and remains nearly constant for women of 18–19 years (Table 2). The pre-enactment to post-enactment change in the late abortion rate, when compared between age groups, evidences a greater decline in late abortions for 15–17 than for either 18–19 or 20–44 year-old women (Table 3).

The late-to-early abortion ratio increased after the enactment of the law in all age groups (Table 2). However, the increase was greater among 15–17 year-old women than 20–44 year-old women (Table 3). Figure 2 reveals that a steep decline in early abortions, not an increase in late abortions, accounts for the increased late-to-early abortion ratio in 15–17 year-old women.

Discussion

Data presented in this study are compatible with the hypothesis that, initially, parental notification facilitated pregnancy avoidance in 15–17 year-old Minnesota women. Abortion rates fell markedly in this age group relative to older women. Birth rates also fell, but only in keeping with a long-term trend established before enactment of the law. One possibility is that when minor women are restricted from abortion without notifying parents or seeking court approval, and are geographically prohibited from easy access to out-of-state abortions,[2] they are more likely to take measures to avoid pregnancy.

Although the data are compatible with this hypothesis, other explanations are possible. For example, a growing concern over human immunodeficiency virus infection, and/or awareness and availability of birth control may explain in part or in full these findings. However,

TABLE 2—Contrasts Between Pre- and Post-Enactment Periods*

Outcome Measures	Age (years)	Pre-Enactment**	Post-Enactment†	Contrast Ratio (Post/Pre) With 95% CI
Abortion Rate††	15–17	19.012	13.635	0.717 (0.692, 0.743)
	18–19	38.181	34.638	0.907 (0.883, 0.932)
	20–44	13.280	13.931	1.049 (1.034, 1.064)
Birth Rate††	15–17	17.663	15.510	0.878 (0.848, 0.909)
	18–19	57.338	50.213	0.876 (0.857, 0.895)
	20–44	77.962	76.191	0.977 (0.971, 0.983)
Abortions/Births	15–17	1.076	0.879	0.817 (0.777, 0.859)
	18–19	0.666	0.690	1.036 (1.000, 1.074)
	20–44	0.170	0.183	1.074 (1.057, 1.091)
Early Abortion Rate††	15–17	15.343	10.507	0.685 (0.658, 0.713)
	18–19	32.413	28.749	0.887 (0.861, 0.914)
	20–44	12.032	12.554	1.043 (1.027, 1.059)
Late Abortion Rate††	15–17	3.653	3.114	0.852 (0.788, 0.921)
	18–19	5.750	5.867	1.020 (0.952, 1.093)
	20–44	1.247	1.375	1.103 (1.052, 1.157)
Late/Early Abortions	15–17	0.238	0.296	1.245 (1.140, 1.359)
	18–19	0.177	0.204	1.150 (1.067, 1.241)
	20–44	0.104	0.110	1.058 (1.006, 1.112)

*Raw data provided by the Minnesota Center for Health Statistics.

**Geometric mean, years 1978–80, Table 1.

†Geometric mean, years 1982–85, Table 1.

††Abortion, birth, early abortion and late abortion rates are expressed as the number of abortions or births per 1000 women.

NOTES: 1) Early abortions: ≤12 weeks; Late abortions: >12 weeks.
2) Pre-enactment (1978–80) to post-enactment (1982–85) means are compared (post/pre) in the form of contrast ratios. A contrast ratio of one implies no pre-enactment to post-enactment change.

TABLE 3—Age by Time Interactions*

Outcome Measures	Age Group Comparison	Post- / Pre-enactment Ratios**		Contrast Ratio (younger/older) with 95% CI
		Younger	Older	
Abortion Rate	15–17 vs 18–19	0.717	0.907	0.791 (0.758, 0.827)
	15–17 vs 20–44	0.717	1.049	0.684 (0.658, 0.710)
	18–19 vs 30–44	0.907	1.049	0.865 (0.839, 0.892)
Birth Rate	15–17 vs 18–19	0.878	0.876	1.003 (0.962, 1.045)
	15–17 vs 20–44	0.878	0.977	0.899 (0.867, 0.931)
	18–19 vs 20–44	0.876	0.977	0.896 (0.876, 0.917)
Abortions/Births	15–17 vs 18–19	0.817	1.036	0.788 (0.741, 0.839)
	15–17 vs 20–44	0.817	1.074	0.761 (0.722, 0.802)
	18–19 vs 20–44	1.036	1.074	0.965 (0.928, 1.003)
Early Abortions	15–17 vs 18–19	0.685	0.887	0.772 (0.735, 0.812)
	15–17 vs 20–44	0.685	1.043	0.656 (0.629, 0.685)
	18–19 vs 20–44	0.887	1.043	0.850 (0.822, 0.879)
Late Abortions	15–17 vs 18–19	0.852	1.020	0.835 (0.753, 0.927)
	15–17 vs 20–44	0.852	1.103	0.772 (0.705, 0.846)
	18–19 vs 20–44	1.020	1.103	0.925 (0.850, 1.006)
Late/Early Abortions	15–17 vs 18–19	1.245	1.150	1.082 (0.963, 1.215)
	15–17 vs 20–44	1.245	1.058	1.177 (1.064, 1.302)
	18–19 vs 20–44	1.150	1.058	1.088 (0.994, 1.191)

*Raw data provided by the Minnesota Center for Health Statistics.

**Post- / pre-enactment ratios are from Table 2.

NOTES: 1) Early abortions: ≤12 weeks; Late abortions: >12 weeks.
2) Post-enactment to pre-enactment ratios (Table 2) are compared across age groups (younger/older) to examine age by time interactions. A contrast ratio of "one" implies equivalent post- / pre-enactment ratios for both age groups (no interaction).

the abrupt nature of the change in abortion rate, a phenomenon found also in Massachusetts by Cartoof and Klerman,[1] makes these rival hypotheses less tenable. In any event, the data argue against Clary's[3] concern that more minors might carry pregnancies to term as an indirect effect of the parental notification law. If such were the case, it seems unlikely that birth rates would have continued to decline in 15–17 year-olds along the linear trend line established prior to the law, or that the decline in birth rates would be nearly identical between 15–17 and 18–19 year-old women.

The pre-enactment to post-enactment increase in the proportion of late (>12 weeks) to early (≤12 weeks) abortions was greater for 15–17 than for 20–44 year-old women. At least two hypotheses may explain this finding. First, the law may have been more successful in preventing pregnancy among minors who would have had early abortions than among minors who would have had late abortions. A second possibility is that the law caused delays for a greater percentage of a declining number of minors seeking abortions. Regardless, the claim that the law caused more minors to obtain late abortions is unsubstantiated. In fact, the reverse is true. For ages 15–17 the number of late abortions per 1,000 women decreased following the enactment of the law. Therefore, an increased medical hazard due to a rising number of late abortions was not realized.

In this paper no effort has been made to confront the philosophical and legal issues surrounding parental involvement laws. Rather, the authors have pursued a limited task, that of empirical evaluation within a framework of defined outcome parameters. This study is consistent with the hypothesis that conception among minor women may be reduced immediately following enactment of parental notification legislation when migratory abortion across state lines is not a viable alternative. However, generalizations to other states must be made cautiously, as Minnesota is a unique state with a low minority population and a low pregnancy rate even before the parental notice legislation. The authors emphasize that replication in states other than Minnesota will be required to sustain the hypothesis. □

Acknowledgments

The authors wish to thank the Minnesota Center for Health Statistics, particularly James Wiggington and Carol Vargas for their consid-

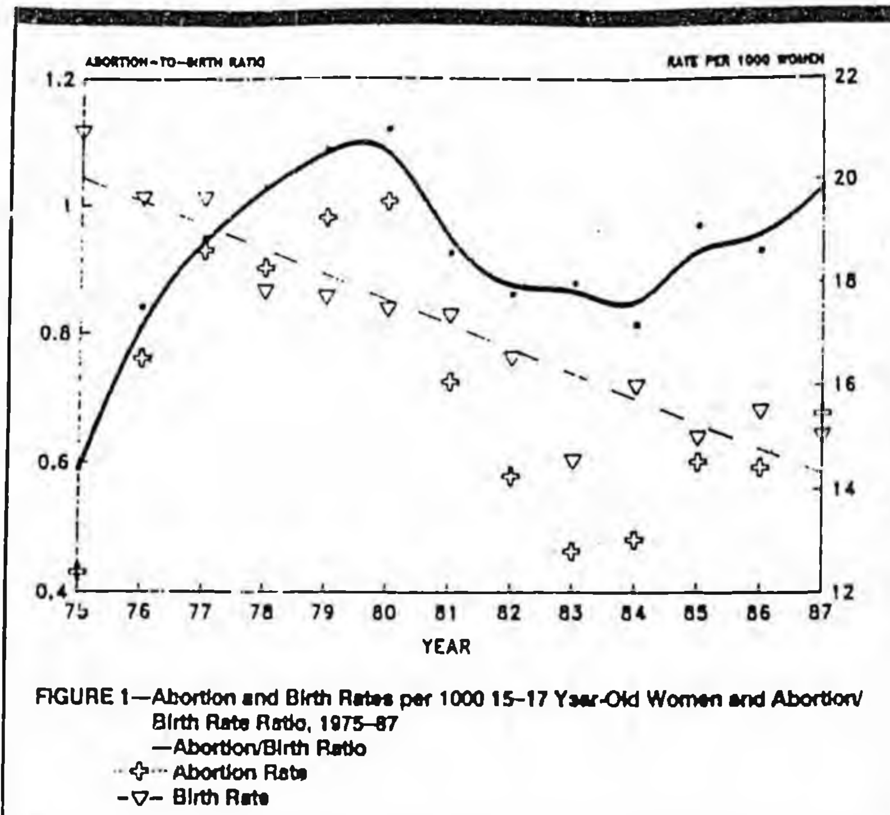

FIGURE 1—Abortion and Birth Rates per 1000 15–17 Year-Old Women and Abortion/Birth Rate Ratio, 1975–87
—Abortion/Birth Ratio
-✣- Abortion Rate
-▽- Birth Rate

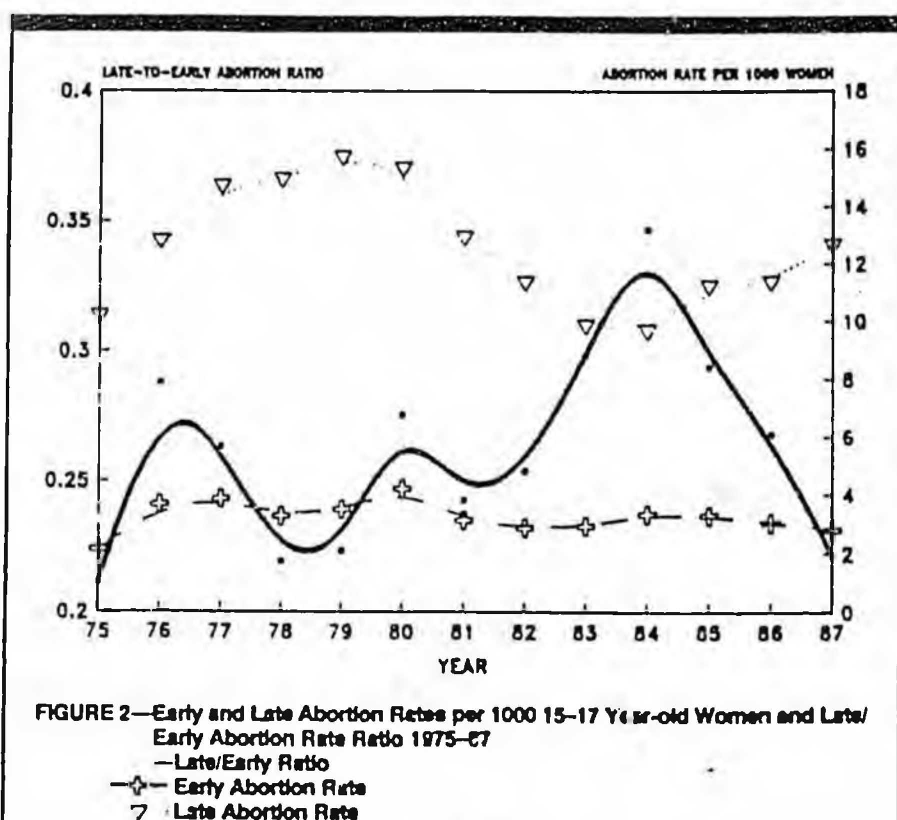

FIGURE 2—Early and Late Abortion Rates per 1000 15–17 Year-old Women and Late/Early Abortion Rate Ratio 1975–87
—Late/Early Ratio
-✣- Early Abortion Rate
▽ Late Abortion Rate

erable work in providing these data in a form suitable for the current analysis. The authors also thank Americans United for Life for purchasing the data from the Minnesota Center for Health Statistics and providing it to the authors. Preparation of this study was supported in part by an Aldeen Grant from Wheaton College.

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LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

<u>MEMORANDUM</u> February 3, 1997

SUBJECT: Parental Consent for Minors' Activities (Work Order No. 20-LS0465)

TO: Senator Johnny Ellis
Attn: Noelle

FROM: Terri Lauterbach
Legislative Counsel

You have asked if state law requires parental consent before a minor's ear can be pierced, before a minor may go on a school field trip, before a minor may attend certain types of movies, and similar situations.

While there are some state laws that require parental consent in other situations, I have not found a state law requiring parental permission in the specific situations you have described. When parental permission is required in a commercial situation, such as ear piercing or to attend a movie, it is usually merely a business practice of the proprietor. The proprietor may require permission for any of several reasons, among them the following: to avoid a suit by the parent for injury to the minor, as a way of ensuring that the item or service will be paid for by an adult, or as a practice to maintain the good will of the parents or to uphold voluntary industry standards. When parental permission is required for a school function, liability and goodwill are probably the main concerns of the school district.

My review of the Alaska Statutes has found the following situations where parental consent **<u>is required</u>** for an activity of or relating to a minor:

(1) possession of a firearm if under 16 (AS 11.61.220(1)(3));

(2) marriage if 16 but under 18 (AS 25.05.171);

(3) testimony if the minor is a victim of a domestic violence crime, unless the court determines that the minor is capable of waiving the privilege not to testify (AS 25.35.100);

(4) informal treatment of delinquency charges (AS 47.10.020);

(5) to be absent from parental custody (AS 11.51.130(a)(4));

(6) to be evaluated for placement in special education classes, but a hearing can be held to determine whether the minor should be tested if the parent fails or refuses to consent (AS 14.30.193(a));

(7) transfer of an exceptional child outside the school district (AS 14.30.285(f));

(8) photographing a minor being evaluated for mental health treatment, except for internal identification purposes (AS 47.30.840(a)(1));

(9) being in or viewing an indecent photograph if under 16 (AS 11.61.123(a)).

State law specifically provides that parental consent **is not required** in the following situations:

(1) medical and dental services for a minor if the parent won't give an answer or cannot be contacted (AS 25.20.025);

(2) medical and dental services to a minor parent and for the minor's parent's child (AS 25.20.025);

(3) diagnosis, prevention, and treatment of pregnancy or venereal disease (AS 25.20.025);

(4) relinquishment of parental rights by a minor parent; (AS 25.23.180(b));

(5) to be interviewed at school by DHSS or law enforcement personnel when an allegation of abuse has been filed (AS 47.17.027(a));

(6) to be x-rayed or photographed when an allegation of abuse has been filed (AS 47.17.064(a)).

Please let me know if you have further questions about this matter or if I can be of other assistance.

TML:glc
97-050.glc

SENATOR LOREN LEMAN

Northwest Anchorage

716 W 4th Ave, Suite 520, Anchorage, AK 99501 (907) 258-8189 Session: State Capitol, Juneau, AK 99801 (907) 465-2095

Sponsor Statement -- SB 24

"An Act relating to a requirement that a parent, guardian, or custodian consent before certain minors receive an abortion; establishing a judicial bypass procedure by which a minor may petition a court for authorization to consent to an abortion without consent of a parent, guardian, or custodian; amending the definition of 'abortion'; and amending Rules 40 and 79, Alaska Rules of Civil Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate Procedure; and Rule 9, Alaska Administrative Rules."

Senate Bill 24 allows enforcement of existing law requiring parental consent before an abortion can be performed on a minor. Parental consent is required under AS 18.16.010, approved by the Legislature in 1970. However, a 1976 Attorney General's opinion declared the statute unenforceable as it lacks a judicial bypass provision which would enable a minor to receive permission from a judge as an alternative to a parent. Various Supreme Court decisions have held that judicial bypass is necessary if parental consent laws are to meet constitutional muster. SB 24 adds the required bypass.

In other states, parental involvement laws have had a positive impact, reducing both the number of abortions *and* the number of teen pregnancies. During the first six years Minnesota's parental involvement law was in effect, the teen pregnancy rate fell 20.5 percent, teen abortions declined 27.4 percent, and the teen birth rate went down 12.5 percent.

SB 24 also upholds the rights of parents, which are uniquely disregarded in the area of abortion. Parental consent is required for virtually every medical procedure. An exception should not exist for abortion. In Alaska, young people under age 18 are not considered mature enough to be served alcohol, buy cigarettes, or vote in elections. Even marriage is not permitted, unless a parent consents. But a teenager can obtain an abortion, even one paid for by the state, and the parents are not even required to be notified of that fact.

A clear majority of Alaskans -- 78 percent -- expressed support for parental consent legislation considered in the 19th Legislature. Parental involvement laws are on the books in 38 states. These statutes are enforced in 27 of these states.

Sectional Analysis -- SB 24

"An Act relating to a requirement that a parent, guardian, or custodian consent before certain minors receive an abortion; establishing a judicial bypass procedure by which a minor may petition a court for authorization to consent to an abortion without consent of a parent, guardian, or custodian; amending the definition of 'abortion'; and amending Rules 40 and 79, Alaska Rules of Civil Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate Procedure; and Rule 9, Alaska Administrative Rules."

Prepared by: Mike Pauley, Staff to Sponsor SENATOR LOREN LEMAN

Last updated: Monday, January 27, 1997

Section 1: Purpose and Legislative findings

- Intent of legislation is to protect the health and welfare of minors, foster and preserve the family structure as a viable social unit, and protect the rights of parents to rear their children.
- The legislature finds that parents often possess information on the medical history of the minor that is essential to a physician's or surgeon's medical judgment.
- The legislature also finds that minors stand to benefit from parental counsel; the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.

Section 2: Amends Title 18 of Alaska Statutes (Health & Safety)

- Repeals existing language on parental consent [AS 18.16.010(a)(3)] and replaces it with language requiring *either* parental consent or court authorization before an abortion can be performed on an unemancipated minor. The bill establishes a rebuttable presumption that an unmarried woman under 18 is unemancipated.

Section 3: Establishes new subsections under AS 18.16.010 (Regulation of Abortions)

- Person who performs an abortion without obtaining the required consent is civilly liable to the minor's parent(s) or guardian for compensatory and punitive damages.
- It is an affirmative defense to prosecution if the person performing the abortion was provided by the pregnant minor with false, misleading, or incorrect information about age, marital status, or emancipation.

- It is an affirmative defense to prosecution if the person performing the abortion could not comply with the consent requirement because the continuation of the pregnancy posed an immediate threat of serious risk to the life or physical health of the pregnant woman, necessitating an immediate abortion.

Section 4: Establishes new sections under AS 18.16 (Regulation of Abortions)

- **Sec. 18.16.020** provides that an abortion may not be performed on an unemancipated minor unless...

  1) one of the minor's parents or the minor's guardian has consented to the procedure in writing; or

  2) a court has issued an order permitting the minor to consent to the abortion without obtaining consent of a parent or guardian; or

  3) a court by its inaction has constructively authorized a minor to consent to the abortion *(see Sec. 18.16.030).*

- **Sec. 18.16.030** outlines the procedure for seeking a court order (judicial bypass) allowing a minor to consent to an abortion without first securing parental consent. Complaints must be filed in superior court. Complaint must be under oath and include a statement that the complainant is pregnant, unmarried, under age 18, unemancipated, and wishes to have an abortion without obtaining parental consent. In addition, the complainant must allege that she is sufficiently mature and well-informed to make an abortion decision without parental consent *and/or* that one or both of her parents or her guardian is abusing the complainant physically, sexually, or emotionally; or that securing consent is otherwise not in the woman's best interest. Sec. 18.16.030 also sets time limits for hearing complaints; establishes an appeals process; requires appointment of an attorney for complainants who have not retained counsel; provides for the anonymity of the complainant. If a court does not act on a complaint within the time limits established in the legislation, it shall be considered a "constructive order" allowing the minor to consent to the abortion without the consent of a parent or guardian.

- **Sec. 18.16.090** defines the terms "abortion" and "unemancipated".

Section 5: Amends Title 44 of Alaska Statutes (State Government)

- Sec. 44.21.410(a) is amended to require the Office of Public Advocacy to provide legal representation for minors seeking a court order for an abortion without parental consent.

Section 6: Repeals Alaska Statute 18.16.010(d)

- The existing definition of abortion under AS 18.16 (Regulation of Abortions) is repealed *(replaced with new definition @ Sec. 18.16.090).*

Section 7: Amending Rule 40, Alaska Rules of Civil Procedure

- Sec. 18.16.030(c) of the bill has the effect of amending Rule 40 by setting time limits for hearing judicial bypass cases.

Section 8: Amending Rules 204, 210, 212, and 213, Alaska Rules of Appellate Procedure

- Sec. 18.16.030(j) of the bill has the effect of amending Rules 204, 210, 212, and 213, by setting time limits for judicial bypass appeals, and also by liberally modifying or dispensing with formal requirements for the form and content of appellants' briefs.

Section 9: Amending Rule 512.5, Alaska Rules of Appellate Procedure

- Sec. 18.16.030(k) of the bill has the effect of amending Rule 512.5 by making certain appellate records and papers confidential.

Section 10: Amending Rule 9, Alaska Administrative Rules; Rule 79, Alaska Rules of Civil Procedure; and Rule 508, Alaska Rules of Appellate Procedure.

- Sec. 18.16.030(m) of the bill has the effect of amending Rule 9, Rule 79, and Rule 508 by prohibiting filing fees and court cost assessments in judicial bypass cases.

JUNEAU EMPIRE

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Girls, abortion and judicial bypass

Abortion is an issue with very little middle ground. Those who call themselves "pro-choice" favor it; those known as "pro-life" fight it at every turn. Rarely, if ever, do the two sides agree. And whenever an abortion-related bill comes up, the battle lines are drawn before the ink is dry.

Such, unfortunately, will probably be the case with Senate Bill 24, introduced recently by Sen. Loren Leman, an Anchorage Republican. His bill requires minors to obtain consent from a parent or guardian before getting an abortion. The provision also allows a minor to petition the courts for permission for the procedure without the consent of a parent or guardian.

The state currently has a parental consent law on the books. However, a 1976 opinion by the attorney general declared it unenforceable because the statute lacked a judicial bypass provision. Various Supreme Court decisions have held that such an option is necessary to meet constitutional muster. Sen. Leman's bill would fix the problem.

Regardless of one's emotional views on the subject, this bill simply follows a fairly logical extension of existing Alaska law. A minor cannot vote, buy cigarettes or be served alcohol. Should we, however, allow minors to get an abortion?

A minor under the age of 16 can't use a firearm unless obtaining consent from a parent; they can't get married without consent; and they can't get any major – or often times – minor medical procedure without parental consent. If one argues abortion is 'just a medical procedure,' then parental consent should be required here as well.

What one calls that which grows inside a women – fetus, egg, child, it, tissue, or whatever – one point remains absolute. An abortion ends the life of a future human being. Such a decision should not be made by one scared young girl alone.

If an under-aged teen-ager needs permission for almost any medical procedure, how is an abortion different? And this law provides an outlet for those, for whatever reason allowable, who cannot obtain permission from their parents or guardians. The law allows for the courts to step in. However, courts must be extremely conservative in allowing this review. This is a matter left to the family except in extreme cases. It should not be an option available just because a girl doesn't want to face her parents.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/13/97

FURTHER: Judiciary (circled)
Finance

Date of 5-Day Notice: 1/23/97
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/3/97

Health, Education and Social Services Committee considered SENATE BILL NO. 24

Require in consent before minors receive an abortion; amend Rules 40 and 79 Alaska Rules of Civil Procedure; Rules 204, 210, 212, 213, 508, and 512.5, Alaska Rules of Appellate Procedure; and Rule 9, Alaska Administrative Rules.

2 fn's
& 2 ø fn's

and recommends:

[ ] be replaced with ______ CS ________________(________)

[ ] adopt previous ______ CS ________________(________)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ________________ Committee

[ ] further referral to the ________________ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR* ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
[signature] Ward	✓	[signature] Ellis		X	
[signature]		/ /			
Loren D. Leman	✓				
Lyda Green	✓				
G. Albert (crossed out)	—				
CHAIR: [signature]	✓	CHAIR:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Alaska Court System	1/28/97		✓
Dept of Admin - Public Defender	1/28/97	✓	
Dept of Health + Social Services	1/24/97	✓	
Dept of Admin - Public Advocacy	1/28/97		✓

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] **APPROPRIATION -- no fiscal note**

***include fiscal notes accompanying Governor's bill**

PREVIOUS COMMITTEE
REFERRALS

FAX TRANSMISSION

TO: Senate Judiciary Committee

FAX: 465-3922

DATE: 2-6-97

MESSAGE: 3 pg letter to follow

PUBLIC COMMENT

Regarding Senate Bill No. 24 **January 31, 1997**
Regarding House Bill No. 37 **February 6, 1997**

My name is Sharylee Zachary,

My husband, Dan, and I have 3 wonderful daughters ages 11, 9, and 7. We are working hard and faithfully at instilling in them high moral values and standards to live by. For every action, there is a consequence and you should own up to those actions and consequences and not blame them on anyone else. No one else should pay the price for your consequences. But also, we stand together as a family to work through the happenings and consequences of our actions. We learn from them, deal with them, encourage each other to make wiser decisions the next time. We are teaching our children to be responsible and to look out for the welfare of those around them.

High on our list is to teach them the great value and sanctity of human life, a precious life that God has given to every conceived baby, whether that baby is two cells or full term. Ideally, we live our life so that a baby is conceived within the bonds of a love relationship between a husband and wife and we do not have sex until marriage. We believe in the preservation of the family unit.

I realize that one of the main reasons this bill has come about is because a lot of people don't feel this way and are not living their lives in this manner and are not teaching these truths to their children. Instead of living according to absolute moral values, they live by their 'feelings' and their 'right' as an American citizen to do what they please. The consequences have been disastrous to our nation. There is now a huge number of broken families, single parent families where there was never a marriage or commitment (just 'feelings'), and a huge abortion rate where the 'consequences' of peoples 'feelings', the resulting babies, are being slaughtered. We have a multitude of fatherless families living in poverty; crime is running rampant, -children are joining 'gangs' in order to find security and a 'family' feeling. The effects of the misuse of drugs and alcohol are running rampant. You are quite aware of all this, I know.

I also realize that another main reason this bill has come about is because of the pregnancy consequences women end up with because of the abuse they have suffered at the hand of some man (men) (which can take many forms). My heart aches for these women. And I am very sorry that our society has given them the message that the only way out is by handing down a death sentence to their unborn child.

I am grateful that this bill is designed to deciso strongly recognize the rights of the family and the parents to support their children through such crisis and to guide them in making wise sions.

Unfortunately, few people are taking appropriate responsibility for the consequences of their actions. For years, now, around the country children are being educated that, 'You

are going to have sex anyway so use condoms, they will protect you from disease and pregnancy'. Well, that does not work. Instead, we need to plant seeds in the children that they have the ability to live an abstinent lifestyle (which is the only true means of birth control and disease prevention) and still be happy and content. Then we need to raise up support groups to encourage that type of responsible behavior. Our children are told that if they get pregnant, the only way out is abortion. "And, by the way, lets keep it a secret from your parents, we will provide all you need to get the abortion." (Who usually pays for the medical costs as the result of the abortion? - the parents, not the clinic that botched things up!)

Talk about driving a major wedge in the parent/child relationship!!! Parents are not even given a chance to help their child through the crisis. If one of our daughters were to become pregnant, we would support her through the pregnancy, and help her make the wisest decision for her and her baby as far as keeping her baby or adoption into a healthy, loving family. It is unfortunate that everywhere you go there are people and resources outside the family who are filling our children with those types of lies.

Please continue to encourage the ability and right of the parents and families to support our children in times of crisis.

I realize that there are those parents who are currently abusing their children and would continue to treat their children badly (or worse) upon hearing the news of an unwanted pregnancy. And there are cases of incest and rape where people feel this is the time for an abortion. My husband and I, and hundreds of thousands of folks like us, are not ignorant nor cold-hearted toward the plight of these unfortunate children. But we do believe that if a baby is on the way, that viable life has a right to be born. Communities do need to support the mother through the pregnancy and onto a healthier life style. There also needs to be community help for the fathers to take on their responsibility for their actions, - they need support groups to help them, also. They should not be ignored. Many of them have had no positive role models to show them the way toward responsible behavior toward those around them, - as well as toward themselves. It is also really 'key' that Churches, once again, are allowed back into the arena of helping folks get their life in shape.

Please continue to work for legislation that does not allow for the breakdown of our families and our nation.

Two questions:

1) If this legislation does not pass, what provisions can be done for the family whose daughter, unknown to them, has had an abortion and is living through the emotional scars of that procedure, the emotional scars of the unwanted pregnancy and often the accompanied abandonment by the father, etc., - - there is something wrong with their daughter, and they don't have a chance to help her through it because they don't even know about it?

2) I have met several adult women who, while in their teens, were forced by their parents to have an abortion, - against their will, and they are still carrying the emotional (and some physical) scares this produced in their lives. Is there legislation to safeguard children against this type of abuse?

Alaska has made many wise pro-family, pro-nation choices in it's laws and I am very proud of that.

Alaska has to stand strong, not to go the route of many of the lower-48 states that are falling apart because of their unwise, anti-family choices in their living styles and laws.

Alaska needs to be the North Star state pointing the way to strong families, strong communities, strong states, and a strong nation founded and built on absolute values and taking responsibility for personal actions and the consequences thereof so that the innocent no longer suffer.

Very Sincerely and Respectfully,

Sharylee Zachary
Box 1531
Petersburg,AK 99833
(907) 772-3681

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

525 Main Street, Juneau AK 99801
586-4438 1-800-478-6279 Fax: 586-4439
naswak@alaska.net

Testimony Regarding

SB 24 - PARENTAL CONSENT FOR ABORTION

Before the
JUDICIARY COMMITTEE
ALASKA SENATE
February 12, 1997

Presented by
Angela M. Salerno, ACSW
Executive Director,
National Association of Social Workers Alaska Chapter

PUBLIC COMMENT

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

525 Main Street, Juneau AK 99801
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The National Association of Social Workers (NASW) is the world's largest organization of professional social workers. NASW's 155,000 members nationwide and 460 in Alaska work in a wide range of settings at all levels in the public and private sectors. Professional social workers focus on vulnerable populations and promote state and federal policies which enhance the lives of the people we serve.

Thank you for the opportunity to address the Committee on SB 24 - Parental Consent for Abortion.

NASW opposes SB 24 and does not recommend its passage.

A pregnant woman's constitutional right to choose between childbirth and abortion was established in 1973 by the Supreme Court's landmark ruling in *Roe V. Wade.* All women, including those under 18, are entitled to a safe, legal abortion.

Of the more than one million teenage pregnancies that occur in the United States each year, over 80 percent are unintended. Nearly all pregnant teens are unwed, and some 40% of them choose abortion. The bill before you will require that young women seeking to terminate an unwanted pregnancy receive the permission of parents, guardians or the court before receiving a safe, legal abortion.

This proposal will not act to promote desirable parental consultation. Ideally, a teenager should be able to tell her parents about her pregnancy, obtain their love and support and arrive at critical decisions about her future through family discussions. In fact, the majority of pregnant teenagers do tell at least one parent about their pregnancies. Based on a national survey of more that 1,600 unmarried minors having abortions in states without parental consent laws, 61% discussed the decision to have an abortion with at least one of their parents. The younger the minor, the more likely she was to have voluntarily discussed the abortion with her parents.

Parental involvement laws do not strengthen family relationships. The need to reinforce family relationships is the reason most often cited to justify state laws requiring parental consent before abortion. But such laws are unnecessary for stable and supportive families, and they are ineffective and cruel for unstable, troubled families. Some teenagers cannot tell their parents. Some are victims of incest or other forms of family violence - one study showed that 14% of minors having abortions believed that, if forced to tell their parents about their pregnancies, they would face physical abuse, and 11% feared violence between their parents. Mandatory parental consent cannot transform abusive families into supportive ones.

Mandating parental involvement poses health risks to teenagers. Young women already are more likely than older women to have later abortions, and parental involvement laws only cause further delays either because of fears of telling their parents or because of the inevitable delays in going to court for a judicial bypass hearing. While abortion at all stages of pregnancy is safer than childbirth, the risk of major complications increases 15 - 30% per week. Statistics compiled by the Federal Centers for Disease Control indicate that the risk of death from childbirth is, on average, 24 times higher than the risk of death from abortion up to 12 weeks of pregnancy. Following enactment of Minnesota's parental notification laws, second-trimester abortions among minors increased by 18%. Minors who cannot obtain an abortion in their small towns or villages must travel to other sites to have the procedure, are forced to carry their pregnancies to term, or resort to illegal abortion. Under Minnesota notification statute, the birth rate in Minneapolis for 15 -17 year olds rose 38%. The American Medical Association has long recognized that parental notification and consent requirements deter minors from seeking necessary health care. The desire to maintain secrecy has been one of the leading reasons for illegal abortion deaths since the Supreme Court recognized the constitutional right to abortion in

1973. Further, the AMA believes some minors may be physically or emotionally harmed if required to involve a parent in the abortion decision.

Teenagers faced with the choice between childbirth and abortion can make a responsible decision without parents or courts. The American Psychological Association has found that minors are usually able to make intelligent, informed decisions about pregnancy. Even young women from severely troubled families often show great maturity and sensitivity when seeking confidential birth services.

A judicial bypass option is inadequate and discriminatory in Alaska. Young women using this procedure often experience fear, anxiety and shame as they are forced to reveal detail of their private lives to strangers in the courtroom. Mandatory representation by the currently overburdened Office of Public Advocacy will surely result in delays or inadequate representation. In rural Alaska, confidentiality will be severely compromised as a young woman will most likely be recognized by the judge or other court personnel.

In Alaska, the courts are moving toward assigning teenagers greater responsibility for their actions, not imposing further restrictions. During the last legislative session lawmakers were successful in passing laws to treat certain juvenile offenders as adults. In the 20th Legislature, bills have been introduced to remove the protections of immaturity from teenagers who commit minor offenses. It is unfair to treat pregnant teens differently with proposals to strip personal responsibility in decisions about reproductive matters.

Parental consent laws are an unconstitutional attack on a women's right to abortion, and in Alaska, on an individual's right to privacy. *Roe v. Wade* entitled all women to legal, safe abortion. Parental consent as well as other provisions of SB 24 such as the creation of civil liability for performing abortion, are barriers manufactured to interfere with this constitutional guarantee. Should this bill become law in Alaska, there will most certainly be court challenges, as the Constitution of the State of Alaska specifically guarantees each citizen the right to privacy.

While NASW supports strong families and believes that parents have profound interests in their children's well-being, in the case of pregnancy, a teenager's privacy rights must be paramount. Courts have found that teenagers who want to keep their pregnancies a secret almost always have sound reasons. When there is a reason to expect an extremely abusive parental reaction to a young woman's unplanned pregnancy, her right to privacy must come first since she is in the best position to know whether or not she is in danger. A legislature that is unfamiliar with a young woman's particular situation is not is a position to force her to involve her parents. Where abortion is concerned, privacy can be a life or death matter for teenagers.

In acknowledging and affirming the social work profession's commitment to respecting diverse value systems in a pluralistic society, we recognize that the issue of abortion is controversial because it reflects the different value systems of different groups. Consequently, NASW does not take a position concerning the morality or immorality of abortion.

NASW's position concerning abortion services is based on the principle of self-determination. Every individual must be free to participate or not participate in abortion services. In the event that a woman choose abortion the following services should be available to her:

- *counseling and referral provided by professionally trained staff who are knowledgeable of the social and psychological dynamics of unwanted pregnancy and abortion*
- *safe surgical care, including pre- and post-operative services*
- *counseling regarding the use of contraception and the prevention of unwanted pregnancies*
- *provision of appropriate contraceptive devices. These devices should be available to all women.*

NATIONAL ASSOCIATION OF SOCIAL WORKERS
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FACTS ON ABORTION

Safety of Abortion

- 97% of women who obtain abortions before 13 weeks of pregnancy report no complications. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- Abortion is 11 times safer than carrying a pregnancy to term. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

- **Teenage girls are more than 24 times more likely to die from childbirth that from a first trimester, legal abortion.** (Ory, H W, "Mortality Associated with Fertility and Fertility Control," *Family Planning Perspectives*, vol. 15, no. 2).

- Of the 3.4 million woman who become pregnant unintentionally in the U.S. each year, approximately 1.6 million terminate their pregnancies by medically safe, legal abortion. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

Health Risks to Women

- Legislation mandating parental involvement in decisions about abortion does **increase the risk of harm to the adolescent** by delaying access to appropriate medical care. (American Academy of Pediatrics, Committee on Adolescence, "The Adolescent's Right to Confidential Care When Considering Abortion," *Pediatrics*, vol. 97, no 3).

- Complication rates increase for abortions performed between 13 and 24 weeks. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- The American Medical Association noted that "because the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a "back alley" abortion, or resort to self-induced abortion. The desire to maintain secrecy has been **one of the leading reasons for illegal abortion deaths since...1973.** (AMA, "Mandatory Parental Consent," 83.).

Possible Links Between Abortion and Breast Cancer

- Only about 20 studies have examined the risk of developing breast cancer for women who have has abortions. (National Women's Health Network Fact Sheet: "*Abortion and Breast Cancer: The Unproven Link.*" January, 1994).

- Cancer researchers at the **National Cancer Institute,** the **American Cancer Society,** and major universities say that the most reliable studies show no increased risk, and they call the entire body of research inconclusive.

- **Harvard School of Public Health** researchers concluded in the January issue of *Cancer Causes and Control,* that abortion does not appreciably increase or decrease a woman's risk for breast cancer.

Long-Term Effects of Abortion

- Anti-choice groups are circulating unfounded claims that a majority of American women who choose to terminate their pregnancies suffer severe and long-lasting emotional trauma as a result. They call this largely nonexistent phenomenon "post-abortion trauma," or "post-abortion syndrome." They hope that terms like these will gain wide currency and credibility despite the fact that **neither the American Psychological Association nor the American Psychiatric Association recognizes their existence.**

- For most women who have had abortions, the procedure represents a maturing experience, a successful coping with a personal crisis situation. In fact, **the most prominent emotional response of most women to first-trimester abortion is relief.** (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6), Nov/Dec 1989; Adler, N. et al. "Psychological Responses After Abortion." *Science*, April 6, 1990; Lazarus, A. "Psychiatric Sequelae of Legalized Elective First Trimester Abortion." *Journal of Psychosomatic Obstetrics & Gynecology,* 43(3), September 1985; Russo, N.F. and Zierk, K.L. "Abortion, Childbearing, and Women's Well-Being." *Professional Psychology: Research and Practice,* 23(4), 1992; Armsworth, M.W. "Psychological Response to Abortion." *Journal of Counseling and Development*, 69, March/April 1991.).

- A study of a group of teenage black women who obtained pregnancy tests at one of two Baltimore clinics found that the young women who choose to have abortions were **are more likely to graduate from high school** than those of similar socioeconomic status who carried their pregnancies to term or who were not pregnant. They showed no greater levels of stress at the time of the pregnancy and abortion and no greater rate of psychological problems two years after the abortion that did the other women. (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6)).

- Up to 98% of the women who have abortions **have no regrets and would make the same choice again** in similar circumstances. (Dagg, P.K.B., MD "The Psychological Sequelae of Therapeutic Abortion - Denied and Completed." *American Journal of Psychiatry*, 148(5), May 1991).

- In July 1987, President Ronald Regan directed Surgeon General C. Everett Koop to provide the administration with a report on the health effects of induced abortion. In a letter to the president dated January 8, 1989, Dr. Koop stated that he could not form a conclusion with the available data. (Koop, C. Everett, letter to President Regan, January 9, 1989. Reproduced in "A Measured Response: Koop on Abortion," *Family Planning Perspectives*, 21(1), Jan/Feb, 1989.

- In a 1988 closed meeting, Surgeon General Koop told representatives from several anti-abortion organizations that the risk of **significant emotional problems following abortion was "minuscule"** from a public health perspective. (House Committee on Government Operations. *"The Federal Role*

in Determining the Medical and Psychological Impact of Abortions on Women, H.R. Rep. No. 329, 101st Congress, 2d Sess. 14 (1989)).

- In 1989, a panel of experts assembled by the **American Psychological Association** concluded unanimously that legal abortion **"does not create psychological hazards for most women undergoing the procedure."** The panel noted that, since approximately 21% of all U.S. women have had an abortion, if severe emotional reactions were common there would be an epidemic of women seeking psychological treatment. There is no evidence of such an epidemic. (Adler, N., University of California at San Francisco, statement on behalf of the American Psychological Association before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, March 16, 1989.)

FAX TRANSMISSION FORM

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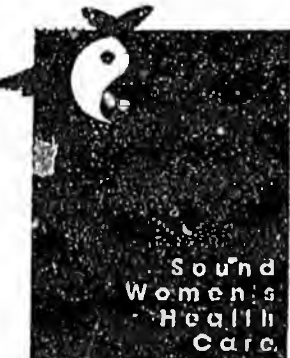
NUMBER OF PAGES TO FOLLOW 4

TO: Robin Taylor ATTN: Laurel

FROM: Dr Cynthia Brooke

MESSAGE

2/12/97



Cynthia Brooke, MD
A balance of treatment and prevention.

Cynthia Brooke, M.D., F.A.C.O.G
Diplomate of the American Board of Obstetrics and Gynecology

attention: Laurel & Honorable Robin Taylor
Judiciary committee;

Please include written testimony should I not be available for oral testimony today. (I have a patient in Labor).

my comments for House Bill 37 may be used in their entirety for Senate Bill 24.

Thank-you for considering the testimony for the alaska State medical association,

Sincerely,
Cynthia Brooke

3340 Providence Drive • Suite 450 • Anchorage Alaska 99508 • 907-563-5588
Fax: 907-563-6903

Cynthia Brooke, MD
A balance of treatment
and prevention.

Cynthia Brooke, M.D., F.A.C.O.G
Diplomate of the American Board of Obstetrics and Gynecology

Written testimony regarding House Bill #37 Introduced by Rep. Kelly, Kohring, Vezey and Molder. Senate Bill #24, Robin Taylor.

I would like to thank the members of the legislature for allowing me to testify both verbally and in writing. As a brief introduction, my name is Cynthia Brooke and I am a board certified Obstetrician/Gynecologist practicing in Anchorage. I did my medical school training at the University of Washington and was a WAMI student in Alaska for 3 months in the summer of 1985 and have considered myself lucky to be able to come back to Alaska to practice medicine. I did my specialty training at the University of Texas in San Antonio which is a very busy county hospital serving south Texas and central Mexico. I have been practicing Obstetrics and Gynecology in Alaska since 1992 and have been a solo practitioner in Anchorage since 1995. I am currently on the Board of Trustees of the Alaska State Medical Association and have been asked to review any legislative bills that may impact on my specialty.

Obstetrics and Gynecology is a specialty that deals with pregnancy, pregnancy complications and any medical or surgical diseases associated with female reproduction. Because of this, we also deal with infertility, hormonal disorders, pelvic anatomy dysfunction including bladder and rectal problems and pelvic tumors. Our daily interaction with patients include detailed histories which because of the nature of our specialty impacts on very private issues. We would be of little use to patients if they could not confide such private matters such as sexual dysfunction, unwanted pregnancies, inability to become pregnant, abuse issues including physical, psychological and sexual abuse and anatomical dysfunctions. The privacy of this relationship between the doctor and the patient is absolutely essential to provide appropriate treatment, care and support. Those of us who live in Alaska and understand what a small community this really is, can probably understand the importance of this confidentiality better than persons who live in more urban settings.

I have some significant concerns about this bill and most of them center around the confidentiality issues. We all know that teenage pregnancy is far too common. I deal with this issue on a daily basis. Whether or not one considers teenagers too immature to make decisions about their own health, future and reproduction; as human beings they deserve to expect the same level of confidentiality and professionalism from their health care providers as their parents would expect. I treat many families in my practice. I would never consider breaking the confidence of one of my teenage patients with one of her family members without that teenager's permission any more than I would tell the

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teenager of a personal issue that her mother has discussed with me. We actively encourage teenage patients to confide in their parents and the vast majority of them do. However, they do this on their own terms and I think with more honesty than in any artificial scenario I could manipulate. In this way I can keep my relationship with both the mother and daughter intact as confidant and health care provider, giving them unbiased medical facts versus being a policewoman or unwanted arbiter of family tensions.

I think you as a legislature should also know that some teenage pregnancies are the result of extremely harmful, abusive living situations in which it is not in the patient's best interest to inform one or both of her parents. Specifically in the case of incest or abuse by a mother's boyfriend or rape by a close family friend, it is sometimes unrealistic or even unwanted to inform certain family members without the patient's permission. There are some situations where this could even put the patient in harm's way. I think it is absolutely inconceivable to think that a teenager who cannot tell her parents or family members that she is pregnant would be willing to go in front of a judge and a bunch of strangers and tell them of her dysfunctional situation. I know for a fact that there are many teenagers out there who would rather die than confront relatives, friends, parents or strangers who would be disapproving of what they have done and of their situation. Anyone who works with teenage pregnant girls can tell you the risk of suicide, botched abortion attempts (sometimes even conducted by a fellow teenager) and even as evidenced recently in a case in Delaware, attempted infanticide. As you have already stated in your bill, teenagers may not always think clearly. Situations that to many adults may seem tough but not insurmountable can seem insurmountable to a teenager. They may truly feel that their life is not worth living anymore.

In my experience, teenagers with unwanted pregnancies who come from loving households do eventually tell their parents. I cannot imagine the loving parents of a teenage girl not wanting their daughter to get all the medical facts so that she can make the best decision about her own health, body and reproductive future. The fact is, she is five times more likely to die if she carries the pregnancy to term than if she has a legal first trimester termination of pregnancy. I cannot imagine loving parents forcing their daughter to make the decision one way or another that so heavily impacts on her health and her future. In my experience this does not happen. In the opposite situation when teenagers do not come from loving homes, sometimes the situation is so dysfunctional and so bizarre it is not feasible for the parents to participate in the decision making. It is these girls that are at risk with this bill. They are at risk and if this bill passes it is just a matter of time before one of them dies as a result. We have already seen this happen in Ohio. There a couple who spearheaded a similar law in Ohio requiring parental consent for teenagers to receive an abortion lost their own daughter to an illegal, botched abortion. They changed their point of view 180 degrees, but at what cost??

I have included with my testimony some statistics for you, a copy of an oath based on the Hippocratic Oath which has been adopted by the AMA that illustrates succinctly the importance of confidentiality. Whether or not you pass this law, I will not violate this oath with my patients, and I think that you will find a similar response from other physicians in my association. You can call it a misdemeanor, you can call it a felony, you can put me in jail. I need to act in the best interest of my patient. I welcome parents and other interested parties to help me with this commitment to my patients but I am realistic that sometimes relatives including parents do not have the patient's best interests at heart. It is those patients for whom I am the only advocate and if I betray them, who do they have left? We have had many examples in the past where the interference of big government, or legislators and well-meaning community members has resulted in disaster. I cannot support this bill and I have urged all members of the Alaska State Medical Association to do the same.

Sincerely,

Cynthia Brooke, M.D

Cynthia Brooke M.D.

Alaska State Legislature

Please enter into the record my testimony to the Senate Judiciary
committee name

committee on SB 24, dated 2/12/97.
bill/subject

Signed: ____________________
Testifier

____
Representing (Optional)

____
Address

____
Phone No.

9/88 Legislative Information Office

PUBLIC COMMENT

12 February, 1997

To: Senate Judiciary Committee

Re: SB 24, Parental consent or Judicial Bypass for Minor Women

From: Natasha I. Calvin for Sitkans for Choice

Honorable Senators:

Why require a pregnant 13 year old girl to go to court to get the safest of all alternatives, i.e. a safe, legal abortion? Under former Surgeon General Koop, it was determined that carrying a pregnancy to term is 7 to 24 times as likely to cause a woman's death as a safe first trimester abortion.

Alarms raised about dangers of abortion are true for illegal, unsafe abortions, not for those performed by qualified personnel. Illegal, unsafe abortions require no parental consent or judicial bypass. It is illegal, unsafe abortions that kill women by the thousands. Roe v Wade was promulgated to protect the lives and health of women. Should we in Alaska do less for our children?

Please do not pass SB 24 out of your committee.

Thank you.

Natasha I. Calvin

Natasha I. Calvin for
Sitkans for Choice
PO Box 2966
Sitka, Alaska 99835
(907) 747- 8950

WRITTEN TESTIMONY ON SB 24

I am writing to ask the Legislature to support SB 24 which upholds the requirement of parental consent in the case of a minor seeking an abortion. This bill is necessary to support family unity and protect and support a minor in making this momentous decision. I feel it will allow parents to be more involved in their children's lives by supporting them in this critical time and helping them to make a difficult decision. The family unit and value system is chiseled away enough in our society by the media and externals that parents have no control over. Please support this piece of legislation that strives to uphold the family unit and allow parents to have a say in this vital decision that will follow their children all their lives-no matter what decision is made.

Thank you for your time.

Beverly J. Kokke

Beverly J. Kokke
631 DeGroff
Sitka, AK 99835
966-2570