HB
329

TONY KNOWLES, GOVERNOR

PLEASE REPLY TO:

☐ 1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-1994
PHONE: (907) 269-5100
FAX: (907) 276-3697

☐ KEY BANK BUILDING
100 CUSHMAN ST., SUITE 400
FAIRBANKS, ALASKA 99701-4679
PHONE: (907) 451-2811
FAX: (907) 451-2846

☐ P.O. BOX 110300-DIMOND COURT HOUSE
JUNEAU, ALASKA 99811-0300
PHONE: (907) 465-3600
FAX: (907) 465-6735

(FAX)465-2539

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

March 25, 2000

The Hon. Fred Dyson
The Hon. John Coghill, Jr.
Co-Chairs, House HESS Committee
Alaska State Legislature
Juneau, AK 99801-1182

Re: SSHB 329

Dear Representatives Dyson and Coghill:

SSHB 329 proposes to establish particular information, to be obtained or prepared by the Department of Health and Social Services (DHSS), that must be provided by a physician to a patient who is seeking an abortion. It further proposes to establish a 24-hour waiting period from the time the patient is provided with the information to the time that the patient may receive the abortion. It also proposes to establish that a physician may be subject to civil lawsuit for failure to provide the specific information required by this bill to a patient before the patient receives an abortion, except in the case of a medical emergency.

The imposition of the requirements set out in this bill are likely to be held unconstitutional under the privacy provisions of the Alaska Constitution, Art. I, Sec. 22. In *Valley Hospital Association v. Mat-Su Coalition*, 948 P.2d 963 (Alaska 1997), the Alaska Supreme Court explicitly rejected the lessening of protections of the right to an abortion that were articulated in the plurality opinion in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Instead, the Alaska Supreme Court established a test similar to that expressed in *Roe v. Wade*, 410 U.S. 113 (1973), affirming the right to an abortion as a fundamental right that can be legally constrained only when the constraints are justified by a compelling state interest and no less restrictive means could advance this interest. The application of this test to specified information requirements, a 24-hour waiting period, and the physician liability provision will likely result in a determination that one or more of these provisions are unconstitutional because they employ excessive means to accomplish the ends of assuring that a patient is informed and has given her consent before receiving an abortion.

This bill, as presently written, raises the following legal problems:

Section 1: Concerning the information required to be obtained or prepared by DHSS and given to each woman who seeks an abortion, in accordance with this bill:

Page 2, line 4 requires a statement that "a person may not lawfully coerce a woman to undergo an abortion." This is not a legally accurate statement. There are many things that constitute coercion and that are lawful that can be leveled against a woman who may not want to undergo an abortion; i.e., a husband may threaten divorce or a boyfriend may threaten not to marry. As worded, this statement is inaccurate and should be rephrased.

Page 2, line 9 of this bill requires that the informational pamphlet contain a statement that "the father of the child is liable to assist in the support of the child . . . " This may lead a woman to believe that she will, in fact, obtain that support unless a provision is added to explain that child support may be difficult to obtain.

Page 3, line 1 requires that the pamphlet be written in easily comprehensible language; however, this bill fails to address the responsibilities of the department or the physician in circumstances in which a patient has limited English proficiency or is developmentally disabled. These concerns raise legal issues and need to be addressed.

Page 3, line 7: Testimony was offered by DHSS at a recent HESS committee hearing that these definitions, and the definitions included in Sec. 4, are not medically accurate or meaningful. This will lead to confusing medical information in the pamphlet and create confusion for physicians about the requirements of the law. Additionally, the definitions, as applied, may be considered to be in conflict with pre-viability and post-viability distinctions made by the courts when dealing with the subject of abortion.

Section 2: There is a long-standing Attorney General's opinion that advises that some of the provisions of AS 18.16.010 are unconstitutional or may only have limited application. (See October 21, 1976 Op. Att'y Gen.) Some of these same provisions are restated in Sec. 2. The legislature should consider amending these provisions to bring them into compliance with this opinion. Furthermore, while amendments are being made to AS 18.16.010, it is important to note that *Valley Hospital Association v. Mat-Su Coalition* explicitly found that AS 18.16.010(b) is unconstitutional to the extent it applies to quasi-public institutions.

Section 3: Concerning physician liability

Page 4, line 2: In some states, the imposition of civil liability on physicians on the basis of requiring that specific information be provided to a patient seeking an abortion has been determined unconstitutional where there was no *scienter* (knowing) requirement. (Please see *Okpalobi v. Foster*, 190 F.3d 337 (5th Cir. 1999), *rehearing granted en banc*, 201 F.3d 353 (5th Cir. 2000); *Planned Parenthood, Sioux Falls v. Miller*, 63 F.3d 1452 (8th Cir. 1995), *cert. denied*, 517 U.S. 1174 (1996).) Though the cited cases do not address the same kind of liability provisions as the one that appears in this bill, they do address the importance of establishing a standard that is sufficiently clear so that a physician is able to determine whether he or she is complying with the law. In this case, the term "knowingly" that appears at AS 18.16.060 may be

read into AS 18.16.010(h). However, the confusion caused by definitions that do not conform to medical practice creates too much uncertainty for a physician to be able to make a "knowing" determination of what constitutes lawful action. Consequently, the uncertainty created by inaccurate definitions may be found to have a chilling effect on the availability of abortions because physicians will face uncertain civil liability. The definitions must be revised to prevent this confusion.

Furthermore, since some of the specific information requirements will likely be found unconstitutional in their application to certain circumstances (see comments on Sec. 4), the clear application of the law is going to be compromised. Even with the severability provision included in this bill, a physician will face potential civil liability for guessing incorrectly about which information is required or whether some information can be omitted because it serves no medical purpose. Generally, physicians are required, both by sound medical practice and by their malpractice insurance providers, to assure that informed consent is obtained from their patients. To the extent that there is reasonable confusion about the specific information requirements, the civil liability provision is likely to have a chilling effect on the availability of abortions.

Section 4: Information requirements and 24-hour waiting period:

The 24-hour waiting period presents legal problems on both equal protection and privacy grounds. Abortion is a medical procedure sought only by women. Abortion would be the only medical procedure on which a requirement of a 24-hour delay is imposed as a matter of law if the bill is enacted. This intrusion into the physician-patient relationship for this sole procedure may fail an equal protection challenge.

Furthermore, because this state has a significant rural population and many urban communities in which abortion services are not available, many patients must travel away from home to obtain this kind of medical care. The imposition of a 24-hour delay will often result in greater expenses for these patients and may result in delays in seeking the abortion procedure until it is possible for the patient to be away from home for a longer period of time. Placing this burden on a woman seeking an abortion will not likely meet the requirement of being the the least restrictive means to accomplish the purpose of assuring a woman is informed and has given her consent to the abortion procedure.

Page 4, lines 29-31, through page 5, lines 1-2: These provisions require the physician or referring physician to convey information about state medical assistance benefits that may be available for the child and that the father of the child is liable to assist in the support of the child. However, in *Karlin v. Foust*, 975 F. Supp 1177 (W.D.Wis. 1997), the court opined that a requirement that physicians provide this type of information to a woman who is pregnant as a result of rape or incest or who is carrying a fetus that has been diagnosed with a lethal fetal anomaly would not be constitutional since it would likely cause psychological harm and serve no

medical purpose. (These circumstances were further addressed in the appeal of the same case, *Karlin v. Foust,* 188 F.3d 446 (7th Cir. 1999*) affirming that such information need not be given to these women because the provision of this information would further no legitimate interest; rehearing and rehearing en banc denied, Karlin v. Foust,* 198 F.3d 620 (7th Cir. 1999).) Changes should be made to the bill in order to permit a physician to make special considerations for women who are pregnant due to rape or incest, are carrying fetuses that have been diagnosed with a lethal fetal anomaly, or are facing comparable circumstances where the information may serve no legitimate purpose.

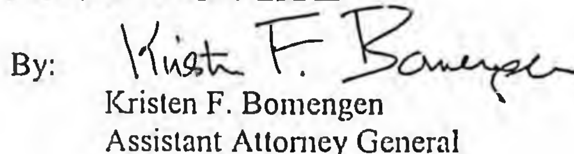
Page 5, line 25: The medical emergency definition fails to provide for an exception to consider the emotional health of the woman. This provision will be vulnerable to constitutional challenge unless the definition is amended to include an exception that can address emotional conditions that the physician believes will affect the patient's health.

In summary, abortion law in the state of Alaska is undergoing clarification through the appeals that are working their way through the Alaska courts. In the meantime, it is almost certain that, if this bill passes and is enacted into law, a lawsuit will be filed. A conservative estimate of the cost of the defense of this lawsuit by the State of Alaska begins at about $50,000, plus costs for the hiring of legal experts. If the state does not prevail, the attorney's fees and costs that will be assessed against the state are estimated to be at least the same. The Department of Law will be able to provide clearer legal guidance on the constitutionality of the provisions of this bill once these pending appeals before the Alaska Supreme Court are decided.

Please accept my apologies for not being available to discuss these matters at the House HESS hearing on March 28, 2000. I will be returning to Juneau by April 3rd and will be available to discuss these issues with the House HESS Committee or with legislative counsel at that time.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: 

Kristen F. Bomengen
Assistant Attorney General

/KFB:ebc

cc: DHSS Commissioner, Karen Perdue
Pat Pourchot
Chrystal Smith
Deborah Behr

4/10/00
JUD

TO: Representative John Coghill

FROM: Denise M. Burke
Staff Counsel, Americans United for Life

DATE: 10 April 2000

SUBJECT: Alaska House Bill 329

Thank you for your request that Americans United for Life provide testimony and input on Alaska House Bill 329. I have reviewed the legislation and will provide testimony later today. I also would like to propose the following changes and additions to the legislation. The proposed changes and additions are bolded and in italics. The purposes of these proposed changes and additions are to add specificity and clarity to portions of House Bill 329 and to enhance its constitutionality and enforceability.

1. **Section 18.05.032: Information Relating to Unborn Children and Abortion.**

Section 18.05.032(a) should read: "The department shall obtain or prepare ***comprehensive*** written information, ***updated annually***, that"

Section 18.05.032(a)(1) (line 2) should be modified to read: "... private agencies and services, including ***but not limited to*** adoption agencies"

Section 18.05.32(a)(1) (line 5) should be modified to read: "... manner in which the agencies may be contacted, including telephone numbers ***and addresses.***"

I would also add the following language to the end of Section 18.05.32(a) (1): "...locality of the caller ***and of the services they offer. The department shall ensure that the materials described in this section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any agency or service described in this section."***

Section 18.05.032(a)(6) (line 1) should be modified to read: "... inform the woman of the ***probable*** anatomical and physiological..."

I would add the following definitions to Section 18.05.032(c):

"Department" means the Department of Health and Social Services.

"Physician" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy."

"Qualified person" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse or physician."

2. **Section 18.16.060: Informed Consent Requirements:**

Section 18.16.060(b) should be modified to read: "Consent to an abortion is voluntary and informed ***if and*** only if all the following are true."

Section 18.16.060(b)(1) should be modified to read: " ... the referring physician has orally ***and in person*** informed the woman of"

Section 18.16.060(b)(1)(B) should be modified to read: "... medical risks includ[***ing***] ***but not limited to***"

I would add the following line to Section 18.16.060(b)(1)(G): ***"In the case of rape or incest, this information may be omitted."***

I would add the following line to Section 18.16.060(b)(2)(B): ***"If the woman is unable to read the materials, they will be read to her. If the woman asks questions concerning any of the information or materials, answers shall be provided."***

I would add the following definitions to Section 18.16.060(c):

"Department" means the Department of Health and Social Services.

"Physician" means any person licensed to practice medicine in this State. The term includes medical doctors and doctors of osteopathy."

"Qualified person" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse or physician."

3. **Additional Provisions**: I propose that the following additional provisions be added:

a. **Certification of Compliance with Law**: I proposed that Section 18.16.060(b)(4)(A) be modified to read: ***"The woman certifies in writing on a checklist provided by the department prior to the abortion that the information required to be given under (1) – (3) of this subsection has been received. Prior to the performance of the abortion, the physician who is to perform the abortion or a qualified person shall receive a copy of the written certification and a copy of the certification shall be maintained in the woman's medical record. Physicians who perform abortions shall report the total number of certifications received monthly to the department. The department shall make the number of certifications received available to the public on an annual basis."***

Currently, the bill does not indicate what type of written certification of informed consent is required. The Department of Health and Social Services should produce and provide a checklist certification form for distribution to abortion providers. A provision requiring the Department to produce or procure this checklist can be added

to Section 18.05.032. This will ensure standardize practice and more complete compliance with the law.

b. **Delegation of Counseling Responsibility**: Section 18.16.060(b)(2) allows either the physician who is performing the abortion or the referring physician to delegate a portion of the required counseling to a third party. However, the bill does not specify limitations on this delegation or qualifications for the delegatee. This third-party delegatee should be a "qualified person"; the definition of a "qualified person" should be added, as recommended to Sections 18.05.032(c) and 18.16.060(c). This change could be accomplished by modifying the language of Section 18.16.060(b)(2)(B) to read: ***"at least 24 hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has informed the woman, orally and in person, that:"***

c. **Medical Emergencies**: As drafted, the bill has no requirement, when an abortion is performed in a medical emergency, that a physician inform the woman of the medical indications supporting his or her judgment that an abortion is necessary to avert the woman's death or to avert substantial and irreversible impairment of a major bodily function. Even in such an emergency, it is still important that the woman receive information about the abortion procedure. I would propose that the following provision be added to House Bill 329:

> ***"Where a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting his or her judgment that an abortion is necessary to avert her death or to avert substantial and irreversible impairment of a major bodily function."***

4. **Proposed Deletion:** Finally, I recommend that Section 18.16.010(a)(4), the section requiring a 30-day domicile in Alaska before receiving an abortion, be deleted for the legislation. The Supreme Court has upheld the constitutionality of a 24-hour waiting period to allow for an informed and mature decision and has even allowed for a 48-hour waiting period for minors seeking abortions. However, Section 18.16.010(a)(4) could be construed as requiring a 30-day waiting period for some abortions. Abortion rights proponents have been successful in challenging the constitutionality of state laws that would require a woman to wait until later in her pregnancy to obtain an abortion, recognizing that the risks associated with abortion increase as the pregnancy progresses. Under this analysis, Section 18.16.010(a)(4) could be deemed an undue burden and unconstitutional. There is a severability provision in Alaska Statute 01.10.030 and this section could be severed if a court determined it to be unconstitutional. However, leaving this provision in the statute will almost certainly subject the entire piece of legislation to a constitutional challenge.

Testimony of

Vincent M. Rue, Ph.D.
Institute for Pregnancy Loss
Stratham, New Hampshire

Regarding

HB 329

Before the House
Judiciary Committee

Juneau, Alaska

April 10, 2000

By way of introduction, I am a traumatologist, psychotherapist and researcher. I have testified before several federal legislative committees in Washington and have provided testimony in numerous state abortion-related statutory challenges. I have provided testimony or consultation with 18 states regarding abortion decision making and the psychological aftereffects of abortion. In addition, I am a practicing psychotherapist and have treated hundreds of women who have elected abortions over the past 25 years. I am also an author, international lecturer and researcher on abortion related trauma and treatment.

One of the best kept secrets about induced abortion pertains to its emotional aftereffects. *Greater than any other single physical health risk, the psychological complications of abortion range from 5% - 60% depending on the study.* Even Planned Parenthood has acknowledged that abortion causes significant depression in 10% of women! Yet the mental health complications from abortion are underestimated and underreported by state health departments & the Centers for Disease Control, perhaps by a factor of 50%. In my opinion, women rarely return to the site of trauma to acknowledge their emotional injury and seek palliative care.

From the evidence presented below, it is apparent that the abortion decision is a complex and terrifying one, that the current practice of abortion counseling does not adequately address women's mental health care needs, that abortion carries certain and significant mental health risks, and that a statute enhancing informed consent is necessary to prevent further harm. I support HB 329 and believe such a bill would benefit Alaska women with unwanted pregnancies if enacted into law.

1. The Nature of the Abortion Decision

The process of informed consent and abortion decision making has all too often been left to the discretion of a non-professional, well-meaning, but likely misinformed "abortion counselor" whose typical job requirement is a "pro-choice" sentiment. The women of Alaska and throughout the United States deserve far more and better precautions for their mental and physical health.

The abortion decision is a unique one, complex in nature, necessitating due deliberation and the evaluation of considerable information, some of which may be emotionally trying. The U.S. Supreme Court has ruled: (1) "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." Harris v. McRae. 448 U.S. 297, 325 (1980); (2) that the decision whether or not to abort should be made "in light of all circumstances - psychological and emotional as well as physical - that might be relevant to the well being of the patient." Planned Parenthood v. Danforth 428 U.S. 52, 66 (1976); and (3) that the "medical, emotional and psychological consequences of an abortion are serious and can be lasting..." H.L. v. Matheson 450 U.S. 411 (1981).

Alaska is not alone in setting forth minimum standards of informed consent and abortion counseling. Because of the medical, moral, societal and psychological controversies surrounding abortion, some states are now insisting that reasoned and deliberate abortion decision making be legally mandated. In particular, women's "right to know" laws have been enacted that precisely determine the content of information and the timing as to when information should be made available before an abortion may be performed.[1]

In the United States today, the following elements of informed consent have been mandated in a number of states: (1) the medical risks associated with pregnancy termination; (2) the probable gestational age of the unborn child; (3) the alternative risks associated with carrying to term; (4) the medical assistance benefits if childbirth were elected; (5) the father's liability for financial assistance; (6) the opportunity to

review printed information descriptive of fetal development; and (7) some waiting period for deliberation, usually 24-48 hours.

These informed consent requirements are additive in nature, insuring the woman has more rather than less information. These requirements do not appear to restrict the patient's decision making capacity - they enhance it. How is it possible for a woman to weigh the benefits and risks of electing an abortion if information regarding abortion alternatives are conspicuously absent in the "counseling process?" Indeed, if informed consent is not obtained prior to an abortion, then grounds for medical malpractice litigation are warranted based on personal injury.[2]

Because the doctrine of informed consent is well established, courts and legislatures have consistently required physicians to provide a minimum of information to the patient prior to making a decision regarding treatment. This information is generally composed of a determined diagnosis, reasonable prognosis, the risks and benefits of proposed treatment and non treatment, all of which should be provided in terms that the patient can comprehend. The practice of abortion has been a lamentable and solitary exception to this standard of care.

2. The Known Deficiencies of Abortion Counseling

The two most common causes of action in abortion malpractice are: (1) negligence in evaluating/screening a patient preabortion; and (2) lack of informed consent which constitutes battery. Because abortion is a medical procedure, legally it is the physician's duty to evaluate, counsel and assess the patient beforehand.

Current abortion practice though severely limits physician-patient contact and instead preabortion counseling is most typically delegated to the physician's agent, i.e., the abortion counselor. Nevertheless, it is the physician who actually performs the abortion, and it is always his/her ultimate responsibility to (a) protect the patient's health; (b) to see to it that the patient's decision is firm, freely made, and duly thoughtful; and (c) that her consent is truly informed.

The Abortion Counselor

Abortion counseling in most countries suffers from obvious and serious conflicts of interest and procedural inadequacies. Abortion counseling between physician and patient is largely nonexistent. Instead, the patient is "counseled" by someone other than a physician, i.e., his agent, who most typically is not professionally trained and who receives "on the job training." In the U.S., abortion counselors as a "profession" are unlicensed and are unregulated in 95% of the states. "Professional background is considered less important than such personal attributes as warmth, caring, empathy and a commitment to the pro-choice cause."[3]

Counselor bias can clearly be a negative force in the counseling process, particularly if the situation is compounded by a conflict of interest, i.e. pecuniary benefit in the outcome, namely, abortion.

All too often the abortion counselor has only a high school diploma, has herself had one or two abortions and feels compelled to assist others by affirming the abortion decision. She thereby affirms her own decision, unknown to her and her client. Because she may be in denial about the emotional aftereffects of her own abortion, she is either unaware of postabortion emotional trauma because she needs to be, or is simply uninformed.

One abortion counselor worked two days at the clinic and the remainder of her work week as a bartender at a "biker's bar." Another abortion counselor responded at her deposition when asked when human life began: "it begins at birth." Sadly, this kind of counselor and counseling may be more normative than the exception.

Duration of Preabortion Counseling

Contemporary abortion counseling is so time limited and volume oriented as to be impossibly tailored to the unique needs and circumstances of the individual patient. Indeed, thorough, thoughtful, and deliberative pregnancy outcome decision making is handicapped by existing abortion counseling procedures.

Several empirical studies in the U.S. have indicated the deficiencies of current abortion counseling practices with the majority of respondents reporting insufficient information provided by the abortion counselor, insensitive, unhelpful abortion clinic personnel with respect to providing assistance in decision making, and the provision of misinformation thereby contributing to increased anxiety, confusion and levels of post abortion depression and hostility.[4]

Clearly, effective counseling that is empathic, durational and substantive in content benefits women considering abortion as a solution to an undesired pregnancy. On the other hand, biased "counseling" which is of 5-15 minutes duration, one outcome oriented, deficient of sufficient information and not allowing for multiple visits or time deliberation is harmful of women considering abortion.

Nature of Preabortion Counseling

Current standards of care for abortion counseling have appropriately been criticized in the U.S. on at least three counts: (l) the health profession inadequately fulfills women's needs for abortion counseling; (2) current laws, by not mandating or regulating the practice of abortion counseling, fail to address women's needs for abortion counseling, thus undermining maternal health; and (3) abortion counseling must of necessity expand and include assistance in remediating post procedural problems.[5]

The value of nondirective crisis pregnancy counseling was underscored by Cook. She reported: "When women may act only within a short span of gestation, they may be denied the opportunity to consider their options fully and take necessary steps for continuation or termination. Women could thereby be denied the choice to continue a pregnancy and give birth. The agendas of both antichoice and prochoice activists may be served by affording women opportunities for nondirective counseling and planning, and not obliging them to make their decisions in haste."[6]

Information Deficiencies

It is a tragic reality that abortion clinics go to great lengths to disguise, minimize, deny, disavow or dissaude their patients' concerns about the humanity of the fetal child.

Not offering a woman the opportunity to receive fetal information is also not following good counseling procedures for, in the absence of such, a directive counseling environment is created. In the absence of an opportunity to receive fetal information, the woman's attention is focused on the limited information which the counselor chooses to disclose and her decision is thereby directed by the limited information she receives. In such a directive counseling situation, the woman is denied the opportunity to consider thoroughly all her options, as information that would allow such has been withheld by the counselor.

In addition, many women are not familiar with the facts of fetal development, but would consider information on fetal development to be important in making their abortion decision because they would not wish to have an abortion if their unborn child were sufficiently developed to have readily identifiable arms, legs, a beating heart, etc.

The provision of information on fetal development further insures that, in deciding whether or not to have an abortion, a woman has an opportunity to use her own personal values, including her view of the time at which human life begins. If she is informed about fetal development and concludes that the unborn child is indeed a human life, then given her legal options, she can act accordingly in light of her own values. If she concludes that either the product of conception or the aborted material is not human,

and decides to abort it, then she will have minimized the risk of future potential psychological harm arising from post-operative reflection prompted by obtaining fetal information not made available to her before it took place.

If information causes discomfort or dissonance, this does not mean it is antithetical to the doctrine of informed consent. According to former U.S. Supreme Court Chief Justice Rehnquist and Justice White: "It is in the very nature of informed consent provisions that they may produce some anxiety in the patient and influence her in her choice. This is in fact their reason for existence, and - provided that the information required is accurate and nonmisleading - it is an entirely salutary reason."[7]

Decision-Expediting & Non-Evaluating

One of the most important roles of the abortion counselor is to ascertain whether or not a woman's decision is indeed her own, made with sufficient information and reflection, is made voluntarily, and that undue pressure or coercion is not present. In addition, the counselor should obtain a psychosocial history as well as a medical history, and accordingly assess the risk for any postabortion negative emotional adjustment.

The current nature of preabortion counseling virtually insures the impossibility of achieving its objectives. This is so because of: (a) the lack of professional education and training on the part of the counselor; (b) the severe time constraints placed upon the session (5-15 minutes); (c) the often reliance upon group versus individual counseling; (d) the absence of objective information; (e) the non-exploration of alternatives; (f) the absence of information on fetal development; (g) the conflict of interest for the abortion counselor; and (h) the counselor biases.

3. Psychological Risk Factors for Postabortion Trauma

Research evidence is clear that certain women are predisposed to significant negative post abortion adjustment. Existing biased abortion counseling places maternal health of these women at risk. These women are in need of more counseling, more information, exploration and deliberative time, and more assistance than others.

Abortion traumatization may in many cases be prevented or remediated if women who give evidence of documented risk factors receive adequate counsel to make a decision that fits their unique psychological and social needs.

Empirical evidence suggests emotional harm from abortion is probable when the following risk factors are present:

1. *preabortion emotional maladjustment*
2. *immature interpersonal relationships*
3. *unstable, conflicted relationship with one's partner*
4. *history of a negative relationship with one's mother*
5. *conflicted abortion decision, including considerable ambivalence*
6. *when abortion violates personal beliefs, morals and values*
7. *single status, especially if one has not borne children*
8. *age, particularly adolescents versus adult women*
9. *mid or late-term abortions*
10. *abortion for genetic reasons, i.e., fetal anomaly*
11. *pressure or coercion to abort*
12. *prior abortion*
13. *prior children*

14. maternal orientation
15. when the abortion choice is not duly considered, counseled or informed & biased preabortion counseling
16. a secret abortion
17. when a woman perceives her uterine contents as "human" and a "child"
18. when the abortion event is perceived by the woman as violent and death producing

4. THE RESEARCH EVIDENCE OF POSTABORTION PSYCHOLOGICAL HARM

Extensive research has documented how traumatic stress can significantly alter individuals' lives. Traumatic stressors are strong predictors of PTSD (Foy, Osato, Houskempt & Neuman 1992). While the prevalence of PTSD has been estimated to affect up to 12% of the U.S. population (Breslau, Davis, Andreski & Peterson 1991), limited research has examined the role of elective abortion as a traumatic stressor causing symptoms of PTSD.

Most trauma victims encounter feelings of horror or terror at the time of the traumatic episode. Bagarozzi has reported that women who came for mental health treatment were in complete denial that they had experienced an abortion and that indeed it was a traumatic and horrific experience for them. "This denial was seen as a major contributing factor to the development of post traumatic stress in these women" (1993:67). Clinical research findings highlighting the power of denial before, during and after an abortion have also been reported by Torre-Bueno (1996). As a pro-choice advocate and long-time Planned Parenthood abortion counselor, her assertion is all the more compelling:

> *"I believe passionately that I can be supportive of every woman's right to make her own pregnancy decisions, and still recognize the fact that her decision may cause her tremendous suffering. While many women do not have emotional or spiritual difficulty after an abortion, I know from twenty years of experience working with women before, during, and after abortions, that many women have more emotional and spiritual pain after abortion than the current research suggests." (1996:3)*

In another clinical study, pro-choice psychotherapists De Puy and Dovitch (1997:13-14) reported that 10% of women experience "severe emotional trauma" following abortion. According to these clinician/researchers: "Many women acknowledge a feeling of relief after their abortion, yet are understandably upset by facets of the experience that they had never anticipated. Many are distressed and unaware of the ways in which their choice has changed their lives and, sometimes, the lives of those around them."

In a study of 80 women in the U.S., Barnard (1990) used standardized posttraumatic stress disorder (PTSD) instruments and found: 3-5 years following the abortion, 18% of the sample met the full diagnostic criteria for posttraumatic stress disorder (PTSD) and 46% displayed high stress reactions to their abortion. Her findings were not explained by religiosity as 68% reported that at the time of the abortion they had little to no religious involvement.

Subsequently, similar findings were also reported by Hanley et al. (1992) in a comparison study of women distressed postabortion which also used standardized PTSD instruments and interviews. They found: "*Women who were distressed following an abortion scored significantly higher than the non-distressed group on PTSD symptoms of intrusion and avoidance.*" The investigators evaluated whether some women in outpatient mental health treatment with a presenting problem of postabortion distress met Diagnostic & Statistical Manual of Mental Disorders III Revised (DSM-III-R) criteria for the posttraumatic stress disorder (PTSD) categories of intrusion, avoidance, and hyperarousal. One hundred and five women were administered the SCID-PTSD module, the Impact of Event Scale, as well as the Social Support Questionnaire and the Interview for Recent Life Events, in addition to completing a semi-structured

interview. The researchers concluded: "*the data from this study are suggestive that women can report abortion-related distress similar to classic PTSD symptoms of intrusion, avoidance and hyperarousal and that these symptoms can be present many years after the abortion.*"

Posttraumatic reexperiencing has also been documented in anniversary reactions. In a small study conducted by Franco et al. (1989:154), 30 out of 83 women reported experiencing anniversary reactions that included intense emotional psychosomatic pain. They noted: "Unresolved grief and preexisting dysphoria have been suggested as increasing the likelihood of anniversary reactions."

Another recent study compared two groups of 25 women who elected abortion: those who identified themselves as distressed (D) and those who reported more neutral or non-distressing responses (ND). PTSD symptomatology was found in the distressed group: changes in male-female relationships, suppression of feelings/thoughts about the abortion, reactions to catalytic events that aroused thoughts/feelings about the abortion, trying to get pregnant again, becoming promiscuous, and avoiding reminders of babies. More than two out of three women in Group D were distinguished by reports of "suppression" or "denial" of parts of the abortion experience or negative emotional reactions to it. Additionally, women in the distressed group were more than twice as likely to report abortion trauma related symptoms on the Impact of Event Scale than those in the non-distressed group (Congleton and Calhoun 1993).

In this same study, women who identified themselves as distressed postabortion indicated feeling: a sense of loss/emptiness (48%); shock/detachment (28%); anger toward partner/others (24%); depression (20%); loneliness, betrayal, loss of self-worth, and relief (16%); guilt and sorrow (12%); confusion (8%); fear of dying and suicidal thoughts (4%). Interestingly, in the group of women who elected abortion and did not believe they were distressed, 20% had symptoms of depression, an equivalent percentage experienced by the distressed group. The authors concluded: (1) for some women, abortion is a "critical event" which produces high levels of psychological distress; (2) informed consent should insure accurate information is conveyed about physical pain and possible negative and positive emotional reactions; and (3) when dealing with depression among women, exploring reproductive history for unresolved emotional reactions to pregnancy termination may prove beneficial.

In a large scale prospective cohort study (N=13,261, of whom 6410 experienced a pregnancy termination) conducted in the United Kingdom, Gilchrist et al. (1995) found evidence of the traumagenic nature of abortion when examining relative risks of suicidal behavior in women who had previously terminated their pregnancy, and who had no prior history of psychiatric illness. A recent study in Finland of all deaths of women of childbearing age concluded: "Our data clearly show, however, that women who have experienced an abortion have an increased risk of suicide which should be taken into account in the prevention of such deaths" (Gissler, Hemminki and Lönnqvist 1996:8).

A recent Swedish study examined emotional distress (ranging from 1 month to 12 months follow-up) after abortion at a university hospital. Risk factors identified were: living alone, poor emotional support from family and friends, adverse postabortion change in relations with partner, underlying ambivalence or adverse attitude to abortion, and being actively religious. The researchers concluded: "Thus, 50-60% of women undergoing induced abortion experienced some measure of emotional distress, classified as severe in 30% of cases." (Soderberg, Janzon & Sjoberg, 1998:173)

In a study just published, Reardon & Ney (2000) examined the mental health risks of abortion relating to subsequent substance abuse. They found that women who aborted a first pregnancy were five times more likely to report subsequent substance abuse than women who carried to term, and they were four times more likely to report substance abuse compared to those who suffered a natural loss of their first pregnancy due to miscarriage, ectopic pregnancy or stillbirth.

In addition to the above, there are a number of reviews of the literature on postabortion sequelae that are instructive (Speckhard & Rue, 1992; Rue, 1995; Speckard, 1997; Ney & Wickett, 1989; and

Angelo, 1992).

5. The Need for Mandated Informed Consent & Waiting Period

The nature of an unwanted pregnancy suggests pressure and str There is considerable pressure on the woman to make a decision as quickly as possible. Women who ake decisions in haste and without sufficient time for reflection are less likely to be satisfied with the quality of their decision making later on. Then too, many women change their minds regarding the outcome of the pregnancy a number of times due to the daily pressures of life, relationships and feelings. Reardon (1988) reported that 83% of women in his study felt "rushed" to make a decision. He also found the majority of women in his study were dissatisfied with the kind of preabortion counseling they received, 71% stating they believed the preabortion counseling at the abortion clinic was biased.

In a joint U.S. & Russian study, Rue et al. (2000) reported a number of factors women found disturbing in their preabortion counseling experiences. Specifically, in Table 1 several factors are identified by women who have had abortions that were c ntributory to postabortion emotional injury. These factors included lack of preabortion counseling, needing more time to decide, having sufficient opportunity to discuss alternatives, pressured abortion decision, preabortion counseling adequacy, uncertainty about abortion decision, etc. In this sample, 49% needed more time to make their decision. Sixty-two percent of the women studied felt pressured to abort. Only 89% of women who elected to abort were satisfed with the quality of the abortion counseling they received. Slightly more than one out of two women (52%) felt unsure about their decision at the time of their abortion. It is clear that a waiting period can benefit women who feel pressured; that counseling must be unbiased and include alternatives to abortion, and that decision certainty is critical before proceeding with what amounts to an irrevocable decision, one that can affect them for the rest of their lives.

In my opinion, HB 329 is a step in the right direction to help remedy these known deficiencies. HB 329 is critical in safeguarding Alaska women's health; it will help insure that women's abortion decisions are their own, that sufficient information is conveyed so as to be informative versus perfunctory, that women's abortion decisions be formed without pressure and bias, and that alternatives are objectively presented and considered. In the final analysis, if women choose to terminate their pregnancies, they deserve the best assistance we can offer them in their decision making process, and at the very least, provide the context and content of a consent that is voluntary and informed.

Table 1. Selected Preabortion Factors by Number & Percent of U.S. Women Who Have Aborted (N = 320)*

	N	%
Received counseling beforehand	95	29.7
Needed more time to decide	157	49.1
Was counseled on alternatives	59	18.4
Felt pressure to abort	200	62.5
Preabortion counseling was adequate	36	11.3
Partner was supportive	77	24.1
Unsure about decision at time of abortion	166	51.9
Personal beliefs oppose abortion	151	47.2
Multiple emotional stressors preabortion	152	48.0
Kept pregnancy/ abortion a secret	121	37.8

*Rue et al. (forthcoming) Abortion & Trauma

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FOOTNOTES

1. In the U.S , there are approximately 25 states that have enacted statutes that expressly proscribe the nature and content of informed consent in pre-abortion counseling and decision making and proscribe a minimum waiting period

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Palmer, Alaska
March 29, 2000

To Whom It May Concern on SSHB 329;
Importance of INFORMED CONSENT bill:

First of all I'd like to address FERTILIZATION and how it occurs: Fertilization occurs when sperm enter the woman's vagina and swim through the cavity of the uterus and enter the fallopian tubes, the egg released by the ovary is penetrated by one of the sperm and immediately, within a split-second, a chemical reaction occurs preventing other sperm from entering the egg. When this process is complete a NEW HUMAN BEING exists. This single celled human being divides and splits and continues on its way through the fallopian tube where it implants itself into the lining of the uterus and continues to grow, if allowed, for the next nine months into the human being we are or would like to become as adults.

ABORTION on the other hand is the interruption of a pregnancy or the expulsion of the contents of a pregnant uterus before the fetus is viable and in some cases even after it is viable.
THESE ARE THE THINGS NEEDED TO BE TOLD TO THE MOTHER.
Complications post abortion are: 10,000 deaths occur due to infections (PID), rupture of the uterus, hemorrhage and drug overdosage. Most common delayed complications are bleeding caused by part of the placenta remaining in the uterus, infections (pelvic inflammatory disease) and blood clots in the legs. Also, scarring of the inside of the uterus can cause sterility. Then there are the psychological and psychiatric problems such as feelings of loss, guilt and anger. Sooner or later this mother will go through the five (5) stages of grief.
Then what about the unsuccessful abortions when you have children who survive with partial limbs? Because babies do not want to be aborted and it's a known fact that they fight the suction or instruments of the abortionist. If the woman (mother) really does not want this child, give her the opportunity of having it because there are plenty of people who want children. If you have the funds to pay for abortions then the same amount of funds should be used to help those people who want to adopt.
EQUALITY!!!!

Respectfully submitted,
Janice C. Barrett R.N.
Janice C. Barrett R.N.

CREED MAMIKUNIAN, M.D.
2401 EAST 42ND AVENUE, SUITE 206
ANCHORAGE, ALASKA 99508
(907) 562-1860 • FAX (907) 562-1865

Otolaryngology
Head and Neck Surgery

Facial Plastic and
Reconstructive Surgery

March 31, 2000

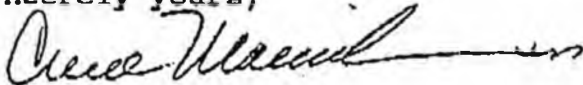
Re: House Bill #HB329

TO WHOM IT MAY CONCERN:

It is my strong opinion that informed consent be a mandatory requirement for any considered abortion. All surgical procedures require informed consent detailing the possible risks and complications of any surgical procedure. In the situation where an abortion is to be performed, there are obvious risks which the mother would be exposed to. It is an essential requirement that the patient understand what the potential risks and complications are, regardless of whom is performing this procedure. This is only common sense in the medical field.

If I can be of any further help to you, please feel free to contact me at any time.

Sincerely yours,



Creed K. Mamikunian, M.D.

CKM:ken

Tanana
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April 7, 2000

Representative John Coghill, Jr.
State Capital, Room 416
Juneau, AK 99801-1182

RE: Informed Consent Bill
#CHSB329 - House Version
#SB300 - Senate Version

Dear Sir,

I am a Family Practitioner who has been in practice in Fairbanks for the last seven years, both in the Native and non-Native health care systems. I have cared for many pregnant women, following them through to their delivery during this time. I have also cared for many woman both pre and post abortion during this time.

On multiple occasions, I have had patients who have later regretted their choice to obtain an abortion. Most of these patients were inadequately educated and/or given a one-sided pro abortion position. They never understood the procedure in terms of the fetal development and especially, the potential psychological trauma to themselves. It is this aspect in particular which have haunted the patients I have seen. Many come to deeply regret and cannot forgive themselves for a decision made during an emotionally charged stressful time. This can then lead to an ongoing battle with depression in later adult life.

I strongly support this bill mandating proper education and a waiting period prior to obtaining an abortion for all women. I feel that the consequences can be too grave following a rapid, emotionally charged, uninformed decision.

Please feel free to call if you have any questions. Thank you for your time.

Sincerely,

Donald L. Ives, M.D.
Family Practice

DLI/dr

1001 Noble Street • Fairbanks, Alaska 99701
(907) 459-3500 • FAX (907) 456-8770

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. HB 341

Revision Date/Time:
Title: Farm Operations:Disclosure / Nuisances
Sponsor: Rep. Harris
Requestor: (H) JUD

Dept Affected: Natural Resources
BRU: Agricultural Development
Component: Agricultural Development
Component No 455

Expenditures/Revenues (Thousands of Dollars)
Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
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 (fund code)	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: $ none

POSITIONS

POSITIONS	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: *(Attach a separate page if necessary)*

The Department does not anticipate any associated costs with this proposed legislation.

Prepared by: Robert Wells
Division: Division of Agriculture
Phone: 907-745-7200
Date: 10-Apr-00
Approved by Commissioner: John Shively
Agency: Natural Resources
Date: 10-Apr-00

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REPRESENTATIVE JOHN COGHILL
STATE CAPITOL, ROOM 416
JUNEAU, ALASKA 99801-1182

PHONE: 1-907-465-3719
FAX: 1-907-465-3258

FACSIMILE TRANSMITTAL SHEET

TO: Lesil McGuire	FROM: Danielle Ferino
COMPANY:	DATE:
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE: CSHB 329	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Lesil,
Just received this FAX. Could you make sure the committee members receive a copy?
Thank you, sorry for the short notice.

Danielle

The term 'a woman's right to choose' is the banner for many people in this nation. I raise the question-How can anyone make an intelligent decision when much of the information during abortion counseling is withheld? The tragic truth is that physical and psychological damages that are incurred by abortion are not revealed during abortion counseling. Nor is information given about the developing child.

There are a few states that have passed 'woman's right to know' informed consent legislation, but, unfortunately Alaska is not one of them. So, until we have complete disclosure when seeking abortion information, here are some interesting and informative facts.

In the medical profession, the debate is not over whether there are risks, but, rather how often complications will occur.

Federal Court rulings have sheltered the practice of abortion in a 'zone of privacy.' This prohibits any meaningful form of state or federal regulation other than broad general requirements as to the maintaining of sanitary facilities and minimal building code standards.(A Lawyer Looks At Abortion.) As a result, any laws which attempt to require that deaths and complications resulting from abortion be recorded, much less reported, are unconstitutional. (Abortion and the Constitution) Thus, the only information available on abortion complications in the U.S., is the result of data which is voluntarily reported. Since abortionists hide their failures, under reporting of complications is the rule, rather than the exception.(Handbook on Abortion. John and Barbara Wilke)
Many European nations have socialized medicine, including Britain and Sweden, and in these cases government control provides a more systematic method for gathering of abortion statistics. I will be including these statistics within the following information.

There are over 100 potential complications associated with abortion. Some can be be immediatly spotted such as a puncture to the uterus or other organs, convulsions, or cardiac arrest. Other complications reveal themselves within a few days, such as slow hemorrahage, pulmonary embolisms, infection and fever. Records at one University hospital in Great Britain revealed a 27% infection rate among aborted women;9.5% hemorrhaged enough to require blood transfusions. Long term complications usually result from damage to the reproductive system and can result in chronic infection or inability to carry a subsequent pregnancy to term or even sterility. According to one Japanese study, women undergoing abortions experienced the following complications: 9% were subsequently sterile; 14% suffered from recurring miscarriages; and there was a 400% increase in ectopic pregnancies.(Handbook on Ab.) Swedish and Norwegian studies indicate an incidence of total sterility following 4 to 5% of all abortions. (Some Consequences - Wynn) Assuming this conservative 4% figure is applicable in America where 1.3 million women are aborted each year, one could conclude that over 52,000 women per year are inadvertently rendered sterile by abortion. In Czechoslovakia, permanent complications such as chronic inflammatory conditions of female organs, sterility and ectopic pregnancies are registered in 20-30% of all women....A high incidence of cervical incompetence resultant from abortion has raised the incidence of spontaneous abortons (miscarriage) to 30-40% (Handbook on Abortion) The Czechoslovia Deputy of Health states that "Roughly 25% of the women who interrupt their first Pregnancy have remained permanently childless. (Handbook on Abortion Wilke) In Great Britain, two meticulous studies revealed 35.6% and 30% of aborted women suffer from abortion related complications. (Some ...)

PSYCHOLOGICAL DAMAGES

Depression and a sense of loss are extremely common after abortion. These 'post-abortion blues' generally fade within a few months, but prolonged, deep depressions are not uncommon. Uncontrollable crying is often part of post-abortion depression. Daily crying may continue for years, sometimes lasting hours or even days at a time. Most women report a 'sense of loss' following their abortion. They feel empty. Those who report this symptom describe a number of related reactions such as inability to look at other babies or pregnant mothers, or a jealousy of mothers.

Abortion often creates feelings of low self-esteem, feelings of having compromised values, having 'killed my child.' The damage abortion inflicts on a woman's sense of confidence and self respect is even worse when these traits are already weak.

Feelings of guilt are among the most common reactions to abortion. Sometimes the feelings of guilt are vague. Other times they are quite specific. Denial and suppression of negative feelings is a common reaction to abortion. In one report, a psychiatrist treated fifty women who had come to him for problems which were supposedly not abortion related. But, after prolonged therapy, it was discovered that their disabilities stemmed from long-buried reactions to previous abortions. On a conscious level, each of these women believed that she has effectively resolved herself to her previous abortion. Each woman believed that the psychological turmoil which had led her to seek treatment was due to other situations in her life. But, in fact, they each revealed under therapy that it was unresolved conflicts associated with their abortions, hidden at a subconscious level, which were precipitating the new problems in their lives. It was only after recognizing their repressed grief that these women were able to make progress towards improving their emotional and mental states. The suicide rate among aborted women is phenomenally high. According to one study, women who have had abortions are nine times more likely to attempt suicide than women who have not aborted. The fact of high suicide rates among aborted women is well known among professionals who counsel suicidal persons. In a 35 month period, the Cincinnati chapter of Suiciders Anonymous,worked with 4,000 women.(aprox. 1,800 of these women had abortions) 1,400 of these women were between the ages of 15 and 24, which is the age group with the highest suicide rate in the country. There has been a dramatic increase in the suicide rate since the early 1970's, when abortion was first legalized. Between 1978 and 1981 alone, the suicide rate among teenagers increased 500%!!!

Sleeping problems are often reported. Some women complain of nightmares concerning the abortion. The experience of a 'phantom child' is not uncommon. This is when a woman imagines her aborted child as old as it would've been if it has been born. Others report frightening flashbacks of the abortion procedure as late as six years after the fact.

General feelings of helplessness, isolation, loneliness, and frustration are expressed. Others claim they are "going crazy."

Studies have found that 90% of aborted women have psychological problems after abortion.

14 weeks

(16 WEEKS after the first day of the last normal menstrual period)

- The fetus is about four and three-fourths ($4\frac{3}{4}$) inches from head to rump.
- The head is erect and the legs are developed.

The fetus can kick, swallow and sleep

16 weeks

(18 WEEKS after the first day of the last normal menstrual period)

- The fetus is about five and one-half ($5\frac{1}{2}$) inches from head to rump.
- The ears stick out from the head.

The photo here is nearly a third of the actual size.

The fetus has been moving for several weeks. Now the woman begins to feel these movements

The photo here is two-thirds actual size.

20 weeks

(22 WEEKS after the first day of the last normal menstrual period)

- The fetus is about seven and one-half ($7\frac{1}{2}$) inches from head to rump.
- The fetus has fingerprints, and may have some head and body hair.
- Although the fetus has been able to move for several weeks, movements, known as "quickening," are now felt by the pregnant woman.

CREED MAMIKUNIAN, M.D.
2401 EAST 42ND AVENUE, SUITE 206
ANCHORAGE, ALASKA 99508
(907) 562-1860 • FAX (907) 562-1865

Otolaryngology
Head and Neck Surgery

Facial Plastic and
Reconstructive Surgery

March 31, 2000

Re: House Bill #HB329

TO WHOM IT MAY CONCERN:

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If I can be of any further help to you, please feel free to contact me at any time.

Sincerely yours,

Creed K. Mamikunian, M.D.

CKM:ken

FROM : ST MICHAELS PHONE NO. : 907 746 7040 Mar. 30 2000 10:50AM P1

This woman is a retired nurse
from Sherrod Ele. - Palmer AK.

Palmer, Alaska
March 29, 2000

To Whom It May Concern on SSHB 329;
Importance of INFORMED CONSENT bill:

First of all I'd like to address FERTILIZATION and how it occurs:
Fertilization occurs when sperm enter the woman's vagina and swim through the cavity of the uterus and enter the fallopian tubes, the egg released by the ovary is penetrated by one of the sperm and immediately, within a split-second, a chemical reaction occurs preventing other sperm from entering the egg. When this process is complete a NEW HUMAN BEING exists. This single celled human being multiplies and divides and continues on its way through the fallopian tube where it implants itself into the lining of the uterus and continues to grow, if allowed, for the next nine months into the human being we are or would like to become as adults.

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THESE ARE THE THINGS NEEDED TO BE TOLD TO THE MOTHER.
Complications post abortion are: 10,000 deaths occur due to infections (PID), rupture of the uterus, hemorrhage and drug overdosage. Most common delayed complications are bleeding caused by part of the placenta remaining in the uterus, infections (pelvic inflammatory disease) and blood clots in the legs. Also, scarring of the inside of the uterus can cause sterility. Then there are the psychological and psychiatric problems such as feelings of loss, guilt and anger. Sooner or later this mother will go through the five (5) stages of grief.
Then what about the unsuccessful abortions when you have children who survive with partial limbs? Because babies do not want to be aborted and it's a known fact that they fight the suction or instruments of the abortionist. If the woman (mother) really does not want this child, give her the opportunity of having it because there are plenty of people who want children. If you have the funds to pay for abortions then the same amount of funds should be used to help those people who want to adopt.
EQUALITY!!!!

Respectfully,

Janice C. Barrett

Janice C. Barrett

Tuesday March 28, 1:39 pm Eastern Time

Company Press Release

SOURCE: American Life League

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American Life League: Abortion-Breast Cancer Connection - Recognized By Law and Medicine

WASHINGTON, March 28 /PRNewswire/ -- Britain's Royal College of Obstetricians and Gynecologists (RCOG) has issued its new "Evidence-based Guidelines No. 7: The Care of Women Requesting Induced Abortion."

The 1996 "Comprehensive review and meta-analysis," by Dr. Joel Brind and colleagues at the Pennsylvania State College of Medicine, found overwhelming evidence of an abortion-breast cancer connection and was found to be credible by the RCOG.

The RCOG report says of the Brind review, "The conflicting review by Brind has examined the same studies and concluded that induced abortion is a significant, independent risk factor for breast cancer. The assessor concluded that both were carefully conducted reviews and that the Brind paper had no major methodological shortcomings and could not be disregarded."

Brind, director of the Breast Cancer Prevention Institute (Poughkeepsie, NY) and a member of the American Bioethics Advisory Commission (a division of American Life League), said he is encouraged that RCOG has clearly acknowledged "the existence of valid evidence of the abortion-breast cancer connection."

"The RCOG represents the abortion practitioners themselves," said Brind. "This is the first time that any such group has clearly acknowledged the evidence of the abortion-breast cancer connection."

In a related matter, silence over the evidence of an abortion-breast cancer connection was broken recently in a landmark lawsuit filed in Fargo, North Dakota. The plaintiff in the case, Amy Jo Mattson, an employee of North Dakota Life League (an associate of ALL), alleges that the Red River Women's Clinic broke North Dakota laws against false advertising when it gave Mattson a deceptive brochure about abortion health risks.

In reference to claims that abortion increases a woman's chance of developing breast cancer, the brochure reads, "None of these claims are supported by medical research or established medical organizations."

A circuit judge in Cass County District Court denied the abortion clinic's motion to dismiss the lawsuit in January. Mattson's attorney, John Kindley, is arguing that medical research shows that having an induced abortion increases the average woman's risk of breast cancer by about half. Kindley's law review article on the scientific evidence connecting induced abortion with increased breast cancer risk can be found online at http://www.johnkindley.com.

Judie Brown is president of American Life League, the nation's largest pro-life educational organization with more than 367,000 supporting families.
ALL / P.O. Box 1350 / Stafford, VA 22555 / 540-659-4171 / http://www.all.org

SOURCE: American Life League

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Questions or Comments?

John Kindley J.D.

Author of 'The Fit Between the Elements for an Informed Consent Cause of Action and the Scientific Evidence Linking Induced Abortion with Increased Breast Cancer Risk,' 1998 Wisconsin Law Review, Pages 1595-1644.

The above article was distributed in August 1999 to every member of the House of Representatives by U.S. Rep. Dave Weldon, R-Fla., a physician who described it in an accompanying letter as making a "persuasive case for the potential legal liability of abortion providers who do not inform women about the prospect of increased risk for breast cancer following an induced abortion." An Executive Summary of this article as well as the complete article are posted on this site.

Scientists have long suspected that the hormonal disruption that occurs when a woman's pregnancy is artificially interrupted leaves the breasts with an abnormally high number of cells vulnerable to cancerous mutation. The first American study on abortion as a risk factor for breast cancer was published in 1981 and reported that abortion "appears to cause a substantial increase in risk of subsequent breast cancer." Almost two decades later, thirteen out of fourteen American studies bear out this early warning, but to this day women considering abortion are still not informed about this significant health threat.

In fact, the Red River Women's Clinic, an abortion provider in Fargo, North Dakota, was until recently not only failing to warn women about the abortion-breast cancer link, but actually distributing to prospective customers a pamphlet that included the following false statement: "Anti-abortion activists claim that having an abortion increases the risk of developing breast cancer and endangers future childbearing. **None** of these claims are supported by medical research or established medical organizations." (Emphasis in original.)

I am lead counsel in a suit filed in December 1999 to enjoin this clinic from its false advertising. This suit was brought on behalf of women considering abortion and the general public, and thus seeks prospective relief rather than money damages. A woman who has already had an abortion, without being told that it would increase her risk of breast cancer, may be able to sue the abortion provider for compensatory and/or punitive damages, even if she has not yet developed breast cancer. Indeed, women in several states are now considering suing their abortion providers for failing to warn them about the abortion-breast cancer link.

It is time for the American people to decide for themselves whether the evidence is such that it warrants disclosure. As noted by Marcia Angell, M.D., executive editor of the New England Journal of Medicine, it is a "false belief that medical research is somehow too

complex to be understood by nonscientists." I am convinced that once juries have the opportunity to hear fully both sides of this scientific controversy they will agree that women had a right to know about this evidence decades ago.

Please e-mail me with any questions or suggestions, especially if you:

1. know a woman who has had an abortion and might need a referral to a medical malpractice attorney in her state;
2. know an attorney who might be interested in taking cases based on the cause of action outlined in my law review article;
3. would like to help raise necessary funding for the costs of pending litigation;
4. are interested in spreading the word about these health and legal issues and would like to order informational materials for this purpose.

John Kindley is a Wisconsin licensed attorney. While the information on this site is about legal issues, it should not be construed as legal advice.

You may contact me at jkindley@johnkindley.com
Phone: (608) 294-6936
This page was last updated on 03/11/00

BREAST CANCER

has a proven link to abortion

" A woman who finds herself pregnant at age 15 will have a higher breast cancer risk if she chooses to abort that pregnancy than if she carries the pregnancy to term, correct?" "Probably yes." ***Response of Lynn Rosenberg, PhD., Boston Medical School, in sworn testimony as the expert witness for the abortion providers in a case involving Florida's parental notification law, Nov. 1999***

◆ "(I)t will surely be agreed that open discussion of risks is vital and must include the people - in this case the women concerned. I believe that if you take a view (as I do), which is often called pro-choice, you need at the same time to have a view which might be called 'pro-information,' without excessive, paternalistic censorship (or interpretation) of the data." *Dr. Stuart Donnan, editor-in-chief, British Medical Association's* Journal of Epidemiology and Community Health *editorial (1996) 50:605*

◆ "Some 1.5 million women undergo abortion in this country each year; if the breast cancer connection is valid, we will be seeing a continuous rise in breast cancer in this country for many years to come." *Bernadine Healy, M.D., former director of the National Institutes of Health,* A New Prescription for Women's Health: Getting the Best Medical Care in a Man's World, *Viking Penguin (1995), p. 237*

◆ "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." "Highest risks (more than double) were observed when the abortion was done at ages younger than 18 years... or at least 30 years of age or older." *Dr. Janet Daling, lead author of the only published study specifically commissioned by the National Cancer Institute to investigate the link between abortion and breast cancer,* Journal of the National Cancer Institute, *Vol. 86, No. 21, pp. 1584-1592, Nov. 2, 1994*

◆ "I have three sisters with breast cancer and I resent people messing with the scientific data to further their own agenda, be they pro-choice or pro-life. I would have loved to have found no association between breast cancer and abortion, but our research is rock solid and our data is accurate." *Dr. Janet Daling, who is strongly pro-choice,* L.A. Daily News, *Sept., 1997*

◆ "This reasoning overlooks the more likely role of other factors, especially induced abortion. Induced abortion before first term pregnancy increases the risk of breast cancer." *In 1986, four prominent epidemiologists (including Bruce Stadel of the National Institutes of Health and Phyllis Wingo of the Centers for Disease Control, now with the American Cancer Society) published a letter in* Lancet *(Feb. 22, 1986, p. 436) criticizing another group's suggestion that the increasing incidence of breast cancer among Swedish women was due to oral contraceptive use.*

◆ "Interruption during the first trimester of a first pregnancy causes a cessation of cell differentiation, which may result in a subsequent increase in the risk of cancerous growth in these tissues." *Planned Parenthood Federation of America (1994)*

◆ Jose and Irma Russo, in a landmark 1980 experiment published in the *American Journal of Pathology* (Vol. 100, pp. 497-512), found that 77% of laboratory rats whose first pregnancy was surgically aborted developed breast cancer after exposure to a carcinogen, compared to 0% of identically exposed rats in the control group whose pregnancy was carried to term.

HOW?

Abortion interrupts the natural process of breast development, leaving the breast with more cells that can become cancerous. Extra estrogen of pregnancy causes cells to proliferate. Third trimester hormones of a full-term pregnancy turn cells into milk-producing cells and turn off their growth (and cancer-forming) potential.

As of February, 2000, twenty-seven out of the thirty-three studies in the world-wide literature indicate an increased risk of breast cancer associated with induced abortion. Seventeen of the twenty-seven are "statistically significant," a technical term which means the data provided at least 95% certainty that the association measured was not due to chance.

The Coalition on Abortion/Breast Cancer is a women's health organization founded to protect the health and save the lives of women by educating and providing information on abortion as a risk factor for breast cancer.

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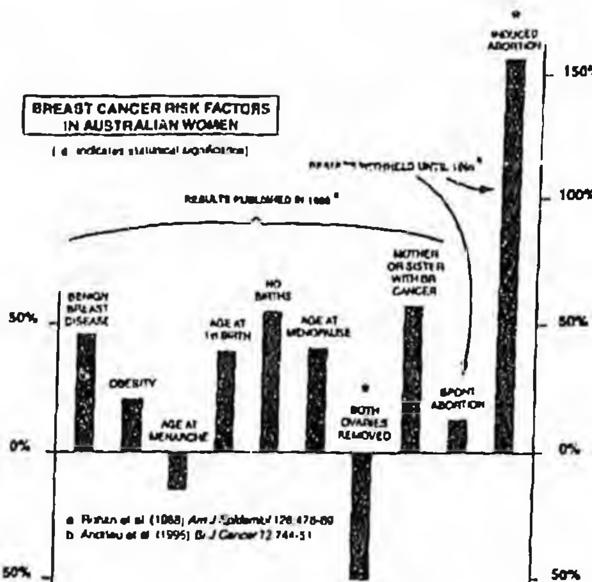

This 1988 study shows the reluctance of researchers to publish data showing the abortion/breast cancer link. Abortion data (see two rightmost bars) were withheld for seven years. Note that spontaneous abortion has no significant effect on risks; whereas, induced abortion does significantly increase a woman's breast cancer risk.
a. Thomas E. Rohan et al, "A Population-Based Case-Control Study of Diet and Breast Cancer in Australia," American Journal of Epidemiology *(1988), Vol. 128, pp. 478-489. b. Nadine Andrieu et al, "Familial Risk, Abortion and Their Interactive Effect on the Risk of Breast Cancer," a combined analysis of six case-control studies,* British Journal of Cancer *(1995), Vol. 72, pp. 744-751.*

If you would like to help dispense information about the abortion/breast cancer link or wish to offer financial assistance, please contact:

Coalition on Abortion/Breast Cancer
AN INTERNATIONAL WOMEN'S ORGANIZATION
P.O. Box 152
Palos Heights, IL 60463
Call **Toll-free 1-877-803-0102**
www.abortionbreastcancer.com

Abortion raises Breast Cancer risk.

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Testimonials of Women Who Have Had Abortions

Name	---	Statement
Mae Abbott		• I was told "that I would be out for 8 minutes and I would feel only a little discomfort afterwards (they lied, it ruined 10 years o my life)" • Surgery -- (that's what they call it). They put us on gurneys and put us through like cattle on a conveyer belt. So sad. • They never explained anything about the procedure or let me se the baby. They gave me no alternatives and never mentioned hc killing my baby would affect me emotionally.
Tewannah Aman		• I was 18 when I got pregnant. At three months pregnant I had : abortion. About seven years later I was listening to a Christian radio broadcast. It described an unborn child during an abortio procedure. It talked about the baby's frantic attempts to escape the tools of the abortionist and how the child's heartbeat accelerated as it sensed apparent danger. My hea. broke. I was overcome with grief. How could I have taken the life of my unborn child? • About seven years later I married a wonderful man. Five month later, surprise! I'm pregnant. I had always longed to be a wife an mother. Now my dream was going to come true. • The pregnancy was going well but 21 ½ weeks into my pregnan I went into labor. I gave birth to a little boy. He lived three hou. The doctor said there was nothing they could do. He was too small We named him David Nathan. I had imagined us feeding the ducks, playing in the park, but instead I was saying goodbye • In the book, "What to Expect When You're Expecting", I came across information that said a miscarriage in the fifth month could be due to previous abortions. • It said that I understood there was a probability or a possibility that I might not go on to have children. That meant I wouldn't a parent. • Women need to know the facts regarding abortion. If I could share my story, then others might be spared the heartbreak that have had to go through. If we remain silent the other side wins. There are many more like me. If more people come forward the truth can't be denied. And confession is good for the soul. • Below is part of the information from the "Release Form" that

		Tewannah signed for her abortion. Ambulatory Surgical Facility Consent to Operation, Anesthetics and Other Medical Services I authorize the performance upon Tewannah Harper of the following operation Therapeutic Vacuum Curettage *** It has been explained to me, and I am aware, that I may be sterile a result of this operation and that I may no longer have menstrual periods, although no such result is warranteed or guaranteed. I know that a sterile person is incapable of becoming a parent, and in giving consent to this operation I have in mind the probability or possibility such a result.
Margaret Birky		• Panic in my heart. Knowing it was too late. • What have I done? What kind of person could do this? I want it all to do over, Please God. Obsessed with how old my child would be – what he looked like, *if* he forgave me. Hatred for myself, for being weak. Anger at boyfriend for not being white knight and saying "it's all going to be o.k., I love you, I will love this baby, together we'll make it work." Now, I cried hystericall most times and my arms would ache so terribly from agonizing hold that child that I'd hug a teddy bear just to have something there. • An abortion can take your baby from your body but never from your heart.
Lisa Burroughs		• It helped me to seek the face of Jesus through His word and He has turned my sorrow into joy. • Please understand that by aborting your unborn child that does not make the baby go away. Your baby will be in your heart unt you die. After abortion – the guilt and shame and loneliness is horrible. Once you abort, you cannot go back and change it.
Carrie Camilleri		• Women and men need to know the truth! • I was an emotional wreck. The following day I was empty, sad, numb. I knew that day I had made a huge mistake. I wish with my heart I would have done things differently
Cecilia Gomez		• I had 4 abortions. Due to one of them, my uterus was lacerated will never deliver a child natural. My first child delivered, Dillon Matthew, could not be carried to full term because of my incompetent cervix and uterus. My membranes apparently ruptured at 24 ½ weeks gestation. My son died 13 weeks later. That was the most traumatic experience I've ever gone through • After the first abortion, I did get more depressed, I developed a very angry character; I became very violent. The second, I really

		didn't notice a change. By the third I had a really low self-esteer and after the fourth, I became extremely promiscuous and self-destructive, throughout the years, with each abortion, I became more and more depressed and I gained more and more weight. • What would you say to a friend who's considering having an abortion? PLEASE DON'T! This is something that damages a woman forever! You can never get over it! Praise the Lord, one can get beyond, but never over it. • What has helped you heal from the pain of your abortion? It's just been the Lord and this gift of eternal life.
Michaelene Jenkins		• Abortion appeared to be the only answer. At the clinic I was tol the procedure would be quick and safe, allowing me to continu my activities the next day. • I turned to the nurse and told her I didn't think I could go through with it. She held my hand, telling me it would be over i a few minutes. Be fore I could reply, the suction machine was turned on, causing tremendous pain. • I was frightened, it hurt so much. I wanted to scream I wanted to stop. I suddenly knew there was a baby inside. They were killing my baby! • Limping to the recovery room I felt nauseated, weak and defeated. I couldn't stop crying, and neither could the other women there. My life was irreversibly changed at that moment. cried for days and weeks – eventually years. I felt so dirty, so guilty, so unworthy to live. • I could have died from the operation and that my future ability carry a baby full term had been lessened. • I would end up sobbing in a corner, fearful I was going crazy. It culminated one evening when I tried to cut my wrists with a broken plate. This desperate act scared me into getting help. • Through counseling I let go of my anger and accepted the forgiveness that Jesus offers. Months later I forgave myself and began to mourn the loss of my child.
Jeniece Learned		• I never realized I was going in for a surgery to have my baby killed. • Explain what the abortion provider told you about other option They had never even mentioned the work "Adoption." They would not have made any money by doing that. Abortion is a business. They had nothing to profit by giving me the help I rea needed. • Don't believe them. They want your money! Which ever decisi you choose between adoption or abortion you will always wond about that child, his or her looks, personality, smile, character. I wonder those things. You are a mother if you are pregnant. You will still be a mother if you abort, only you will be the mother o

		him life. • Immediately after my abortion I went to my job at a local fast food restaurant. I proceeded to the restroom and filled the toile with blood. I was very, very scared. I knew this was not normal. knew my periods weren't like this. The cramping was excruciating. The bleeding got worse. I believe now when I lool back, I was hemorrhaging. I had blood clots the size of grapefrı I bled like that for two more days. • It was as if we were in an assembly-line, we were all waiting to have our babies vacuumed out of our bellies. I know how this h shattered lives. • When the actual procedure was over I felt very empty. It was st a roller-coaster ride because of the bleeding. • Do you feel you were lied to or deceived by the abortion provider? Absolutely! They were concerned about the money We are not animals, we are human beings with a conscience, wi the ability to stay pure for the person God has intended us to marry. I wish I could have given my virginity to my husband whom I truly adore. I felt violated and raped for $350. • Without the Lord's healing I would have a hard time dealing wi the blood on my hands. Abortion is not a quick fix. It's not a bandage you can put on the sore. When that bandage falls off, a scar remains forever. • Growing and maturing in a relationship with God has taken the pain from my past sins. Jesus alone is the only healer of our hu Going through the grieving process for my child, as you would for anyone you've lost to death is very important. For those tha have had multiple abortions, your sin is not worse than my abortion of one. Sin is sin. Ask God for forgiveness, repent – H sees them no more. • Don't believe the lies! Everyone makes mistakes, but we can tak responsibility for them and make the right choices. Choices we can truly live with and be proud of. You who are reading this have had abortion thrown in your faces your whole life. You ar precious and your aborted siblings and peers were precious. You can change the world, you can say enough is enough. You can say, "LIFE IS OUR FIRST INALIENABLE RIGHT!" **Stay Pure and Stay Free.**
Susan Carpenter McMillan		• Susan Carpenter McMillan, a long time feminist and activist, received international acclaim in 1986 when she spearheaded a campaign which gave "Baby Jesse" a much needed heart transplant. • Susan has been an active media spokesperson since 1980, appearing on more than 4,000 radio and television shows rangir from Donahue to Politically Incorrect and she has guest hosted CNN and other media programs. Susan was also a commentato from 1991 to 1994 on KABC TV Channel 7 News.

		• She was appointed by the Board of Supervisors as a Commissioner on the Los Angeles County Commission for Women, where she currently heads the Los Angeles Rape Task Force. • Susan's unrelenting determination to end all child molestation is her greatest passion. In 1996 she personally wrote and sponsore the first chemical castration law to ever pass in the United State • I remember that horrible day 21 years ago. The drive to the abortion clinic, the waiting, the other women, those last second of consciousness before the anesthesia set in, lying alone on the gurney as I placed my hands on my stomach and inwardly screamed "I'm sorry. I'm so, so sorry" As I drifted into unconsciousness, I remembered feebly pulling the hospital gow down and sliding it between my lets, semi-consciously hoping that then they couldn't get to my baby. • My deep pain about the unnecessary death of a child…my child It was like reading an obituary. I'd close my eyes and see this tin helpless little baby6 peacefully floating in amniotic fluid, did it struggle, did it die quickly…oh, how I hurt. • My eldest daughter's response…"Mom, you knew I always wanted an older brother or sister, so why did you kill them?…I had no answer. • I know millions and millions of women across this country feel I do about abortion, we all somehow know deep down inside th we alone made a horrible decision and no coined phrase about choice and rights or the denial of biological and fetal facts can ever erase the truth. For we as mothers instinctively know durin those still moments of aloneness, that we ended the life of a separate human being growing inside of each and every one of t
Michele Slaffey		• I could find no one to help me. • Planned Parenthood is a big lie! What happened to me was not counseling, it was a plan to make money off my mother and myself by lying and tricking us at a very vulnerable time. • Having sex before marriage is the wrong move. It leads to all kinds of problems. Avoid this by not having pre-marital sex. • I realized that my baby would die a horrible death and I knew I would be in pain both physically and mentally and I knew this was wrong. Planned Parenthood told me nothing about the sali abortion procedure but the way it sounded, just the name itself "saline", I knew I was in for the worst experience of my life. • The physical pain of a saline abortion is very great. After being injected with the saline, the pain begins. I felt labor pains for approximately 16 to 18 hours, there is never a moment when th pain stops. The medication given to me to help the pain not onl didn't work but caused much vomiting and diarrhea. • I felt so, so, so lonely!! • I really though I loved the baby's father but I don't know if I w just with him because I was desperate for someone to love. He

		wanted a sexual relationship and I just gave in thinking I could handle it, but I couldn't. After the abortion I just didn't feel the same about him anymore. He wanted to continue to have sex ai I was in too much pain (emotionally). We stopped seeing each other and when I did see him he would curse me out and call m a "baby killer." He did that 2 times. One time when I saw him a party and another time when I saw him at a bar. I believe he wa very hurt to lose a child to abortion. I'm sure he felt like he had no say in this decision. I believe, that men can be emotionally traumatized by abortion.
Stephanie Williams		• I can share that as a result of that abortion it has been difficult f me to get pregnant or carry a baby to term. Now at the age of 3 my husband and I are still in hopes that one day we will bear children. • I remember coming out of the anesthesia and being in tremendous pain, lots of severe cramping. I moaned and groan because of the discomfort and the nurse kept coming by and telling me to shut-up the noise. The pain was so intense that I began vomiting. • I was deceived because I was not told the truth about what an abortion means to the life of an unborn baby. I was not told tha there were other options. I was not told that at 10 weeks (which is when I had my abortion) my child was already fully formed. I was made to believe that I was doing something that was as natural as going to the dentist for teeth cleaning. • But there will come a time when you will regret not knowing th joy of raising your child. There is always a reminder of what kin of person your child would have been.
Lisa Windham		• Now that I think about it, it really was a selfish choice

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League of Women Voters of Alaska

P. O. Box 484
Kasilof, Alaska 99610
(907)262-3941

April 10, 2000

The Honorable Pete Kott, Chair
The House Judiciary Committee
And All Committee Members
Alaska State House of Representatives
Juneau, Alaska

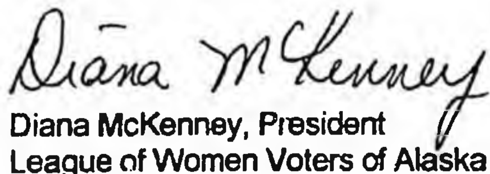
Dear Representative Kott,

I have faxed a copy of the League of Women Voters of Alaska Resolution 00-1 to be considered in your meeting today, April 10, 2000. We adopted this resolution at our state convention on April 9, 2000.

The League of Women Voters of Alaska urges you to oppose House Bill 329. League members strongly support reproductive rights and the Constitutional right of privacy pertaining to reproductive choices. Many of those that would be most affected by the types of excessive restrictions recommended in this bill are those who do not have the means, skill, or emotional stability to operate within these proposed parameters.

The League respectfully requests that you oppose House Bill 329. The unfortunate reality of our society is that many women find themselves in life situations that leave them in impossible situations. While we do not have all the answers to the ills in our society, we do not believe that this bill is in the best interest of the citizens of Alaska.

Sincerely,



Diana McKenney, President
League of Women Voters of Alaska

LEAGUE OF WOMEN VOTERS OF ALASKA
RESOLUTION 00-1

A RESOLUTION OPPOSING HOUSE BILL 329 AND SENATE BILL 300 RELATED TO BIASED COUNSELING AND A WAITING PERIOD FOR ABORTION

Whereas, the League of Women Voters holds a public policy position, protecting the Constitutional right of privacy of the individual to make reproductive choices; and

Whereas, the Alaska Constitution protects reproductive autonomy, including the right to abortion, more broadly than does the United States Constitution; and

Whereas, reproductive rights are fundamental and that they are encompassed within the right to privacy expressed in Article 1, Section 22 of the Alaska Constitution; and

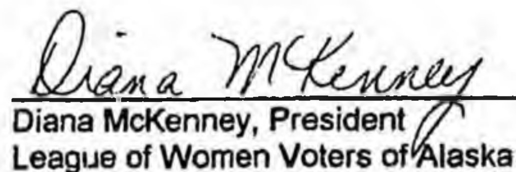
Whereas, these rights may be legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest; and

Whereas, House Bill 329 and Senate Bill 300 employ excessive means that constrain reproductive rights; and

Whereas, House Bill 329 and Senate Bill 300 violate privacy protections assured under the Constitution of the State of Alaska,

NOW, THEREFORE, BE IT RESOLVED, that the League of Women Voters of Alaska Convention 2000 delegates urge the Alaska State Legislature to oppose House Bill 329 and Senate Bill 300 relating to biased counseling and a waiting period for abortion

Passed and approved this 9th day of April, 2000, by the delegates to the League of Women Voters of Alaska convention in Anchorage, Alaska.



Diana McKenney, President
League of Women Voters of Alaska

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-1994
PHONE: (907)269-5274
FAX: (907)278-7022

March 22, 2000

The Honorable Pete Kott
Chair, House Judiciary Committee
Alaska State House
State Capitol
Juneau, Alaska 99801

Re: House CS for CS for Senate Bill No. 24 (Work Draft R, February 15, 2000)

Dear Representative Kott:

On February 7, 2000, at your invitation, I submitted a letter reviewing Work Draft P of Senate Bill 24. Subsequently, the Committee moved to Work Draft E. Yesterday I received Work Draft R, which deletes one set of provisions from the versions previously under discussion and rearranges the others. Because it will be difficult to correlate the comments on Work Draft P with the rearranged sections of Work Draft R, I am submitting this letter to specifically address Work Draft R. In substance, however, all of the comments made in this letter are comments I have made before.

The first six sections of Work Draft R apply to all agencies and relate to the procedure for giving notice of regulations. My comments do not address that portion of the bill.

Section 7 of Work Draft R would enact provisions aimed at regulations proposed by the Department of Environmental Conservation (DEC). The first part of Section 7 is a marked expansion of the public notice process for DEC regulations, including amendments and repealers. It increases both the volume of material to be published and the amount of time required to complete the process. The second part of Section 7 attempts to ensure that regulations are adopted soon after the effective date of the authorizing statute. Both parts of Section 7 are problematic as currently drafted.

As you know, Senate Bill 24 was first conceived as a broad regulatory reform bill governing several agencies. As a partial response to industry and Administration concerns raised about that earlier version, Section 7 of the bill has been narrowed to cover only DEC. Special administrative procedures applicable to only a single department should appear in the statutory title for that agency (Title 46 in the case of the Department of Environmental Conservation). Currently, the statutes already contain some special departures from the Administrative

Procedure Act for DEC, and those are codified in Title 46. An example is AS 46.35.090. To avoid confusing the public, the new statutory section proposed in Section 7 should be revised to appear in Title 46 rather than Title 44.

I now turn to the particular subsections of the new AS 44.62.213, which Section 7 would create.

Subsection (b) presents two technical issues that need correction. First, the thrust of subpart (1) apparently is to require the agency to provide continuing notice to commenters as the multiple rounds of public notice called for in subpart (d) go forward. In other words, if someone comments on the first draft regulation put out to public comment, that person should receive notice of any revised draft following the first round of comment. If this is the intent, the subpart should be clarified by deleting the words "on the" from line 25 of page 4 and replacing them with the phrase: "under AS 44.62.210 upon a substantially similar". Otherwise, the language could require notice to people who have commented informally, outside of the Administrative Procedure Act context and not on the record.

Second, subsection (b), as simply an addition to the list of requirements in AS 44.62.190, should be tied to the limitation in AS 44.62.190(c) that applies to the other items on the list.

Subsection (d) requires a new round of public notice and comment each time the agency responds to previous comments by "substantially chang[ing] the substance" of the proposed regulation, provided the agency "would not normally consider the change to be significant enough to require additional notice." The quoted language creates an uncertain standard. As a practical matter, the agency will feel it must go back out to comment if it makes any change other than a change to form in response to public comments. The process will then be longer and more expensive.

Frequently, it is industry that is most anxious to get new regulations in place. An illustration of how this requirement might operate in practice is found in the recent process of adopting a site-specific water quality criteria regulation for Point Woronzof. The Municipality of Anchorage, which operates a water treatment plant at the location, desired an immediate state regulatory change to protect itself from potential liability for federal penalties. DEC took the new criteria from public notice through adoption in four months. However, the adopted version of the regulation contained a substantive change from the proposed version, because a criterion had been proposed for total chromium whereas it became apparent that the limit should apply to only one type of chromium. Had SB 24 been law, the agency would have had to put the regulation out to a second round of comment. This would have lengthened the process from four months to at least seven, and made it impossible to meet the municipality's target date for putting the new regulation in place.

Subsection (e) requires the agency to explain a negative, that is, to publish an explanation of why subsection (d) does not apply to a particular situation. The benefit of this added effort and expense, in terms of informing the public, is questionable.

Subsection (f) attempts to create certain exceptions to the multiple notice rounds envisioned by subsection (d). Exception (2) is vague, and it would be risky to rely on it. It speaks of reducing "any burden imposed by a federal requirement" in connection with a "situation in the state." Whether a particular requirement imposes or relieves burdens often depends on one's point of view, and to avoid this uncertainty and the attendant risk of litigation the agency is likely to choose to re-notice. Note that the Point Woronzof regulation would not have qualified with any degree of confidence for either of the listed exceptions.

Subsections (g) through (j) appear to be aimed at requiring DEC to announce its intention to adopt, or not to adopt, regulations as soon as the authorizing statute is passed, and to complete the process of proposing regulations within two years. The premise of these subsections is unreliable: they are based on the assumption that each regulation draws on a single authorizing statute and that the statute is static. Instead, most regulations draw on multiple statutes, all enacted at different times and all amended from time to time. Applying the time limits imposed by subsections (g)-(j) would frequently entail guesswork.

Adding to the confusion is Section 12 of Work Draft R, the applicability provision for Section 7. That section makes the time limit provisions applicable only to regulations for which "the" statutory authority comes from an act with an effective date on or after July 1, 2000. Again, the multiple bases of authority for most regulations, and the tendency of statutes to be amended from time to time, makes this provision difficult to put into practice.

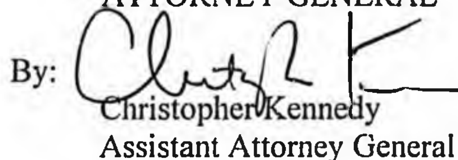
The difficulty of applying these subsections would be a serious problem indeed if regulations could be invalidated because some later litigant was able to convince a court that a deadline had been missed. Lines 19-20 of page 6 appear to be aimed at preventing that from occurring. However, to be fully effective in this regard, line 20 must be changed to "to comply with subsections (g) through (i) of this section."

* * *

Thank you for the opportunity to comment on Work Draft R of Senate Bill 24. Should the committee require further information, please do not hesitate to ask.

Sincerely,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: 
Christopher Kennedy
Assistant Attorney General

cc: The Honorable Dave Donley (by fax and hand delivery)
Committee Members, House Judiciary
Commissioner Michele Brown
Pat Pourchot
Shari Kochman
Janice Adair
Chrystal Smith
Deborah Behr

Testified before House Judiciary 4/10/00

To: House Judiciary Committee
From: Dixie Hood, Juneau, Alaska
Date: April 10, 2000
RE: HB 329

Thank you for allowing me the opportunity to express my opposition to house bill 329 which would impose a 24 waiting period on women seeking an abortion, and which would require a woman go through biased counseling before getting an abortion.

I certainly favor health professionals giving a patient informed consent before undertaking a medical procedure, and to my knowledge, there is no reason to think women seeking abortions are not being given all the information they need to make a reasoned decision.

Mandatory anti-choice lectures don't give women unbiased meaningful medical information, but rather they are told a laundry list of possible complications from the abortion procedure which are rare. In fact, this law would require that false medical information be given to a woman because it instructs a doctor to tell a woman that the risks from getting an abortion include breast cancer. I am not aware of any such studies that prove this that are accepted in the medical community.

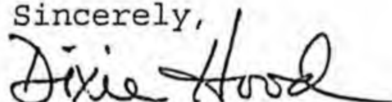
Legislators should not be in the business of telling medical professionals what is important and not important to advise a patient about a medical procedure, and abortions are being singled out for the biased counseling requirement not because the sponsors are concerned about women's health, but because they want to try to coerce women into carrying their pregnancy to term by whatever means possible.

I also oppose the 24 hour waiting period that is required by this bill. Medical professionals who perform abortions in this state are few and many women must travel great distances to obtain an abortion. By imposing a waiting period, women are put to much greater expense and inconvenience. Apart from making an abortion more expensive and logistically difficult, a waiting period also puts a woman's health at risk. If a woman has to reschedule work, make arrangements for child care, or perhaps juggle school responsibilities, compounded by a provider's scheduling issues, a 24 hour waiting period can

result in a delay of 10 days to two weeks or longer. Such a delay can push a first-trimester abortion into a second-trimester abortion, making what would have been a routine procedure into a more complicated and dangerous one.

I urge committee members to vote against this bill. It hurts women. Please leave these decisions to a woman and her doctor.

Sincerely,



Dixie Hood
Juneau, Alaska

No: 1

FISCAL NOTE

Bill Version: CSSSHB 329(HES)
(H) Publish Date: 3/30/00

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Revision Date/Time (Note if correction):
Dept. Affected: Health and Social Services
Title: Relating to Unborn Children and Abortion
BRU: Health Services
Component: Maternal child and Family Health
Sponsor: Coghill
Requester: HOUSE (HES)
Component No. 290

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services	28.2	30.0	31.1	32.7	34.3	36.0
Travel	10.0	4.0	4.0	4.0	4.0	4.0
Contractual	25.2	13.0	14.0	14.5	15.0	15.5
Supplies	2.0	1.0	0.8	0.9	0.9	1.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	65.4	48.0	49.9	52.1	54.2	56.5
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
1002 Federal Receipts						
1003 GF Match						
1004 GF	65.4	48.0	49.9	52.1	54.2	56.5
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	65.4	48.0	49.9	52.1	54.2	56.5

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Full-time	0.5	0.5	0.5	0.5	0.5	0.5
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

See attached detail-The two .25 postions equal .50 FTE as indicated above.

Prepared by: Peter M Nakamura MD
Phone: 269-3400
Division: Public Health
Date/Time: 3/21/00 10:19 AM
Approved by Commissioner: Karen Perdue, Commissioner
Date: 3/21/00
Agency: Department of Health and Social Services

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(Rev 10/99) 2000fnform.xls/OMB

Personnel:
.25 FTE Advanced Nurse Practitioner to 1) develop the initial packet, 2) conduct on-going literature review and provide updates when new information becomes available.
$18,385

.25 FTE Admin. Clerk II to 1) provide clerical support for mailings, copying, and ordering materials, 2) answer the 24 hour phone line during business hours.
$ 9,850

Travel:

Travel to areas in Alaska to do training on the new requirements.		$10,000

Contractual:

Contract for printing costs of material	- initial	$10,000
	- on-going	$ 2,000
Contract for 24 hour phone line staff (not during work hours)		$10,000
800 Line		$ 200
Postage	- initial	$ 5,000
	- on-going	$ 1,000

Supplies:

Subscriptions/books for ANP	$ 500
Envelopes	$ 700
Letterhead	$ 800

Alaska State Legislature

Interim:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907) 456-5081 - Phone
(907) 456-8245 - Fax

Session:
State Capitol, Room 416
Juneau, AK 99801
(907) 465-3719 - Phone
(907) 465-3258 - Fax

Representative John Coghill

SSHB 329 - Informed Consent

Sponsor Statement

I have introduced SSHB 329 for the purpose of protecting the health of women. SSHB 329 requires Alaska physicians to provide women seeking elective abortions information regarding the potential physical and psychological risks of the procedure, as well as alternatives to abortion.

The U.S. Supreme Court noted in *H.L. v. Matheson* (1981) that "the medical, emotional, and psychological consequences of abortion are serious and can be lasting." Speaking to the issue of a woman's informed consent, the U.S. Supreme Court also observed in *Planned Parenthood v. Danforth* (1976) that a decision to have an abortion "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences."

Recognizing the need for women to exercise an informed choice about an elective medical procedure, Alaska regulations since the early 1970s have required physicians to advise patients seeking abortion of the "medical implications and the possible emotional and physical sequelae of the procedure." (12 AAC 40.070). However, Alaska's informed consent provision lags behind other states because it exists only in regulation and not in statute. It also lacks specificity and is not uniform in its application. More than twenty-five other states have laws requiring informed consent before abortions are performed, and detailing specific information that physicians must provide. States with the most comprehensive informed consent statutes include Indiana, Kansas, Kentucky, Michigan, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania, South Dakota, Utah, and Wisconsin.

SSHB 329 elevates the informed consent requirement from regulation to statute, and it requires the Department of Health and Social Services to develop a standard information brochure that physicians will make available to women considering abortion. The brochure will include information on public and private agencies that provide services to assist pregnant women, including adoption services. The brochure will include objective information and photographs depicting the anatomical and physiological characteristics of a typical unborn child at two-week gestational increments. In addition, the brochure will describe the specific potential health risks of abortion, including infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility.

Representative_John_Coghill@LEGIS.state.ak.us

March 31, 2000

Dear Representative Pete Kott and the members of the Judiciary Committee,

Subject:House Bill 329

I am a Family Nurse Practitioner and I attended the hearing for HB 329 before the House Hess committee. I noticed that there was controversy regarding the definition of conception. I researched the definition and found that conception and fertilization are often used interchangeably. I looked up conception in a Biology text used by UAA, when I found the word conception the index said, "see also fertilization". The description of conception read, "the fertilization of the egg by a spermatozoon". Please do not let this controversy distract you from the true issue at hand. Women seeking abortion need all the facts and information made available to them. Please see my written testimony to be faxed prior to the House Judiciary committee hearing.

Sincerely yours,

Aleatha Martin

Testimony for Bill 329 – Informed Consent

My name is Alcatha Martin, thank you for allowing me to give my testimony in support of house bill 329 on informed consent. I would like to share my professional history, my personal experience with abortion, and why I support passage of this bill.

Professional History:

I received a Bachelor of Science degree in nursing from the University of Alaska in 1984 and went to work as a staff nurse in a neonatal intensive care unit. I worked there for 6 years and transferred to the pediatric and pediatric intensive care unit where I served as a staff nurse and supervisor for 6 more years. At the same time I worked intermittently for the Alaska Native Medical Center on their pediatric unit and adult ICU as a staff nurse and instructor. I served as the statewide coordinator for the cystic fibrosis clinic for 7 years. In 1995 I completed a Master of Science degree in nursing. My thesis was a qualitative study on the experience of living with cystic fibrosis in Alaska. It provided a vehicle for improving the way we educate children with this life-shortening disease. I am now a certified Family Nurse Practitioner in the State of Alaska. As a nurse practitioner I was part of the management team that developed Pediatric Night Call, an after hours telephone triage program for parents of children who need information or medical care. I have taught for the Community Health Aide Program at the Alaska Native Medical Center in the Emergency Room, Women's Health department, and Pediatric clinics.

Abortion Experience:

I had an abortion over 15 years ago after I experienced an unplanned pregnancy. I was in my early twenties and single at that time. I felt backed into a corner, desperate to preserve my life and no other option. I needed help but did not know where to get it. I went to the Public Health Clinic for a pregnancy test and after being told it was positive I started to cry. Their response to my distress regarding pregnancy was to provide me with a list of numbers to call for an abortion. They did not provide me with information on alternatives to abortion, services available for pregnant women needing assistance, a description of the risks associated with the abortion procedure, or information on the adverse physical and psychological effects of abortion. I decided to have an abortion, thinking that it would take me back to the state I was in before my pregnancy. I was young and and sadly ignorant of the potential consequences of my choice. I read in an entry- level psychology book that, "there are no lasting psychological effects to abortion". When I went to the clinic I was not given any information regarding alternatives to abortion, a description of the abortion procedure, or the risks involved. I was simply given a form to sign saying I would not hold the clinic liable for damages. I was not told the name of the doctor that performed the abortion. I knew during the procedure that I had made a mistake but by then it was too late. Nobody told me how painful the actual procedure would be. I experienced complications from excessive bleeding following the procedure that resulted in a period of unconsciousness and a long recovery. The risk of excessive bleeding was undisclosed. Immediately following the procedure I just wanted to forget it. I drove myself to succeed in many areas of my life trying to blot out the memory and make up for the loss. Despite my efforts the memory

remains and I still feel the loss of the child. I continue to live with the consequences of my choice.

Years later when my husband and I wanted to start a family, I had difficulty carrying a baby to term due to cervical incompetence and premature uterine contractions. I lost four babies before our son was born. We nearly lost our son when I went into premature labor at 23 weeks. In order to save his life I was transported on a medivac flight from Fairbanks to Providence hospital. I spent 6 weeks in the hospital and over 3 months on complete bed-rest. Standard drug therapy would not stop the contractions. The experimental medications that stopped my uterine contractions also stopped both my sons and my kidneys from working. As a result, both our lives were nearly lost. I believe these complications were due to the abortion.

Support for House Bill 329:

I encourage the passage of house bill 329. Providing women with concise written medical information on what an abortion procedure involves, the risk factors, side effects, and the available alternatives to abortion is critical in making an informed decision.

IN REVIEW OF SECTION 1

(1) I believe that geographically-indexed material designed to inform a woman of agencies and services that can help her could give her the hope she needs to believe that there are other options. It is important that there be local phone numbers listed, a woman who has an unplanned pregnancy may be unable to think rationally. It would have been helpful for me to be told that a woman who experiences an unplanned pregnancy can be a successful parent.

(2) Information on medical assistance benefits, as stated in the bill, would be helpful.

(4,6,7) I believe that the name of the physician performing the procedure should be disclosed and that informed consent should include a detailed description of the abortion procedure. When I worked in the hospital I observed physicians describing procedures that patients were about to experience. It was then neatly written out for the patient to sign and a nurse was present when the form was signed. It was all done professionally with ample time for patients to ask questions. Providing a patient with the risks and side effects of a surgical procedure is common practice in the medical industry and should be applied to abortions. The entire procedure should be described as stated in the bill in section 1:7.

The physical and emotional pain is real and these risk factors need to be disclosed. The risk factor of danger to subsequent pregnancies needs to be disclosed!

(5) Information on the state of the unborn child with photographs would be helpful When trying to make a life-changing decision like aborting or parenting a child. Even with my training I had not consciously registered that my baby was formed and had fingers and toes and her heart was beating. It was devastating to find this out after the abortion. You do not think rationally when in a crisis. The 24 hour waiting period may give a women time to think and evaluate all of the options. The bill states that the information would be presented objectively to convey scientific information, I believe this is essential.

I have had extensive post abortion counseling and now am involved in a program providing post-abortion counseling and education for women. I have seen many women seeking support and healing for physical and emotional problems following abortion. I have heard the testimony of these women trying to heal post abortion and the comments that describe the pain they feel. One young woman described the way she felt about herself after an abortion saying, "When I look in the mirror I see a monster".

I can testify that many women experience real and significant physical and emotional problems following an abortion. Therefore, it is vital that they be provided with information relating to abortion alternatives, support services available pre- and post-abortion, the details of the procedure, and the medical risks involved. Again, I would like to express my support for passage of house bill 329.

Thank you.

CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 329(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 3/30/00
Referred: Judiciary, Finance

Sponsor(s): REPRESENTATIVES COGHILL, Kohring, Dyson, Ogan, Sanders, Green, Harris

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to services and information available to pregnant women and**
2 **other persons; and requiring informed consent and a 24-hour waiting period**
3 **before an abortion may be performed unless there is a medical emergency."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 * **Section 1.** AS 18.05 is amended by adding a new section to read:
6 **Sec. 18.05.032. Information relating to unborn children and abortion.** (a)
7 The department shall obtain or prepare written information that
8 (1) contains geographically-indexed material designed to inform a
9 person of public and private agencies and services, including adoption agencies, that
10 are available to assist a woman through a pregnancy, at childbirth, and while the child
11 is dependent; the material must include a comprehensive list of the agencies, a
12 description of the services they offer, and the manner in which the agencies may be
13 contacted, including telephone numbers; in addition to this written material, the
14 department, through a toll-free 24-hour-a-day telephone number, shall orally provide

1 a list and description of agencies that are in the locality of the caller;
2 (2) provides information on the availability of medical assistance
3 benefits for prenatal care, childbirth, and neonatal care;
4 (3) states that a person may not lawfully coerce a woman to undergo
5 an abortion;
6 (4) states that a physician who performs or induces an abortion on a
7 woman without obtaining the woman's informed consent may be liable to the woman
8 for damages in a civil action;
9 (5) states that the father of a child is liable to assist in the support of
10 the child even in instances where the father has offered to pay for an abortion, and that
11 the law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal
12 care;
13 (6) is designed to inform the woman of the anatomical and
14 physiological characteristics of a typical unborn child at two-week gestational
15 increments from fertilization to full term, including photographs representing the
16 development of unborn children at two-week gestational increments and relevant
17 information about the possibility of an unborn child's survival at the various
18 gestational ages; the photographs must contain the dimensions of the fetus and shall
19 be realistic and appropriate for the woman's stage of pregnancy; the information must
20 be objective, nonjudgmental, and designed to convey only accurate scientific
21 information about unborn children at various gestational ages;
22 (7) contains objective information that describes the methods of
23 abortion procedures and treatments commonly employed, the medical risks commonly
24 associated with each procedure and treatment, the possible detrimental psychological
25 effects of abortion, and the medical risks commonly associated with carrying an
26 unborn child to term; the information about the medical risks commonly associated
27 with abortion procedures and treatments must include
28 (A) when medically accurate, the risks of infection, hemorrhage,
29 breast cancer, danger to subsequent pregnancies, and infertility; and
30 (B) where appropriate, the possible adverse psychological
31 effects of an abortion.

(should add continued pregnancy as a medically recognized complication)

none proven

1 (b) The information required under (a) of this section must be written in easily
2 comprehensible language and must be printed in a typeface that is large enough to be
3 clearly legible.
4 (c) The department shall make the information required under (a) of this
5 section available free of charge on request and in an appropriate volume to the
6 requestor.
7 (d) In this section,
8 (1) "fertilization" means the fusion of a human spermatozoan with a
9 human ovum; (need to add implantation)
10 (2) "gestational age" means the age of the unborn child as calculated
11 from the first day of the last menstrual period of the pregnant woman;
12 (3) "pregnant" or "pregnancy" means a female reproductive condition
13 of having a developing fetus in the body from the time of fertilization;
14 (4) "unborn child" means the offspring of human beings from
15 fertilization until birth.

medically inaccurate

16 * **Sec. 2.** AS 18.16.010(a) is amended to read:
17 (a) An abortion may not be performed in this state unless
18 (1) the abortion is performed by a physician or surgeon licensed by the
19 State Medical Board under AS 08.64.200;
20 (2) the abortion is performed in a hospital or other facility approved for
21 the purpose by the Department of Health and Social Services or a hospital operated by
22 the federal government or an agency of the federal government;
23 (3) before an abortion is knowingly performed or induced on an
24 unmarried, unemancipated woman under 17 years of age, consent has been given as
25 required under AS 18.16.020 or a court has authorized the minor to consent to the
26 abortion under AS 18.16.030 and the minor consents; for purposes of enforcing this
27 paragraph, there is a rebuttable presumption that a woman who is unmarried and under
28 17 years of age is unemancipated; [AND]
29 (4) the woman is domiciled or physically present in the state for 30
30 days before the abortion**; and**
31 **(5) the applicable requirements of AS 18.16.060 have been satisfied**.

1 * **Sec. 3.** AS 18.16.010 is amended by adding a new subsection to read:
2 (h) A person who performs or induces an abortion in violation of (a)(5) of this
3 section is civilly liable to the pregnant woman for compensatory and punitive damages.
4 In a civil action under this subsection, there is a rebuttable presumption that an
5 abortion was performed without the pregnant woman's informed consent if the
6 physician who performed the abortion does not submit into evidence the copy of the
7 woman's written certification required to be retained in the physician's files under
8 AS 18.16.060(b)(4)(B).
9 * **Sec. 4.** AS 18.16 is amended by adding a new section to read:
10 **Sec. 18.16.060. Informed consent requirements.** (a) Except in case of a
11 medical emergency, a person may not knowingly perform or induce an abortion
12 without the voluntary and informed consent of the woman on whom the abortion is to
13 be performed or induced.
14 (b) Consent to an abortion is voluntary and informed only if all of the
15 following are true:
16 (1) at least 24 hours before the abortion, the physician who is to
17 perform the abortion or the referring physician has orally informed the woman of
18 (A) the particular medical risks associated with the abortion
19 procedure to be employed; the medical risks include,
20 (i) when medically accurate, the risks of infection,
21 hemorrhage, breast cancer, danger to subsequent pregnancies, and
22 infertility; and
23 (ii) where appropriate, the possible adverse
24 psychological effects of an abortion;
25 (B) alternatives to the abortion that a reasonable patient would
26 consider material to the decision of whether or not to undergo the abortion;
27 (C) the probable gestational age of the unborn child at the time
28 the abortion is to be performed;
29 (D) the medical risks associated with carrying the unborn child
30 to term;
31 (E) the name of the physician who will perform the abortion

1 procedure;

2 (F) the possible availability of medical assistance benefits for
3 prenatal care, childbirth, and neonatal care; and

4 (G) the father's liability to assist in the support of the woman's
5 child, even in instances where the father has offered to pay for the abortion;
6 however, the information required under this subparagraph may be omitted by
7 the physician when the physician considers its omission appropriate under the
8 circumstances of the pregnancy.

9 (2) at least 24 hours before the abortion, the physician who is to
10 perform the abortion, the referring physician, or a person to whom the responsibility
11 has been delegated by either physician has informed the woman that

12 (A) the Department of Health and Social Services provides
13 written information that describes unborn children at various gestational ages
14 and lists the agencies that offer alternatives to abortion; and

15 (B) the woman has a right to review the written information
16 described in (A) of this paragraph and that a copy will be given to the woman
17 at no cost;

18 (3) a copy of the information described in (2)(A) of this subsection has
19 been given to the woman; and

20 (4) before the abortion,

21 (A) the woman certifies in writing that the information required
22 to be given under (1) - (3) of this subsection has been received; and

23 (B) the physician who is to perform the abortion or a
24 representative of the physician receives a copy of the written certificate
25 prescribed by (A) of this paragraph and retains a copy in the physician's file.

26 (c) In this section,

27 (1) "fertilization" means the fusion of a human spermatozoan with a
28 human ovum;

29 (2) "gestational age" means the age of the unborn child as calculated
30 from the first day of the last menstrual period of the pregnant woman;

31 (3) "medical emergency" means a condition that, on the basis of the

1 physician's good faith clinical judgment, so complicates the medical condition of a
2 pregnant woman that the immediate termination of the woman's pregnancy is necessary
3 to avert the woman's death or that a delay in providing an abortion will create serious
4 risk of substantial and irreversible impairment of a major bodily function of the
5 woman;
6 (4) "pregnant" or "pregnancy" means a female reproductive condition
7 of having a developing fetus in the body from the time of fertilization;
8 (5) "unborn child" means the offspring of human beings from
9 fertilization until birth.
10 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section
11 to read:
12 SEVERABILITY. Under AS 01.10.030, the provisions of this Act are severable.