HB

112

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: ____
Bill Version: HB 112
( ) Publish Date: ____

Revision Date/Time (Note if correction): ____
Title: Services available to pregnant women/ informed consent for abortion
Sponsor: Rep Coghill
Requester: House (HES)

Dept. Affected: Health & Social Services
BRU: State Health Services
Component: Maternal, Child, & Family Hlth
Component Number: 290

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	22.1	23.9	25.7	27.5	29.3	31.1
Travel	10.0	4.0	4.2	4.4	4.3	4.5
Contractual	16.0	3.5	3.2	3.3	3.3	3.4
Supplies	2.0	1.0	0.8	0.9	0.9	1.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**50.1**	**32.4**	**33.9**	**36.1**	**37.8**	**40.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
1002 Federal Receipts						
1003 GF Match						
1004 GF	50.1	32.4	33.9	36.1	37.8	40.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**50.1**	**32.4**	**33.9**	**36.1**	**37.8**	**40.0**

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal: [ ]

POSITIONS

POSITIONS	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Full-time						
Part-time	2		2	2	2	2
Temporary						

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

Personnel: $22.1

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

.10 FTE Administrative Clerk II to 1) provide clerical support for mailings, copying, and ordering materials

Travel: $10.0

Travel to areas in Alaska to do training on the new requirements.

This fiscal note does not include any funding for additional licensing costs due to the lack of clarity in the bill regarding exactly what would be required.

Prepared by: Karen E. Pearson
Division: Public Health
Phone: (907) 269-3408
Date/Time: 2/12/01 12:00 AM

Approved by: Elmer A. Lindstrom, Special Assistant
Agency: Department of Health & Social Services
Date: ____

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

Revision Date: Bill Version:

ANALYSIS: HB 112 (continued)

Contractual: $16.0

Material printing costs:

Initial $10.0

Ongoing $ 2.0

Postage:

Initial $6.0

Ongoing $1.5

Supplies: $2.0

Initial $2.0

- Subscriptions/books for ANP $0.5
- Envelopes $0.7
- Letterhead $0.8

Ongoing $1.0

SITE: JUNEAU LIO OFFNET

COMMITTEE:

DATE:

SUBJECT OF MEETING:

UPDATE #:

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
DR. COLLEEN MURPHY			Y-HB-112

SITE: ANCHORAGE LIO

COMMITTEE: House HESS

DATE: 4-21-2001

SUBJECT OF MEETING:

HB 71, HB 112, HB 85, HB 173

UPDATE #: 1

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Robin Smith			Yes HB 112
Pauline Utter			Yes HB 112
~~Dick Block~~ CHRISTIAN SCIENCE			Yes HB 173

COMMITTEE: HOUSE HEALTH, EDUCATION & SOCIAL SERVICES	SUBJECT: HB 173-SCREENING NEWBORNS FOR HEARING ABILITY

DATE: April 21, 2001

PLEASE SIGN IN

PLEASE PRINT: NAME & TITLE	ADDRESS (MAILING & ZIP)	PHONE	REPRESENTING (No Acronyms, Please)	DO YOU WANT TO TESTIFY ?
Karen Pearson	350 Main St	465-3090	Div of Public Hlth	?'s only ✓

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union
P. O. Box 201844, Anchorage, AK 99520-1844
Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

To: Members of the Alaska House
From: Jennifer Rudinger, Executive Director
Date: Friday, April 20, 2001

Re: **HB 112 – MANDATORY EXTRA "COUNSELING" FOR ABORTION**

The US Supreme Court's 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey upheld, among other restrictions, a Pennsylvania law requiring that physicians provide women with state-prepared anti-choice materials prior to the abortion procedure. The law forces a doctor to provide every woman seeking an abortion with information that is intended to discourage the procedure -- even if the information is irrelevant, unnecessary, and ultimately harmful to her health.

Such "biased counseling" laws are currently enforced in more than a dozen states. In a number of other states, these laws have been enacted but are enjoined or otherwise unenforced. Often introduced under the deceptive label of "Informed Consent" or "Women's Right to Know," biased counseling laws in fact serve to hamper women's access to abortion.

Alaska, however, is one of several states that evaluate restrictions on women's reproductive choices under the stricter standard of judicial review established by the US Supreme Court in 1973 in Roe v. Wade. Therefore, the Casey analysis and conclusion do not apply when an Alaska court reviews laws such as HB 112, and it is our opinion that HB 112 may be unconstitutional under the Alaska Supreme Court's decision in Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice, et al. in 1997.

Aside from our concerns that HB 112 may violate the Alaska Constitution, there are many reasons why the bill is bad public policy.

1. This Mandatory Extra "Counseling" Gives Women Inaccurate and Irrelevant Medical Information.

Mandatory extraneous lectures do not give women accurate or meaningful medical information. HB 112 puts words in doctors' mouths and forces them to run through a litany of conceivable pro's and con's for abortion and for all alternatives to abortion – even when those alternatives are not in the patient's best interest and may even *harm* her. Yet, women who are seeking prenatal care in order to carry a pregnancy to term are *not* forced to waste time and money listening to a diatribe about their options and alternatives to pregnancy and

5. Biased Counseling Requirements Violate Standard Medical Practice and the Doctor/Patient Relationship.

HB 112 requires a doctor to supply all of the state-mandated information to every woman in every instance in order to avoid liability. This state-imposed litany may conflict with the doctor's ethical obligation to give the best medical advice to the patient, in view of her individual circumstances. For example, it is both pointless and cruel to "inform" a victim of rape or incest that she has the "alternative" of raising the "unborn child" (as though she did not already know this), or to remind a woman carrying a fetus with impairments so severe that it could never survive outside the womb that her "unborn child" will be 20 weeks old at the time of the abortion. Indeed, the American Medical Association has resolved to oppose these types of measures, finding that "informed consent requirements [for specific medical procedures] often are not medically indicated and never are appropriate areas for codification in law." [American Medical Association, "AMA Opposition to 'Procedure Specific" Informed Consent," House of Delegates Resolution 226 (A-99).]

HB 112 is a perfect example of why legislators should not insert themselves into the business of practicing medicine. The definitions of "fertilization" and "gestational age" contained in the bill are medically inaccurate, and the definition and use of the term "unborn child" is both medically inaccurate and inflammatory.

6. Conclusion: HB 112 Endangers Women's Health and Violates Women's Constitutional Right to Reproductive Choice.

HB 112 is not created to protect women's health. The purpose is clear: this bill is designed to make a woman's very personal decision even more difficult. Fear of civil sanctions and the intrusive nature of the state-prescribed litany also serve to deter doctors from performing abortions, further exacerbating the alarming present shortage of providers in Alaska.

The AkCLU respectfully urges this body not to place any further burdens on women's rights to choose abortion. Please feel free to call on me if you have any further questions or concerns. I can be reached at (907) 258-0044 most days, from mid-morning until mid-evening.

Thank you very much for your careful consideration.

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JR: See also the recent study described in the attached (↓ this factsheet preceded that)

OPPOSING LAWS THAT REQUIRE WOMEN SEEKING ABORTIONS TO BE "INFORMED" OF THE "RISK" OF BREAST CANCER

The latest "scare tactic" initiated by anti-choice groups is to link abortion to breast cancer. Seizing upon scant evidence in a 1994 research study, they have mounted a vigorous advertising and legislative campaign to convince the public that having an abortion increases a woman's chance of contracting breast cancer. The study, published in the Journal of the National Cancer Institute (JNCI),[1] reported a small statistical connection between abortion and breast cancer. Although cancer research experts have characterized the study as inconclusive and methodologically problematic, anti-abortion activists have eagerly wielded it as a new way to frighten women and restrict their reproductive choices.

Opponents of choice have persuaded legislators in several states to introduce or enact bills that require physicians to inform women seeking abortions that abortion increases a woman's risk of breast cancer. Since this "warning" directly contradicts expert medical research, it can only be viewed as a politically inspired scare tactic; it is not motivated by a genuine concern for women's health. Here are some "talking points" that you can use to oppose such requirements when they are proposed as freestanding bills or as specific provisions in broader biased counseling bills (deceptively labeled by their anti-choice sponsors, "Informed Consent" or "Women's Right to Know" bills):

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."[2]

- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."[3]

- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.[4]

- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.[5]

- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."[6]

Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social Services committee name

committee on HB 112 bill/subject, dated 4/21/01.

PLEASE SEE TESTIMONY ATTACHED

This article I had written several years ago. Please read I will be testifying in reference to this article. Thank you.

Signed: Dr. Bob Johnson
Testifier

Representing (Optional)

PO Box 945 Kodiak, Ak 99615
Address

Phone No.

ABORTION
(12-09-93)

I wince whenever I hear the misconceptions voiced by many anti-abortionists. Most are far from the truth. I have received letters over the years expressing these, and I have taken the time to answer each carefully, pointing out the truth for those who might be interested. I have wanted to speak out but, in the interests of my patients, I have kept silent. Now that the issue has been made public, I am freed of this constraint. Dr. Hans Tschersich, Aurora Borealis Radiology, my sponsor this week, encouraged me to write on this subject!

I have been in practice in Kodiak for 38 years. Babies were born to unmarried girls in the 1940's. In the villages it didn't matter as much, for they were like one big family and there was always someone to care for the children. As Kodiak grew, unexpected and unwanted pregnancies increased in number. I was frequently asked for help, often tearfully, but could do nothing, for the law would not permit it. Some patients found an abortionist. Some gave birth and gave up their babies for adoption. Others gave birth and kept them. I will not outline the problems and misery that usually resulted. Most of these babies were neglected, some were mistreated and some were abused. They were my patients, too. The parents, beset with mixed guilt and despair, had a difficult time. There were no easy solutions to the many problems that resulted.

From last week's column you will remember that a review of the literature revealed about 12% of children today are emotionally, physically or sexually abused---children that were presumably wanted, since abortion has been legally and readily available. If abortion were illegal and unwanted children were born, it takes little imagination to realize that abuse would be a more serious problem than it is now.

For these reasons, when the Federal Government legalized abortion, I approved. Most states ratified the legislation within a year--the remainder within 3 years--indicating with little doubt that the need was universal.

I would like to point out that I am not in the abortion business. I am in the practice of medicine: health promotion and problem solving (including emergency care). I provide the service of abortion to those who have made the choice after a carefully considered decision.

First, each patient is given a paper which outlines all the options available and advises caution in the making of their decision. It emphasizes the controversial nature of the issue. The options are discussed and if there is any question, the patient is referred to a counselor (of her choice) for reconsideration. If we are to proceed, the patient is tested for sexually transmitted disease, blood is drawn for typing and a complete blood count and 4 additional visits are scheduled.

At a second, hour-long visit, the procedure is explained in detail, including medications available, indications for their use and the risks of the procedure. At a third visit, a laminaria is inserted into the cervical canal followed by a complete physical examination. The laminaria is a sterile piece of kelp which absorbs water and slowly and painlessly dilates the cervix overnight.

The abortion is performed on the fourth visit. The whole procedure, including preparations, takes about 30 minutes. The patient is observed for an hour during which time a film on contraception and/or a film on breast self examination and PAP smear is shown. A means of contraception is decided upon before discharge, instructions are given and an appointment scheduled for the fifth visit in two weeks.

Abortions are not done here when the pregnancy is beyond 13 weeks which is the end of the period of the embryo. No evidence exists that the embryo experiences pain or even an awareness of its own existence. Consider the fact that it is permissible today to remove life support from comatose or terminal adults who have lost an awareness of their own existence and it will probably eventually be permissible to assist suicide when patients whose situations are intolerable request it.

In Kodiak there are 40-50 abortions performed per year. This makes a total of approximately 700 in 15-16 years. Of these, there have only been 4-5 with sexually transmitted disease (which were treated), 2 post-abortion infections, 2 post-abortion hemorrhages, 1 depression requiring medication and no uterine perforations. Those with infection responded to treatment promptly. Those with hemorrhage resolved with no need for intervention and did well. Abortions do not cause infertility nor prevent normal pregnancies or normal births. Contrary to the opinion expressed by many who oppose abortion, the experience is rewarding--patients are grateful and quite happy to have a difficult problem resolved.

This article may well initiate a flurry of responses. I have no intention in engaging in debate! I am simply presenting the facts of my experience and I must pose this question! Under these circumstances, should ANYONE have the right to make decisions for OTHERS regarding their choice? And I would add, should ANYONE have the right to set up rules of procedure for OTHERS that serve as an impediment to their exercise of choice?

22-LS0364\F.1
Lauterbach
4/5/01

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE COGHILL

TO: HB 112

1 Page 3, line 9:
2 Delete "make"
3 Insert "advertise the availability of"
4
5 Page 3, line 10:
6 Delete "available"
7 Insert "and distribute the information"
8 Following "requester.":
9 Insert "The department shall also place the information in public hospitals,
10 clinics, or other health facilities throughout the state and, upon request of an
11 administrator, in a private hospital, clinic, or health facility so that members of the
12 public may obtain the information voluntarily, without request."

Alaska State Legislature

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Representative John Coghill

Sponsor Statement
HB 112

Since the early 1970s, Alaska regulations have required physicians to advise patients seeking an abortion of the "medical implications and the possible emotional and physical sequelae of the procedure." (12 AAC 40.070). However, Alaska's informed consent regulation lacks specificity and is not uniform in its application.

HB 112 elevates Alaska's current informed consent requirement from regulation to statute. This legislation would ensure that a patient is given the appropriate information about an abortion procedure without obstructing a physician's ability to tailor information to the individual needs of the patient.

HB 112 also requires that the Department of Health and Social Services develop a pregnancy informational pamphlet to be made available to the public. The pamphlet would list factual, nonbiased information about pregnancy and abortion, as well as pregnancy and abortion alternative resources, and state services available to pregnant women in Alaska.

HB 112 reinforces the current ethical standards by protecting them from possible systematic abuse in the future, putting a statutory safeguard into place for both women and physicians.

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Representative John Coghill

Sectional analysis - HB 112

Section 1: Creates an information pamphlet that is designed for pregnant women which describes average fetal development and lists both non-profit and state pregnancy and pregnancy alternative resources and options.

Section 2: Amends AS.18.16.010 ("Abortions") to state that an abortion may not be performed unless the provisions of section 4 (AS 18.16.060) have been satisfied.

Section 3: Amends AS 18.16.010 ("Abortions") to include a subsection that states that, except in situations of medical emergency, if an abortion is performed in violation of section 4 (AS 18.16.060), the physician is civilly liable for compensatory and punitive damages.

Section 4: Amends AS 18.16.010 to include a section addressing informed consent requirements. An abortion may not be performed in this state unless the physician or referring physician orally informs the patient of

- The name of the physician performing the procedure.
- Gestational estimate of pregnancy at the time of the procedure.
- Nature and risks of undergoing or not undergoing the procedure, as pertinent to the patient's circumstances and medical history.

Written consent must be obtained from the patient confirming that the required information has been provided.

Section 5: Provides a severability clause. In the event that one or more of these provisions is found to be unconstitutional, the remaining provisions would continue in full force and effect.

CURRENT STANDARD:

ALASKA ADMINISTRATIVE CODE - ABORTION/INFORMED CONSENT

2 AAC 40.070

INFORMED CONSENT.

Unless otherwise provided in 12 AAC 40.060, a written informed consent shall be obtained from the patient or from any other person whose consent is required before termination of a pregnancy. Such written informed consent shall be on the patient's chart. The patient and other persons whose consent is required shall be advised of the medical implications and the possible emotional and physical sequelae of the procedure.

History -

Eff. 12/20/70, Register 36; am 8/29/73, Register 47

Authority -

AS 08.64.105
Sec. 08.64.105. Regulation of abortion procedures.

The board shall adopt regulations necessary to carry into effect the provisions of AS 18.16.010 and shall define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for facilities, equipment, and care of patients in the performance of an abortion.

CONCEPT BEHIND HB 112: REFINE AND ELEVATE ALASKA'S CURRENT ABORTION INFORMED CONSENT STANDARD

EXAMPLE:

AS 18.16. REGULATION OF ABORTIONS
AS.18.16.010. Abortions.

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

(1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on an unmarried, unemancipated woman under 17 years of age, consent has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;* and

(4) the woman is domiciled or physically present in the state for 30 days before the abortion.

HB 112 WOULD INSERT:

(a) Except in the case of a medical emergency, a person may not knowingly perform or induce an abortion without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced.

(b) Consent to an abortion is voluntary and informed when all of the following are true:

(1) before the abortion procedure, the physician who is to perform the abortion or the referring physician has orally informed the woman of the

(A) name of the physician who will perform the procedure;

(B) gestational estimation of the pregnancy at the time the abortion is to be performed; and

(C) nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a voluntary and informed decision of whether to undergo the procedure;

(2) before the abortion, the woman certifies in writing that the information required under (1) of this subsection has been provided; and

(3) the physician who is to perform the abortion or a representative of the physician receives a copy of the written certificate required under (2) of this subsection and retains a copy in the physician's file.

(c) The information required in (b)(1) of this section shall be provided to the woman individually and in a private setting to protect the woman's privacy, maintain the confidentiality of the woman's decision, ensure that the information focuses on the woman's individual circumstances, and ensure that the woman has an adequate opportunity to ask questions.

*Parental Consent/Judicial Waiver struck down - Planned Parenthood of Alaska, Inc. v. State, No. 3AN-97-6014 CI (10/5/98)

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Representative John Coghill

"INFORMED CONSENT FOR ABORTION" LAWS IN THE UNITED STATES

- 30 states, including Alaska, currently have laws detailing informed consent requirements for abortion procedures.

  AL, AK, CA, CT, DE, FL, ID, IN, KS, KY, LA, ME, MA, MI, MN, MS, MT, NE, NV, ND, OH, PA, RI, SC, SD, TN, UT, VA. WI

- 21 states have introduced legislation concerning this issue in 2001 to both initiate laws and to update current laws.

- Alaska is one of 12 states that have legislation in 2001 that would update the current state laws on abortion informed consent.

- Separate medical informed consent laws for abortion procedures have been upheld at the Federal level (U.S. Supreme Court *Casey*). 7 states currently have their laws enjoined due to state court rulings. The central issue behind these injunctions being that the laws also required a waiting period, which was ruled unconstitutional under the individual state constitutions.

- The determining factor for federal constitutionality of informed consent laws is the judgment of whether or not the laws pose an undue burden to a woman seeking an abortion.

  Note: Alaska's abortion laws are held to the more strict interpretation of Roe v. Wade, not the recent U.S. Supreme Court ruling in *Casey.*

Representative Dyson 465-4587
Representative Wilson 465-3175
Representative Coghill 465-3258,
Representative Kohring 465-3818
Representative Stevens 465-3517
Representative Cissna 465-4588
Representative Joule 465-4586

(H) Health, Education, & Social Services

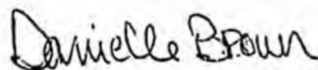
House Bill 112

Representatives,

My name is Danielle B. Brown, I am a Juneau resident, and I am a women. I do not support HB 112 and its intent on regulating the rights of women and their right to choice. In specific, I do not support the 30-day amendment added to this bill. Alaska is a transient state. People come and go throughout their travels and employment. I feel as though the 30-day amendment will just cause more harm than good.

Why is Vigra covered by insurance and contraceptives not? What an ironic twist, don't you think? Do we not have an over population issue going on throughout the world? I do not support abortion as a method of reproductive contraception, however it is very important to have this option available. It is apparent in our society that a large number of children are neglected, abused physically, mentally, and sexually, and malnourished, because of a multitude of reasons. Could these reasons be attributed to young girls, teenagers, having children, women in abusive relationships, women below the poverty level, rape, incest, I don't know and neither do you. But why try and take this choice from women and allow theses incidents to increase. Abortion is not the issue here, it is the quality of life for all people affected by an unwanted birth: child, women, and men. Having the right to choose is something I do not believe should be taken away from women.

Thank you for your time,



Danielle B. Brown

PO Box 22406
Juneau, AK 99802
(907)586-6665

COMMITTEE:HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

SUBJECT:HB 112-ABORTION: INFORMED CONSENT; INFORMATION

DATE: March 8, 2001

PLEASE SIGN IN

PLEASE PRINT: NAME & TITLE	ADDRESS (MAILING & ZIP)	PHONE	REPRESENTING (No Acronyms, Please)	DO YOU WANT TO TESTIFY ?
Karen Pearson	Div of Public Health ~~DPH / DHSS~~	465-8613	350 Main Suite 503	Yes
Peter Nakamura	2346 KaSeeAn Dr Juneau	790 2421	Self	yes
Gillan Tarr	PO Box 1233 Girdwood, AK 99587	783-1334	self	yes
Renee Earhart	PO Box #22237 Juneau	586-2549	Self	yes
Amber Cefalo	Box 21872, Juneau	586-1085	Juneau Coalition for RC.	Yes

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Representative John Coghill

MEMORANDUM

To:	Representative Fred Dyson, Chairman House Health, Education & Social Services Committee
From:	Representative John Coghill
Re:	Request for hearing - HB 112
Date:	February 22, 2001

Please schedule a hearing for House Bill 112 in the House HESS committee at your earliest convenience.

I have attached with the bill a copy of the sponsor statement and sectional analysis. Please contact my legislative aide Danielle Serino at extension 5038 if you have any questions. Thank you.

SITE: HOMER LIO

COMMITTEE: HHES

DATE: 03-08-01

SUBJECT OF MEETING:
HB112:Abortion

Update #1

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY?
Eileen L. Becker	PO Box 2 Homer, AK 99603	Homer Crisis Pregnancy Center	Y- HB112
Amy Bollenbach	PO Box 3429 Homer, AK 99603	Self	Y- HB112

Subject: TESTIMONY--HB112
Date: Sun, 22 Apr 2001 10:31:30 -0800
From: "R. Holmes Johnson" <drbob@keaconnect.net>
To: Representative_Fred_Dyson@legis.state.ak.us

Fred Dyson, Representative
State of Alaska
State Capitol
Juneau, Alaska 99801-1182

Dear Mr. Dyson,

When I had to leave before testifying at the Saturday teleconference on HB112, the LIO in Kodiak forwarded an article of mine that was published in the Kodiak Mirror when I was in practice. The "going public" in the initial paragraph refered to picketing that had just begun and therefore removed the need for secrecy. I was quite happy to "tell it like it is" to correct many misconceptions created by opponents of abortion.

I would urge you to read the article since it establishes my experience and thus qualifies me to testify on this proposed legislation.

HB112 is an unnecessary bill. It needn't have been introduced at all since: a) the Alaska Department of Health presently distributes much information on pregnancy and abortrion, since; b) *informed consent* has been reiterated so many times that no sane phyisian fails to explain whatever procedure is being considered and to obtain signed consent, and since; c) abortion should not be singled out as the *only procedure* in Alaska to be subject to such mandatory "extra" counseling.

Though making a studied effort toward objectivity, the details which serve as an impediment to free choice (of what one wants to know), and the use of the term *unborn child* in place of the proper term *fetus,* make it fairly obvious that this bill was written by those who do not approve abortion!

I heard testimony on SB91 a few days ago by a woman who quoted unbelievable complications of abortion, particularly serious psychological problems. Dr. C. Everett Koop, Surgeon General under President Reagan, himself *not in favor of abortion,* did an exhaustive study of abortion and found *no evidence* of psychological effects. My own experience supports Dr. Koop. This suggests that those who feel abortion is *murder* are so biased that they transmit this to those whom they interview and suceed in creating severe guilt feelings would be, indeed, complications, *but not of abortion.*

Please keep in mind that a woman, now, has the right to ask any question at all of her physician and he has the obligation to answer that question to the best of his ability. To have someone else, particularly legislators, dictate what she must know, is an insult to her intelligence and, furthermore, overlooks individual differences and individual needs.

In summary, this bill is redundant and should not have been introduced at all. It places an unnecessary impediment to the free exercise of choice which has been the legal right of women since Roe vs. Wade. Had it always been their legal right, we would not have seen the *serious complications* that *were* a result of back alley abortionists. To add impediments to free choice, as has already been done in a number of ways, is to chip away at one effective and necessary form of population control.

Realize that I am retired and have nothing to gain personally! I write in defense of women who

become unexpectedly pregnant who should be free to choose what they want to know about their options as well as which, among them, to select. This bill interferes with that freedom and should be buried!

Sincerely,

Dr. Bob Johnson,
drbob@keaconnect.net
Phone 907--486-5171
Box 945 Kodiak 99615

HB 112 Testimony

My name is Debbie Joslin. My husband, Steven and I live in Delta Junction with our three children; Matthew, Emily and Victoria. Steven is the resource forester in our area. I am a homeschooling mom. I teach 3rd and 4th grade Sunday School at my church.

On January 15, 1999 I was 22 weeks pregnant when we drove 100 miles to Fairbanks for an ultrasound on our child. After a lengthy examination of the baby, I was told we were expecting a male child with multiple anomalies. The baby we named Isaiah John had a brain cyst, a missing or unconnected stomach and a hypoplastic left heart. We were given the name of a Perinatologist in Anchorage. A Perinatologist, as I understand it, is a doctor who specializes in unborn babies who have serious health complications. I spoke to this specialist over the phone and made arrangements to go to Anchorage and have another ultrasound. During that phone conversation she urged me to have the pregnancy terminated. The reasons she listed were that the baby would probably die anyway, the medical expenses would be too great and that my own life was probably in danger. Keep in mind, she had not examined me at this point. I made an appointment with this doctor, since I was told she was the only Perinatologist in the state. My husband and I drove 350 miles to keep that appointment, leaving Delta at 40 below zero. When we arrived for our appointment we first saw a genetic counselor who went over some family history with us and explained that they thought Isaiah had Trisomy 18, a chromosomal abnormality (an extra number 18 chromosome). She expressed surprise that we were not considering terminating the pregnancy and asked several times whether we wanted to consider terminating the pregnancy. Another ultrasound was performed by a technician and then the Perinatologist took over the exam and listed the following anomalies: Brain cyst, missing or unconnected stomach, hypoplastic left heart, eyes not properly spaced, underdeveloped chin, something wrong with spinal development, something wrong with his penis, rocker bottom feet, possibly an extra toe and fluid in the abdominal cavity and lungs. We were told the fluid indicated that Isaiah was already in congestive heart failure and that he would never make it to his due date in May. The Perinatologist told us that Isaiah would never respond to us if he were to live, we were told that all Trisomy infants were severely mentally retarded. She described a somewhat vegetative state but more probably he would be stillborn any day. She said that if he were to be born alive he would only live for a few minutes. Later they adjusted it to a few hours and then later yet they said maybe a day at most and then finally they said a few days. We agreed to an amniocentesis to determine whether Isaiah did actually have Trisomy 18. Our hope was that he would not, and we could begin to make plans for heart surgery. She told us doctors will not operate on Trisomy infants since they ALL die in infancy anyway.

You can imagine what heavy hearts we had as we drove back to Delta. The plans and dreams I had had for my son were shelved as we instead discussed his funeral. Within a few days I got a call from the genetic counselor with the preliminary test results which showed Isaiah had Trisomy 13. I asked how that differed from Trisomy 18 and she said it was worse. She asked again about termination and I told her again that we were not interested in that. Almost immediately I got a call from my doctor in Fairbanks who asked

me about termination. I told her (again) that I was not interested in that. She told me that since my life was in danger and I had chosen to continue with the pregnancy, she could no longer be my doctor as she was a general practitioner and not qualified to handle such a case. I began seeing the osteopath doctor in Delta and an OB/GYN in Fairbanks. I told them what I had been told about the baby and about my own health. The OB/GYN doctor told me he could not understand why I had been told my life was in danger. He treated me during the remainder of the pregnancy and I never had any complications or problems. Only the usual complaints pregnant women suffer from.

A couple of weeks after the preliminary results, the genetic counselor called with the final results from Isaiah's amniocentesis. It was final - Isaiah had Trisomy 13. She asked me again about termination and I told her no again. I then asked her out of curiosity what she would do if I did say yes. She got very excited and told me that "there is the most wonderful clinic in Kansas". I asked if she meant Dr Tiller's clinic and she said "yes, do you know him"? "No, I told her, but I know about him". She offered to have other women who had had abortions call me but I declined. Sensing that I was not interested in pursuing this any further she told me in a very apologetic voice that "there is a parent support group, but well....they are rather positive". She made it sound as though positive was a bad thing to be. She then went on to tell me that she had information on the group including an 800 number as well as pamphlets and books in her office that gave detailed information about Trisomy 18, 13 and related disorders including pictures. I called S.O.F.T. (Support Organization for Trisomy 18, 13 and Related Disorders) right away and found that they were indeed positive - but realistic. I told the woman over the phone about Isaiah's diagnosis and she told me that probably they were right but there was a chance he could live. She talked to me about the other "parents" and I remember asking her, "parents, you mean they have children?" "Yes, some did,"she said. "How old". I was told that they varied but there were a few children who were teenagers and even a couple of adults. The lady took my name and address and told me she would send me a family packet right away. I also requested the books they had available; Trisomy 13, a Guideline for Families and Care of the Infant and Child with Trisomy 18 or 13. These were the books the genetic counselor had described, the very ones she had in her office. While the information was heartbreaking, it also offered some hope and some help. Two things we hadn't had much of. Not only did some of these children live - they played and smiled and laughed and talked and learned things and showed affection and responded to love and affection.

We located a wonderful pediatrician in Fairbanks who agreed that Isaiah's chances were not good but she was willing to do what she could to help him. We made the decision to hire her and made plans to deliver our baby in Fairbanks. On May 10, only 11 days before his due date, Isaiah John Joslin was born at Fairbanks Memorial Hospital. He weighed 6 lbs 1 oz and was 18 1/4 inches long. Isaiah was a pretty baby with lots of bright red hair. Isaiah had difficulty breathing when first born but as the doctors and nurses checked him over they could find no sign of the problems seen earlier on three different ultrasounds. The brain cyst, stomach problem and hypoplastic heart were all missing as were all of the other problems earlier noted. However, Isaiah suffered from a ventricular septal defect

(VSD) - a hole in his heart. Although very serious, it was a far cry from the problems he had had earlier. Isaiah required oxygen and a nasal gastric tube for feeding. Because of the hole in his heart he was too weak to nurse and had to be fed with a tube. Isaiah looked so normal that even the nursing staff agreed we should retest him. Test results again showed Isaiah to have Trisomy 13. He stayed in the hospital for 12 days and then came home where we cared for him for 20 days before he left us to go to be with the LORD in heaven. Those were some of the hardest but sweetest days of my life.

I am telling you this story so you can understand why I stand before you today and ask that you pass HB 112

After talking to other doctors and doing a great deal of research and reading about Trisomy infants and because of my own personal experience, I believe my life was never in any danger. Yet, this undue burden was placed on me at a time when I already had plenty to worry about. I believe this was done to try and convince me to have the abortion.

I was told that ALL Trisomy infants die. I now know that somewhere between 90 and 95% of all Trisomy infants die before one year of age. That doesn't leave much room for hope I realize but it is quite different than saying they ALL die.

I was not told about the parent support group (S.O.F.T.) for over two weeks not until they had finally given up on talking me into an abortion. Well, you may say they were not sure your child had Trisomy until the final results were in. Perhaps, but they were sure enough that they continually brought up termination. I drove 350 miles to see the doctor and was never shown the written information about this disorder that they had right there..

Though they were careful to tell me every negative thing they could about the baby, I was never told of any of the risks of having an abortion. There was never any mention made of the risk to my health, either physical or emotional from having the abortion.

I believe the doctors who repeatedly brought up termination probably meant well. The problem comes in where they apparently believed that their professional status, or their medical degrees placed them in a position to know better than me what was best for me, my family and my baby. That simply is not true.

Giving life to Isaiah was hard on our family. But it wasn't TOO hard. It was expensive. But it wasn't TOO expensive. It was hard on the other children. But it wasn't TOO hard on my other children. Giving life to Isaiah blessed our family, including the other children. Because of his heart condition Isaiah was always lethargic and sleepy and tired acting but he was never in pain. The equipment which monitored his oxygen saturation rate showed that whenever we held him or showed affection to him, Isaiah was aware of it. His saturation levels would soar when he was being loved on. My daughter, Emily who is five loves to recount the story of how Isaiah's oxygen saturation level was in the 60s the night before he died. I laid him in Emily's arms and immediately his saturation level rose to 100. There seems to be a feeling out there that a successful life is one that is free from pain or

suffering or trials and that isn't true. Isaiah's life was successful. We loved him and he loved us.

We have been comforted and encouraged even since Isaiah's death by reading of other families with Trisomy children in the S.O.F.T. newsletter. The letters and testimonials are all expressions of the love each family has for their infant or child. Many of them include pictures of their precious children, most of them deceased but some still living. Some of them telling stories of medical professionals pressing them to have abortions are very similar to our experience. Without exception every family expressed love and gratitude for the time they had had with their children, no matter how short.

Uniform written information should include basic facts regarding fetal development and the risks associated with continuing the pregnancy versus terminating the pregnancy. Crisis pregnancies come in many different forms. For some women it can be as simple as finding out about WIC, others are not even aware that the child's father is legally responsible for helping to provide support. Over 90% of all babies diagnosed prenatally with Downs Syndrome are aborted. Could it be that those women don't know about the parent support groups out there? Information on adoption agencies should be as readily available as information on abortion. There is a wealth of information out there and it would be a great help to doctors to have a booklet they could hand out to their patients.

Of course I would like for every mother to make the same decision I did but I realize that won't happen. But every mother deserves to have all of the information pertinent to her situation so that she can make an intelligent informed decision. I stand before you today and say that if you vote against HB 112 you are saying, in effect, that women are not competent enough to be trusted with the facts regarding the health of their own bodies and that of their unborn children. A "no" vote says that you have no compassion for families and believe that doctors are better suited to make decisions for women and their unborn babies.

A "yes" vote for HB 112 sends an entirely different message. A vote *for* informed consent says that you have respect for the intelligence of women and believe that they have the right to be trusted with the information necessary to make decisions for themselves. I trust and hope that this body of legislators will prove themselves to be in favor of women's rights.

Thank you.

Debbie Joslin

Alaska State Legislature

Please enter into the record my testimony to the HEALTH, EDUCATION + SOCIAL SERVICES
committee name

committee on HB # 112, dated 4-19-01.
bill/subject

I would urge passage of this information ensuring informed consent before an abortion may be performed. The consequences of an abortion are so many + so serious. They include potential damage to her cervix, womb, tubes and breasts. Major immediate complications include infection, excessive bleeding, ripping or perforation of the uterus, anesthesia complications, convulsions and hemorrhaging. Women who have had a surgical abortion are at higher risk for breast cancer, pregnancy complications, miscarriage, premature delivery and depression. A study reported in the March issue of the American Journal of Drug + Alcohol Abuse found that women with one abortion were 5 times more likely to abuse drugs or alcohol. A recent study of government medical records in Finland found the risk of suicidal death to be 6 times higher in women who have had abortions. Joel Brind, founder of the Breast Cancer Prevention Institute in Poughkeepsie N.Y. estimated that as many as 10,000 breast cancer cases each year are due to induced abortions. Women are at risk and its unrealistic to expect the abortion industry to talk women out of an abortion. They make their income by providing abortions. The state or a neutral party needs to inform these women of the risks + emotional heartache inherent in an induced abortion.

Signed: ROSANNE CURRAN
Testifier

?
Representing (Optional)

P.O. Box 42, Cordova AK 99574
Address

424-7642
Phone No.

MARY M. DYE

April 21, 2001

Attn: Randy Lorenz

Representative Dyson
Alaska State Legislature
Alaska State Capitol

Re: House Bill NO. 112

Dear Chairman Dyson and Members of the Committee,

I knew your time was limited today, so I opted to testify in writing. Mr. Chairman, thank-you for the options that you offered for my convenience.

As ever, I offer my thoughts from the perspective of a woman, mother and Alaskan. I am writing in support of House Bill 112.

At the last hearing I attended regarding informed consent, I listened to the ACLU, Planned Parenthood, and the Department of Health and Social Services testify in opposition to Senate Bill No. 91. The reasons against informed consent included the antiquated and somewhat paternalistic assertion that the physician should determine what information is made available to the prospective patient, and the prejudicial and condescending assumption that **some** women may not understand the information that is given them. I decided that I wanted to take a closer look at these organizations, specifically at their mission statements, to attempt to understand why they would oppose a patient's right to be informed as to all of the potential benefits, risks and alternatives to the medical procedure known as abortion.

I would like to share with you what I found out at the official websites of these three organizations. Please note that the statements in quotation marks are theirs, not mine.

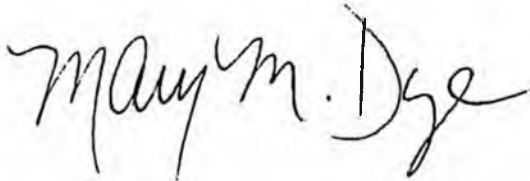
"The American Civil Liberties Union (ACLU) is our nation's guardian of liberty, working daily in courts, legislatures and communities to defend and preserve the individual rights and liberties guaranteed to all people in this country by the Constitution and laws of the United States." Apparently, guardianship includes opposing pregnant women's right to informed consent. Perhaps, the ACLU is against informed consent as a patient's right in all medical procedures. That is doubtful. The ACLU would leave the decision as to what information is offered a pregnant woman, to the attending physician. I definitely wouldn't feel safe with a **guardian** who would prevent me from receiving pertinent information from sources other than the doctor, who is being paid to do my surgery.

"Founded in 1916, Planned Parenthood is the world's largest and oldest voluntary family planning organization. Planned Parenthood is dedicated to the principles that every individual has a fundamental right to decide whether to have a child, and that every child should be wanted and loved." It would appear that Planned Parenthood wants women to be able to opt for abortions without the benefit of informed consent. It is important to note that Planned Parenthood is a business, not a social program. Informed consent may not be good for business, despite being good for women.

The Department of Health and Social Services' mission statement asserts, "The Department's mission is to promote, protect and provide for the health and well-being of the people of the Northwest Territories." Surprisingly, the Department of Health and Social Services doesn't consider informed consent to be integral in promoting, protecting and providing for the health and well-being of women who are considering abortions. Rather than offering them a broad base of information, this organization is **protecting** them from information they claim some women may not understand.

After having considered the mission statements of these guardians, planners and protectors, I find them inconsistent with their opposition to such an important right for women. I am asking you to consider these inconsistencies, when you vote on House Bill NO. 112. I respectfully urge you to vote for every woman's right to be provided with **all** of the facts about how an abortion could affect her health and well-being.

Sincerely,



MIEC Loss Prevention

Claims Alert

Number 17
September 1998

Informed Consent Revisited: What Is Expected of Physicians

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Note: This Claims Alert *summarizes the general principles of informed consent. An enclosed supplement addresses specific consent issues in California, Hawaii, Idaho, Alaska and Nevada*

"Informed consent" has generated many articles, legal opinions and court decisions, yet it is still a misunderstood legal doctrine. The failure to obtain an informed consent is a common allegation in cases that involve surgery, invasive diagnostic studies and medications. In some cases, defendants are absolved of negligence, but are held liable for not adequately disclosing the material risks of treatment which prevented the patient from giving an informed consent. Many physicians think "informed consent" is something they give to patients. In fact, doctors obtain consent from patients who give permission to proceed after they have been informed of a proposed procedure's risks, alternatives and their risks, and expected outcome. To protect themselves from liability, physicians need a consistent policy for informing patients, and for obtaining and documenting patients' informed consent.

Why we have consent laws

In 1914, New York State Supreme Court Justice Nathan Cardozo said, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." Every state's courts recognize this principle. Issues such as *what* a patient needs to know in order to give an informed consent, *who* must provide the information, and *how* to document that an informed consent was obtained are determined by state law and standards of practice in each medical specialty.

Implied consent for minor procedures and for emergencies

Even though a patient may not sign a document or verbalize consent for a particular medical procedure, a patient's conduct will imply consent in some instances. The patient's acquiescence to medical procedures is evidence of consent. For example, the patient may hold out an arm to allow blood to be drawn without ever articulating consent, but consent to the blood test can reasonably be inferred from the patient's conduct. Implied consent is a legal recognition of the reliance on nonverbal communication in simple situations. Consent may not be routinely implied, however, where a medical procedure is complex or not commonly understood by a lay person.

Emergencies: The law generally assumes that a patient who is *in extremis* and unable to communicate would nonetheless desire that appropriate medical assistance be rendered. Unless it is known that the patient does not desire treatment, or unless the patient is able to communicate his or her conscious refusal, in an emergency one may render aid or care to prevent loss of life, serious injury or illness. The emergency doctrine is a form of implied consent. However, implied consent in this circumstance lasts only as long as the emergency, and formal consent must be obtained for procedures performed after the emergency has passed.

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Benefits of informed consent

Studies cite these benefits of informing patients and obtaining their consent: (1) informed patients are less likely to sue; (2) informed consent discussions deter nonmeritorious claims that result from unrealistic expectations or misunderstandings; (3) informed patients are more compliant with medical advice and recover faster; (4) informed consent discussions strengthen doctor-patient relationships and increase patients' confidence in their doctor.

When consent is withheld for religious reasons

When a competent adult refuses treatment for religious or other reasons, there is little that a physician can do. The patient's decision cannot be ignored if the patient has made an informed decision, no matter how unwise. Courts usually respect the wishes of a competent adult to refuse treatment. A court may order medical treatment in very limited circumstances, such as for a mother where the welfare of an infant would be in jeopardy. Problems arise, however, if the patient is incompetent or of questionable competence, or is a minor whose parents refuse to consent to medical treatment in spite of serious medical consequences. If the adverse consequences to the patient are sufficiently grave, the physician may try to obtain consent by asking the family to convince the patient to consent to needed medical care. When persuasion fails, a court may order needed medical treatment directly or by through a temporary guardianship.

MIEC's Claims Department will attempt to assist an insured in situations in which a court order may be needed. See the state law insert for additional discussion of this topic.

Answers to common questions about informed consent

Does getting the patient's signature on a consent form suffice? Not always. A consent form is not the same as informed consent, and the signed consent form is not a substitute for an oral discussion. Even in states in which a signed consent form is regarded as evidence that the patient did give an informed consent, malpractice defense attorneys have considerable difficulty refuting a plaintiff's claim that he or she signed a consent form, but did not understand its contents. Plaintiffs' attorneys are aware that some patients are informed of risks and see a consent form for the first time just prior to surgery. Plaintiffs have successfully argued in court that they were unable to make informed choices minutes before being taken to the operating room. Others have claimed in litigation that even though they had questions or did not fully understand a proposed procedure, they signed the hospital's consent form "under duress," when told that unless they signed, the procedure would be canceled or rescheduled.

Who is responsible for obtaining a patient's informed consent? In most jurisdictions, obtaining consent is the obligation of the physician who will perform a procedure. *(State law may allow consent to be obtained by another physician who is able to perform the procedure and is familiar with the benefits and risks, but who may not perform the procedure on the subject patient. This is a common practice among anesthesiologists and radiologists.)* Courts have recognized that, with respect to a specific patient, only a qualified physician can determine if a procedure is indicated and explain the risks for that patient. Nonphysicians, including nurses and medical assistants, can help educate patients in a general way about a procedure and answer basic questions. But the physician must "fine tune" this information, based on a specific patient's medical condition and history.

How much information does a patient need to give an informed consent? This varies, but in general, physicians are required to tell patients the nature and purpose of a procedure or other recommended treatment, the "significant" or "material" risks, alternative treatments and their benefits and risks, including no treatment, and the expected outcome. "Significant" or "material risks" are those that involve potentially serious temporary or permanent injury or disability. For major surgery, significant risks may include death, paralysis, hemorrhage and infection. Certain procedures involve additional specific risks. For example, a significant potential risk of abdominal surgery is injury to adjacent tissues and organs. The failure of a procedure to resolve a medical condition, or the need to redo a surgery are significant risks of some neurological, ophthalmological and cardiothoracic surgeries. The more elective a procedure, the more physicians are obligated to disclose the risks and less risky alternatives. State laws generally embrace a "reasonable person standard," a "reputable physician standard," or both, for determining how much information a person needs to know for his or her consent to be an informed one. Under a "reasonable

person standard," physicians must disclose what a reasonable person in the patient's situation would need to know in order to make an informed decision. Under the "reputable physician standard," a doctor must disclose to patients what other reputable physicians who perform the same procedure ordinarily disclose to their patients. Both standards must be met in some states. Another guideline for what to disclose to patients is subjective: if the patient was your [the physician's] spouse or child, how much information would you and the patient want to have before consenting to the procedure?

Doesn't telling patients about the risks of surgery frighten them away from needed treatment? Studies show more patients decline surgery because of a lack of information than because they were told the risks of necessary surgery.

In some states, the so-called "therapeutic privilege" permits a physician to withhold a discussion of potential serious risks if the physician has good reason to believe that disclosure would be so upsetting that the patient would not be able to make a rational decision. Physicians should use this therapeutic privilege judiciously. When a patient's emotional or physical condition makes the doctor reluctant to disclose significant risks, the discussion can take place with a spouse or other close relatives. If the patient has no available family, the physician might ask a colleague to evaluate the patient and concur that it would be prudent to not discuss the potential risks.

Do risks have to be disclosed if the patient does not want to know? Patients can decline an informed consent discussion, a decision the physician should document. If the surgery is elective or if nonsurgical alternatives are possible, the physician should encourage the patient to listen to the choices and their risks. Prudent physicians often decline to do elective surgery if a patient is unwilling to be informed about potential risks, adverse outcomes or failure of the surgery. Such patients usually have unrealistic expectations.

California and other states have an **"informed refusal"** doctrine. This doctrine holds that competent adult patients have a right to refuse treatment, surgery, tests or referrals, even if they could suffer severe consequences as a result. Informed refusal requires physicians to disclose material information a patient needs to make an informed decision.

To help a patient understand, the physician should explain the likely, known consequences of not having a surgery, test, medication or referral. A patient who declines treatment for malignant cancer can be told the probable result of foregoing treatment. There is less certainty about what to tell a patient who refuses a test or X-ray the doctor needs to make a diagnosis. In such cases, the physician should explain why the test is needed and what problems could remain unidentified and untreated if the test is not done. How much to disclose depends on what a reasonable person in the patient's position would regard as significant.

Document consent, refusal

For reasons noted earlier, a signed consent form is less likely to be questioned in litigation if it is backed up by a physician's handwritten or dictated note that verifies an informed consent was obtained. Defense attorneys recommend that physicians document their informed consent discussion with a note such as: "I advised patient of the purpose, benefits and significant risks of this procedure, including but not limited to bleeding, infection, [damage to adjacent structures or organs] [other specific, common risks]. I also discussed alternative treatments and their risks, and the risks of non-treatment. I answered patient's questions. (S)he expresses understanding of the risks of the procedure and gives his/her informed consent." Documentation of the informed consent discussion may be handwritten or dictated, and should be made in the physician's office progress record, the hospital admission history and physical report, or both, **but not in operative or procedure reports.** These reports are dictated **after** a surgery or procedure. If problems occur, notes about **preoperative** discussions of complications or adverse outcomes in these after-the-fact reports appear self-serving and may lack credibility in court.

Physicians are encouraged to ask patients to sign a plain-language consent form for office surgery when the procedure is discussed. Include statements on the form for the patient to initial such as: "Dr. *(name)* has explained to my satisfaction the purpose, benefits and alternatives to this procedure, the significant risks, and the consequences of not having the procedure. The doctor answered my questions about the procedure. I wish to proceed." *(A sample form to memorialize the informed consent discussion that takes place in the doctor's office, and which is signed after this discussion, is included with this newsletter.)*

Physicians should document a patient's informed refusal of surgery, diagnostic studies, treatment

or referral to another physician. A brief chart note such as, "Patient refuses test [or procedure]; explained consequences of not having treatment [surgery; referral] and degree of urgency; patient expresses understanding of risks," generally suffices.

Use audiovisual, written aids

It takes time for a physician to explain why a patient needs surgery, what the surgery will entail, alternatives, and the potential risks; it also takes time to listen to and answer the patient's questions. Using written materials and audiovisual aids to supplement, not replace, a physician's face-to-face informed consent discussion with patients facilitates the process and reduces the amount of time doctors must spend explaining procedures and answering questions. In most instances, written information is essential, as many patients cannot remember most of what the doctor told them after they heard the words, "You're going to need surgery." A handout that describes the procedure in plain language and summarizes the key points of the doctor's oral discussion gives the patient another opportunity to review the choices before making a decision. Equally important, patients can take written material home to educate and inform a spouse or other family members. Documentation that written information was dispensed strengthens the doctor's position in a malpractice case in which the patient does not remember preoperative discussions. A number of vendors market informed consent videotapes, computerized consent education programs, and other materials that reduce the amount of time the physician must spend explaining and reiterating.

Summary of Recommendations

1. Understand your state's informed consent laws. Get advice from MIEC's Loss Prevention or Claims Departments if in doubt about what is required in specific situations.

2. Ask colleagues in your specialty what they disclose to patients about specific procedures; physicians in group practices should know how their colleagues obtain and document informed consent.

3. Use plain language to explain medical procedures to patients. The law does not require physicians to give patients a mini-course in medicine or to disclose every problem that could occur.

4. Encourage patients to ask questions. Consider asking the patient to invite a spouse or other relative to join in the informed consent discussion. Don't be offended if a patient seeks a second opinion about the surgery or tests you recommend. Third-party payers often require second opinions; support for your recommendation is a plus.

5. Train your staff to assist you to educate patients and families generally about treatment or surgery. Use written materials, models and audiovisual aids to supplement discussions. Document educational efforts.

6. At the conclusion of an informed consent discussion, ask the patient to sign a consent form, even if the hospital has its own. Sign the form yourself and give the patient a copy.

7. Document a summary of your informed consent discussions in your office chart and in the hospital admitting history and physical report (**not in the operative report**); include the name and relationship of others who were present, and the name of foreign or sign language interpreters who participated in your discussions with the patient.

8. Don't wait until the last minute to discuss a surgery or procedure in order to obtain a patient's informed consent.

9. Don't delegate the task of obtaining a patient's informed consent to your staff or to hospital staff. Although these individuals can help educate patients in a general way about a planned surgery or procedure, a physician should explain to individual patients why they need surgery, what the risks are, and feasible alternatives for that patient.

10. Don't confuse "informed consent" with "consent form." In most jurisdictions, a signed consent form carries little weight if the physician has not discharged his or her obligation to inform a patient of the material risks of a surgery or procedure, as discussed in this newsletter.

11. Don't give guarantees, make exaggerated claims or minimize risks. Patients should understand that problems can occur under the best of circumstances and in the most skilled hands. Refer to the literature, and consider your own experience when responding to questions about the historical success of a surgical procedure.

See supplement for informed consent laws in Alaska, California, Hawaii, Idaho or Nevada

Alaska Supplement to MIEC *Claims Alert* #17

Informed Consent Revisited: What is Expected of Physicians

This supplement contains excerpts from Alaska laws related to informed consent, consent by minors and special consents. Alaska physicians who have questions about a specific patient or who require legal advice may call MIEC's Claims Department in Oakland at 800/227-4527. For general liability questions, physicians and their staff can call MIEC's Loss Prevention Department in Oakland, CA at 800/227-4527.

Informed Consent

In Alaska, the law on informed consent is derived largely from common law and statutes. Court decisions modify and explain the law. The judge in an informed consent case may instruct the jury that:

"A physician is required to give his patient enough information to make an informed decision whether or not to undergo the treatment. If the physician does not do so, he may have to pay for the patient's injury, even though the treatment itself was performed with reasonable care.

"For the plaintiff to win on his claim that he did not give his informed consent, you must decide it is more likely than not that the following things happened:

"1. The treatment was a legal cause of the patient's injury;

"2. The defendant did not tell the plaintiff about the common risks of or reasonable alternatives to the treatment; and

"3. The plaintiff, had he known about these common risks and reasonable alternatives, would not have consented to the treatment given." [*Trial court adaptation of Alaska Jury Instruction 8.06, partial*]

The Alaska Supreme Court has held that a physician is obligated to provide, in layman's terms, the information that a reasonable person in the patient's position would need to know in order to make an informed and intelligent decision about the proposed treatment. A physician must disclose all "material" risks. A risk is material if the probability of that type of harm is a risk a reasonable patient would consider in deciding on treatment. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms. [*Korman v. Mallin*, 858 P.2d 1145 (Alaska 1993)]

Alaska law recognizes that on some occasions a candid and thorough disclosure of information will have an adverse effect on the patient's condition or health. The law allows the physician, in his or her discretion, to withhold such information or to phrase it in a manner that will not upset the patient: "it is a defense to any action for medical malpractice based upon alleged failure to obtain informed consent that . . . the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because the health care provider reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition." [*A.S., Section 09.55.556(b)(4)*]

The decision to withhold such information is based on a practitioner's medical judgment and must be substantiated in order to stand up in a court of law. Three basic criteria should be taken into account in reaching the conclusion that information should be withheld or phrased in such a way as to not upset the patient:

1) The physician must take into account the facts and circumstances of the patient's case. Included in the evaluation should be the patient's physical and emotional condition, whether the patient can assimilate information in a candid and rational manner, and whether the informed consent process or treatment could be delayed under the circumstances, among other considerations.

2) The physician must believe that full disclosure of information will probably have a substantially adverse effect on the patient's condition. Mild upset of the patient would not justify failure to provide full disclosure; the patient must be in danger of significant detriment and impairment of his or her condition.

3) The physician must use reasonable discretion in the manner and extent of disclosure. If a decision is made against full disclosure, the disclosure must be tailored to meet the needs of the patient and geared to avoid an adverse impact on the patient's well-being. Documentation written at the time is necessary to support the decision to withhold information. A detailed note in the patient's health record must be made by the physician, including the physician's observations of the patient, reasons why the physician believes certain details should be withheld, a description of the

information that was not disclosed, a summary of the medical findings used to justify the decision not to disclose, and the details that were disclosed to the patient. Where there has been a decision to forego or limit the consent discussion, defense attorneys advise physicians to have a consent discussion with the patient's closest relative. A discussion with a relative may help the doctor determine the value of withholding certain details from the patient. Discussions with relatives should be noted in the chart.

Physicians are excused from disclosing risks if the patient requests not to be informed: "It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that ... the patient stated to the health care provider that the patient would undergo the treatment or procedure regardless of the risk involved or that the patient did not want to be informed of the matters to which the patient would be entitled to be informed." [See citation above] The patient's refusal to have the risks explained should be documented.

Who may give consent? Those who may consent for treatment of a patient include the patient himself, the nearest living relative (i.e., a spouse or parent), or the parent or guardian of a minor.

The courts have held that in certain urgent situations, in emergencies, and in cases in which the patient is unable to give consent, the physician may proceed without the formality of a consent discussion.

When a patient is mentally incapable of giving informed consent, a physician or mental health professional is required to obtain informed consent from the patient's guardian, spouse, or parent; where there is no guardian and the patient designates a specific adult, the designee may give consent. When necessary, application can be made to the court for an order to permit the treatment.

A patient who is capable of giving informed consent has an absolute right to refuse electroconvulsive therapy or aversive conditioning. The law also provides that a patient who lacks substantial capacity to make that decision may not be given such therapy without a court order.

Physicians should be familiar with each hospital's policy concerning obtaining consent from legally or mentally incompetent patients.

Who is responsible for obtaining consent?

In Alaska, statutory law makes a health care provider liable for failure to obtain the informed consent of the patient. Alaska law goes on to define health care provider as including a physician, chiropractor . . . and an employee of a health care provider. On its face, the statute may suggest that the task of obtaining informed consent can be delegated to an employee of a physician. *However, MIEC's legal counsel recommends that the physician not delegate to an employee the task of explaining the nature of a procedure or treatment that the physician proposes to do, or the risks attendant thereto, or the alternatives to the procedure or treatment. The physician should personally undertake this task.*

Consent for treating minors

The age of majority in Alaska is 18 years. A minor may, in certain circumstances, consent to receive medical and dental services, including the diagnosis, prevention and treatment of pregnancy, and the diagnosis and treatment of sexually transmitted disease. A minor may consent to medical treatment under these additional circumstances:

1. The minor lives apart from his or her parents and is managing his or her own financial affairs;
2. If a parent cannot be contacted, or if the parent is unwilling to grant or withholds consent, provided that the physician counsels the minor;
3. When the minor is the parent of a child; the minor parent may consent to medical treatment for him- or herself, as well as for the child.

Payment for treatment of a minor

The parents or guardian of a minor who consents to his or her own medical treatment under any of the circumstances outlined above, absent an emergency, are not responsible for payment for medical services rendered to the minor.

Treating minors in emergencies

In case of an emergency in which any minor is in need of immediate hospitalization, medical attention or surgery and, after reasonable efforts have been made, the parents or guardian of the minor cannot be located for the purpose of consenting to medical care, consent for emergency medical attention may be given by any person standing *in loco parentis* to the minor.

Parental consent for minor seeking an abortion

On February 25, 1998, Alaska Superior Court Judge Sen Tan ruled

in the case of *Planned Parenthood of Alaska v. State of Alaska* that it is unconstitutional to require written parental consent before a doctor may perform an abortion on an unemancipated minor under the age of 17. Specifically, Judge Tan indicated in his decision that such a requirement breaches a minor's right to privacy and her fundamental reproductive rights, which include the right to have an abortion.

The Court's decision also negates the "judicial bypass" procedure whereby a pregnant unemancipated minor under the age of 17 can file a complaint with the superior court to request the issuance of an order authorizing the minor to consent to her abortion.

The State of Alaska is appealing Judge Tan's decision to the Alaska Supreme Court. MIEC will notify Alaska policyholders of the Supreme Court's ruling.

Because this is an unsettled issue, physicians who have a question about a specific patient or who need legal advice are encouraged to contact MIEC's Claims Office for assistance.

'Informed Refusal'

Patients have the right to refuse medical treatment, surgery, or diagnostic tests. When a test or procedure is recommended but initially declined, physicians are encouraged to inform patients of the consequences of their refusal to undergo recommended treatment, surgery, or diagnostic tests. Because it is not always possible to know the eventual effect of the patient's failure to accept a physician's advice, the consequences of the patient's decision sometimes must be discussed in general terms. When the consequences are likely to be significant, such as the worsening of an existing condition, serious bodily harm or death, or the possibility that a serious disease will go undetected, the physician should review these possibilities with the patient. Whenever a patient refuses to undergo recommended treatment, surgery, or diagnostic tests, the physician should note the patient's decision in the medical chart, and also indicate that the risks of the decision have been discussed with the patient. As with all entries, such notes should be initialed and dated.

Revised October 1998

Physician's Surgery and Procedure Consent Form

[*For completion at conclusion of informed consent discussion*]

Date:________________. Time:______ am/pm

_ 1. *Initials* — I consent to the performance of the following operation or procedure *(technical name)*: ________________________________ upon ____________________ *(myself or name of patient)*.

The purpose of this operation or procedure is *(lay language)*: ________________________________ and will be performed by ______________________ and whomever (s)he may designate as assistants.

__ 2. *Initials* — The nature and purpose of the operation or procedure, the benefits and risks of the operation or procedure, the possibilities of complications, and the alternatives to this operation or procedure and their risks and benefits, have been explained to me.

__ 3. *Initials* — It has been explained to me that a satisfactory result is expected, but that the following are some of the complications or effects that could or may occur: bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations, and in rare instances, paralysis or death; other: ____

__ 4. *Initials* — No guarantee or assurance has been given by anyone about the results that may be obtained.

__ 5. *Initials* — I consent to the doctors performing whatever different or additional operations or procedures they deem necessary or advisable during the course of the operation or procedure.

__ 6. *Initials* — I consent to administration of such anesthetics as may be considered necessary or advisable for this operation or procedure.

__ 7. *Initials* — I do not have allergies or intolerance to anything except __________________________.

__ 8. *Initials* — I was invited and encouraged to ask any questions I may have. All of my questions have been answered to my satisfaction.

I have read and understand the content of this form and have received a copy.

____________________ ______________________________________
Witness to signing — Patient, parent or person authorized to sign for patient *(please print)*

____________________ ______________________________________
Physician's signature — *Signature* of patient, parent or person authorized to sign for patient

✔ COPY GIVEN TO PATIENT

Subject: **TESTIMONY--HB112**
Date: Sun, 22 Apr 2001 10:31:30 -0800
From: "R. Holmes Johnson" <drbob@keaconnect.net>
To: Representative_Fred_Dyson@legis.state.ak.us

Fred Dyson, Representative
State of Alaska
State Capitol
Juneau, Alaska 99801-1182

Dear Mr. Dyson,

When I had to leave before testifying at the Saturday teleconference on HB112, the LIO in Kodiak forwarded an article of mine that was published in the Kodiak Mirror when I was in practice. The "going public" in the initial paragraph refered to picketing that had just begun and therefore removed the need for secrecy. I was quite happy to "tell it like it is" to correct many misconceptions created by opponents of abortion.

I would urge you to read the article since it establishes my experience and thus qualifies me to testify on this proposed legislation.

HB112 is an unnecessary bill. It needn't have been introduced at all since: a) the Alaska Department of Health presently distributes much information on pregnancy and abortrion, since; b) *informed consent* has been reiterated so many times that no sane phyisian fails to explain whatever procedure is being considered and to obtain signed consent, and since; c) abortion should not be singled out as the *only procedure* in Alaska to be subject to such mandatory "extra" counseling.

Though making a studied effort toward objectivity, the details which serve as an impediment to free choice (of what one wants to know), and the use of the term *unborn child* in place of the proper term *fetus*, make it fairly obvi us that this bill was written by those who do not approve abortion!

I heard testimony on SB91 a few days ago by a woman who quoted unbelievable complications of abortion, particularly serious psychological problems. Dr. C. Everett Koop, Surgeon General under President Reagan, himself *not in favor of abortion*, did an exhaustive study of abortion and found *no evidence* of psychological effects. My own experience supports Dr. Koop. This suggests that those who feel abortion is *murder* are so biased that they transmit this to those whom they interview and suceed in creating severe guilt feelings would be, indeed, complications, *but not of abortion.*

Please keep in mind that a woman, now, has the right to ask any question at all of her physician and he has the obligation to answer that question to the best of his ability. To have someone else, particularly legislators, dictate what she must know, is an insult to her intelligence and, furthermore, overlooks individual differences and individual needs.

In summary, this bill is redundant and should not have been introduced at all. It places an unnecessary impediment to the free exercise of choice which has been the legal right of women since Roe vs. Wade. Had it always been their legal right, we would not have seen the *serious complications* that *were* a result of back alley abortionists. To add impediments to free choice, as has already been done in a number of ways, is to chip away at one effective and necessary form of population control.

Realize that I am retired and have nothing to gain personally! I write in defense of women who

become unexpectedly pregnant who should be free to choose what they want to know about their options as well as which, among them, to select. This bill interferes with that freedom and should be buried!

Sincerely,

Dr. Bob Johnson,
drbob@keaconnect.net
Phone 907--486-5171
Box 945 Kodiak 99615

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House HESS
Committee Name

Committee on HB 112 Informed Consent Dated Mar. 8, 2001
Bill / Subject

"Information-providing" should always be a given before a mother makes a medical decision such as abortion. I personally would want to know my risks of the surgical procedure, who my abortionist is, and any other information that would help me to move forward with information and not blindly [having regrets afterward with new knowledge]. The pamphlet requirement is excellent, and the accountability by the Physician in writing assures a checks and balances that is built into our government. This is an excellent piece of legislation that will help women.

SIGNED: Ruth Ewig
Testifier

Alaska Interior Right to Life
Representing

2325 - 30th Avenue, Fairbanks, Alaska 99701
Address / Phone Number

HB112

HB112 Testimony

My name is Debbie Joslin. My husband, Steven and I live in Delta Junction with our three children; Matthew, Emily and Victoria. Steven is the resource forester in our area. I am a homeschooling mom. I teach 3rd and 4th grade Sunday School at my church.

On January 15, 1999 I was 22 weeks pregnant when we drove 100 miles to Fairbanks for an ultrasound on our child. After a lengthy examination of the baby, I was told we were expecting a male child with multiple anomalies. The baby we named Isaiah John had a brain cyst, a missing or unconnected stomach and a hypoplastic left heart. We were given the name of a Perinatologist in Anchorage. A Perinatologist, as I understand it, is a doctor who specializes in unborn babies who have serious health complications. I spoke to this specialist over the phone and made arrangements to go to Anchorage and have another ultrasound. During that phone conversation she urged me to have the pregnancy terminated. The reasons she listed were that the baby would probably die anyway, the medical expenses would be too great and that my own life was probably in danger. Keep in mind, she had not examined me at this point. I made an appointment with this doctor, since I was told she was the only Perinatologist in the state. My husband and I drove 350 miles to keep that appointment, leaving Delta at 40 below zero. When we arrived for our appointment we first saw a genetic counselor who went over some family history with us and explained that they thought Isaiah had Trisomy 18, a chromosomal abnormality (an extra number 18 chromosome). She expressed surprise that we were not considering terminating the pregnancy and asked several times whether we wanted to consider terminating the pregnancy. Another ultrasound was performed by a technician and then the Perinatologist took over the exam and listed the following anomalies: Brain cyst, missing or unconnected stomach, hypoplastic left heart, eyes not properly spaced, underdeveloped chin, something wrong with spinal development, something wrong with his penis, rocker bottom feet, possibly an extra toe and fluid in the abdominal cavity and lungs. We were told the fluid indicated that Isaiah was already in congestive heart failure and that he would never make it to his due date in May. The Perinatologist told us that Isaiah would never respond to us if he were to live, we were told that all Trisomy infants were severely mentally retarded. She described a somewhat vegetative state but more probably he would be stillborn any day. She said that if he were to be born alive he would only live for a few minutes. Later they adjusted it to a few hours and then later yet they said maybe a day at most and then finally they said a few days. We agreed to an amniocentesis to determine whether Isaiah did actually have Trisomy 18. Our hope was that he would not, and we could begin to make plans for heart surgery. She told us doctors will not operate on Trisomy infants since they ALL die in infancy anyway.

You can imagine what heavy hearts we had as we drove back to Delta. The plans and dreams I had had for my son were shelved as we instead discussed his funeral. Within a few days I got a call from the genetic counselor with the preliminary test results which showed Isaiah had Trisomy 13. I asked how that differed from Trisomy 18 and she said it was worse. She asked again about termination and I told her again that we were not interested in that. Almost immediately I got a call from my doctor in Fairbanks who asked

me about termination. I told her (again) that I was not interested in that. She told me that since my life was in danger and I had chosen to continue with the pregnancy, she could no longer be my doctor as she was a general practitioner and not qualified to handle such a case. I began seeing the osteopath doctor in Delta and an OB/GYN in Fairbanks. I told them what I had been told about the baby and about my own health. The OB/GYN doctor told me he could not understand why I had been told my life was in danger. He treated me during the remainder of the pregnancy and I never had any complications or problems. Only the usual complaints pregnant women suffer from.

A couple of weeks after the preliminary results, the genetic counselor called with the final results from Isaiah's amniocentesis. It was final - Isaiah had Trisomy 13. She asked me again about termination and I told her no again. I then asked her out of curiosity what she would do if I did say yes. She got very excited and told me that "there is the most wonderful clinic in Kansas". I asked if she meant Dr Tiller's clinic and she said "yes, do you know him"? "No, I told her, but I know about him". She offered to have other women who had had abortions call me but I declined. Sensing that I was not interested in pursuing this any further she told me in a very apologetic voice that "there is a parent support group, but well....they are rather positive". She made it sound as though positive was a bad thing to be. She then went on to tell me that she had information on the group including an 800 number as well as pamphlets and books in her office that gave detailed information about Trisomy 18, 13 and related disorders including pictures. I called S.O.F.T. (Support Organization for Trisomy 18, 13 and Related Disorders) right away and found that they were indeed positive - but realistic. I told the woman over the phone about Isaiah's diagnosis and she told me that probably they were right but there was a chance he could live She talked to me about the other "parents" and I remember asking her, "parents, you mean they have children?" "Yes, some did,"she said. "How old". I was told that they varied but there were a few children who were teenagers and even a couple of adults. The lady took my name and address and told me she would send me a family packet right away. I also requested the books they had available; Trisomy 13, a Guideline for Families and Care of the Infant and Child with Trisomy 18 or 13. These were the books the genetic counselor had described, the very ones she had in her office. While the information was heartbreaking, it also offered some hope and some help. Two things we hadn't had much of. Not only did some of these children live - they played and smiled and laughed and talked and learned things and showed affection and responded to love and affection.

We located a wonderful pediatrician in Fairbanks who agreed that Isaiah's chances were not good but she was willing to do what she could to help him. We made the decision to hire her and made plans to deliver our baby in Fairbanks. On May 10, only 11 days before his due date, Isaiah John Joslin was born at Fairbanks Memorial Hospital. He weighed 6 lbs 1 oz and was 18 1/4 inches long. Isaiah was a pretty baby with lots of bright red hair. Isaiah had difficulty breathing when first born but as the doctors and nurses checked him over they could find no sign of the problems seen earlier on three different ultrasounds. The brain cyst, stomach problem and hypoplastic heart were all missing as were all of the other problems earlier noted. However, Isaiah suffered from a ventricular septal defect

(VSD) - a hole in his heart. Although very serious, it was a far cry from the problems he had had earlier. Isaiah required oxygen and a nasal gastric tube for feeding. Because of the hole in his heart he was too weak to nurse and had to be fed with a tube. Isaiah looked so normal that even the nursing staff agreed we should retest him. Test results again showed Isaiah to have Trisomy 13. He stayed in the hospital for 12 days and then came home where we cared for him for 20 days before he left us to go to be with the LORD in heaven. Those were some of the hardest but sweetest days of my life.

I am telling you this story so you can understand why I stand before you today and ask that you pass [illegible]. HB112

After talking to other doctors and doing a great deal of research and reading about Trisomy infants and because of my own personal experience, I believe my life was never in any danger. Yet, this undue burden was placed on me at a time when I already had plenty to worry about. I believe this was done to try and convince me to have the abortion.

I was told that ALL Trisomy infants die. I now know that somewhere between 90 and 95% of all Trisomy infants die before one year of age. That doesn't leave much room for hope I realize but it is quite different than saying they ALL die.

I was not told about the parent support group (S.O.F.T.) for over two weeks not until they had finally given up on talking me into an abortion. Well, you may say they were not sure your child had Trisomy until the final results were in. Perhaps, but they were sure enough that they continually brought up termination. I drove 350 miles to see the doctor and was never shown the written information about this disorder that they had right there..

Though they were careful to tell me every negative thing they could about the baby, I was never told of any of the risks of having an abortion. There was never any mention made of the risk to my health, either physical or emotional from having the abortion.

I believe the doctors who repeatedly brought up termination probably meant well. The problem comes in where they apparently believed that their professional status, or their medical degrees placed them in a position to know better than me what was best for me, my family and my baby. That simply is not true.

Giving life to Isaiah was hard on our family. But it wasn't TOO hard. It was expensive. But it wasn't TOO expensive. It was hard on the other children. But it wasn't TOO hard on my other children. Giving life to Isaiah blessed our family, including the other children. Because of his heart condition Isaiah was always lethargic and sleepy and tired acting but he was never in pain. The equipment which monitored his oxygen saturation rate showed that whenever we held him or showed affection to him, Isaiah was aware of it. His saturation levels would soar when he was being loved on. My daughter, Emily who is five loves to recount the story of how Isaiah's oxygen saturation level was in the 60s the night before he died. I laid him in Emily's arms and immediately his saturation level rose to 100. There seems to be a feeling out there that a successful life is one that is free from pain or

suffering or trials and that isn't true. Isaiah's life was successful. We loved him and he loved us.

We have been comforted and encouraged even since Isaiah's death by reading of other families with Trisomy children in the S.O.F.T. newsletter. The letters and testimonials are all expressions of the love each family has for their infant or child. Many of them include pictures of their precious children, most of them deceased but some still living. Some of them telling stories of medical professionals pressing them to have abortions are very similar to our experience. Without exception every family expressed love and gratitude for the time they had had with their children, no matter how short.

Uniform written information should include basic facts regarding fetal development and the risks associated with continuing the pregnancy versus terminating the pregnancy. Crisis pregnancies come in many different forms. For some women it can be as simple as finding out about WIC, others are not even aware that the child's father is legally responsible for helping to provide support. Over 90% of all babies diagnosed prenatally with Downs Syndrome are aborted. Could it be that those women don't know about the parent support groups out there? Information on adoption agencies should be as readily available as information on abortion. There is a wealth of information out there and it would be a great help to doctors to have a booklet they could hand out to their patients.

Of course I would like for every mother to make the same decision I did but I realize that won't happen. But every mother deserves to have all of the information pertinent to her situation so that she can make an intelligent informed decision. I stand before you today and say that if you vote against ~~HB329~~ HB112 you are saying, in effect, that women are not competent enough to be trusted with the facts regarding the health of their own bodies and that of their unborn children. A "no" vote says that you have no compassion for families and believe that doctors are better suited to make decisions for women and their unborn babies.

A "yes" vote for ~~HB329~~ HB112 sends an entirely different message. A vote *for* informed consent says that you have respect for the intelligence of women and believe that they have the right to be trusted with the information necessary to make decisions for themselves. I trust and hope that this body of legislators will prove themselves to be in favor of women's rights.

Thank you.

Debbie Joslin
Box 377
Delta Junction, AK 99737

(907) 895-4565

Alaska Civil Liberties Union

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To: House HESS Committee
From: Jennifer Rudinger, Executive Director
Date: Thursday, March 8, 2001

Re: **HB 112 – MANDATORY EXTRA "COUNSELING" FOR ABORTION**

The US Supreme Court's 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey upheld, among other restrictions, a Pennsylvania law requiring that physicians provide women with state-prepared anti-choice materials prior to the abortion procedure. The law forces a doctor to provide every woman seeking an abortion with information that is intended to discourage the procedure -- even if the information is irrelevant, unnecessary, and ultimately harmful to her health.

Such "biased counseling" laws are currently enforced in more than a dozen states. In a number of other states, these laws have been enacted but are enjoined or otherwise unenforced. Often introduced under the deceptive label of "Informed Consent" or "Women's Right to Know," biased counseling laws in fact serve to hamper women's access to abortion.

Alaska, however, is one of several states that evaluate restrictions on women's reproductive choices under the stricter standard of judicial review established by the US Supreme Court in 1973 in Roe v. Wade. Therefore, the Casey analysis and conclusion do not apply when an Alaska court reviews laws such as HB 112, and it is our opinion that HB 112 may be unconstitutional under the Alaska Supreme Court's decision in Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice, et al. in 1997.

Aside from our concerns that HB 112 may violate the Alaska Constitution, there are many reasons why the bill is bad public policy.

1. **This Mandatory Extra "Counseling" Gives Women Inaccurate and Irrelevant Medical Information.**

Mandatory extraneous lectures do not give women accurate or meaningful medical information. HB 112 puts words in doctors' mouths and forces them to run through a litany of conceivable pro's and con's for abortion and for all alternatives to abortion – even when those alternatives are not in the patient's best interest and may even *harm* her. Yet, women who are seeking prenatal care in order to carry a pregnancy to term are *not* forced to waste time and money listening to a diatribe about their options and alternatives to pregnancy and

childbirth, even though the mortality risk of full-term pregnancy and childbirth is more than 20 times *greater* than that of a first-trimester abortion.

2. **HB 112 refers to "possible psychological effects that have been associated with having an abortion," substituting politicians' judgment for that of doctors.**

This reference is misleading because no such psychological harms have been proven to exist. In fact, according to a 1987-88 investigation by the former Surgeon General of the United States, Dr. C. Everett Koop (who is no champion of choice), as well as a study by the World Health Organization, there is no medical evidence that abortion causes psychological injury. On the contrary, relief is the most common reaction to a voluntary abortion, whereas women who are forced to continue unwanted pregnancies suffer adverse and sometimes severe psychological consequences. It should be left to doctors to decide, based on their best medical judgment, what risks and benefits are relevant to their particular patients and what medical information is scientifically sound.

3. **Requiring That *Physicians* Deliver These Extraneous Lectures Makes Access to Quality Reproductive Health Care More Difficult and Expensive.**

HB 112 prohibits a trained counselor, nurse, or other health care practitioner from providing this mandatory lecture to the patient, requiring instead that a doctor deliver the state's message. This requirement has a direct effect on women's health. Many clinics experience serious difficulty in finding doctors willing and able to perform abortions, and the few who are available often find themselves barely able to meet the needs of their patients. By prohibiting doctors from delegating counseling and related tasks to other trained professionals, these laws make it far more difficult for clinics to provide women with the quality health care they deserve. Furthermore, since a doctor's time costs much more than that of a nurse, clinician, social worker, or counselor, the doctor-only stipulation drives up the costs of abortion and other health services provided by clinics.

4. **Informed Consent Is Already Required For All Medical Procedures.**

A woman must already give her informed consent before undergoing *any* surgical procedure, including abortion. The standards of the medical profession, as well as state laws, ensure that health care practitioners provide women with accurate and unbiased information regarding the risks and benefits of their various treatment options, and obtain their informed consent. HB 112 singles out abortion from all other medical procedures. Implicit in the requirement of a biased lecture is the assumption that women do not adequately think through their abortion decision and that the State must do their thinking for them. This assumption reflects a lack of respect for women's moral decision-making. In fact, virtually all women have carefully considered their decision to have an abortion by the time they arrive at the clinic. Clinics in Alaska routinely refer for additional counseling the small number of women who remain ambivalent.

5. Biased Counseling Requirements Violate Standard Medical Practice and the Doctor/Patient Relationship.

HB 112 requires a doctor to supply all of the state-mandated information to every woman in every instance in order to avoid liability. This state-imposed litany may conflict with the doctor's ethical obligation to give the best medical advice to the patient, in view of her individual circumstances. For example, it is both pointless and cruel to "inform" a victim of rape or incest that she has the "alternative" of raising the "unborn child" (as though she did not already know this), or to remind a woman carrying a fetus with impairments so severe that it could never survive outside the womb that her "unborn child" will be 20 weeks old at the time of the abortion. Indeed, the American Medical Association has resolved to oppose these types of measures, finding that "informed consent requirements [for specific medical procedures] often are not medically indicated and never are appropriate areas for codification in law." [American Medical Association, "AMA Opposition to 'Procedure Specific' Informed Consent," House of Delegates Resolution 226 (A-99).]

HB 112 is a perfect example of why legislators should not insert themselves into the business of practicing medicine. The definitions of "fertilization" and "gestational age" contained in the bill are medically inaccurate, and the definition and use of the term "unborn child" is both medically inaccurate and inflammatory.

6. Conclusion: HB 112 Endangers Women's Health and Violates Women's Constitutional Right to Reproductive Choice.

HB 112 is not created to protect women's health. The purpose is clear: this bill is designed to make a woman's very personal decision even more difficult. Fear of civil sanctions and the intrusive nature of the state-prescribed litany also serve to deter doctors from performing abortions, further exacerbating the alarming present shortage of providers in Alaska.

The AkCLU respectfully urges this Committee not to place any further burdens on women's rights to choose abortion. Please feel free to call on me if you have any further questions or concerns. I can be reached at (907) 258-0044 most days, from mid-morning until mid-evening.

Thank you very much for your careful consideration.

March 7, 2001

Rep. Fred Dyson

Rep. Peggy Wilson

Rep. John Coghill, Jr.

Rep. Vic Kohring

Rep. Gary Stevens

Rep. Sharon Cissna

Rep. Reggie Joule

I recently read House Bill No.112 proposed by Representatives Coghill and Dyson. I must object to this bill on multiple grounds. This bill is a thinly veiled attempt squarely aimed at making it more difficult for women of Alaska to receive abortions. It contains biased language throughout, and indirectly suggests placing new limitations on the availability of the abortion procedure.

The bill claims to be about informed consent. As physicians, we are quite familiar with informed consent. If there is a complication of a procedure and informed consent was not obtained, we are painfully aware of the consequences. Getting proper informed consent before an abortion is very high on my list of priorities. Contrary to what some people may think, there is no monetary gain in performing abortions to a physician who does both prenatal care and abortion. If a patient carries a pregnancy to term, our practice will see a much larger revenue stream than if the patient has an abortion. There is no incentive on our part to encourage abortion over an ongoing pregnancy.

The bill starts in a biased manner by saying that it is meant to "ensure informed consent before an abortion may be performed, except in the cases of medical emergency." A pregnancy has several possible outcomes including carrying and delivery, abortion, adoption, miscarriage, and ectopic pregnancy and others. There is no mention of giving informed consent to women regarding carrying a pregnancy to delivery, or giving the pregnancy up for adoption. In my practice as a physician, I perform abortions as well as multiple other procedures including both office and hospital procedures. The legislature has not chosen to pass a bill on how I obtain consent from a person for a C-Section, or hysterectomy – both of which carry far more risk to the patient than an abortion. Clearly, the abortion is being singled out, but not for medical reasons. This bill relates to politics and beliefs, not medicine or the safety of Alaska women.

Throughout the bill the term "unborn child" is used. A review of the 23rd edition of Stedman's medical dictionary reveals that the term "unborn" or phrase "unborn child" are not recognized. There are medical terms such as blastocyst, morula, embryo, fetus, and several others terms referring to the "conceptus." The term "unborn child" is included to incite only emotion. On page 2, line 25 the term "nonjudgmental" is used when the decidedly judgmental phrase "unborn child" is used in the very same sentence, a contradiction of terms.

In pages 1 line 1 through 3, line 23 a "standard pamphlet of information" is described, again using biased terms defined by the legislators, not terms recognized in science. Paragraph (7), page 2, lines 19-27 describes in detail the pictures that need to be included in this pamphlet. Why are those to be included? Are these meant to "educate" the patient regarding the fetal development when she is deciding whether to carry a pregnancy rather than to have an abortion? If so, where are the parallel photographs describing the complications of abortion as well as the complications

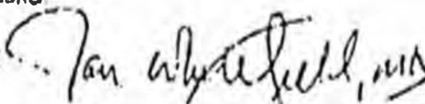
of carrying a pregnancy to term? Of what value are these pictures? When I counsel patients regarding an ongoing pregnancy or an abortion, should a patient ask me for drawings or photographs of a fetus at various stages of development, I have an encyclopedia containing the information, and I go over it with the patient, but I tailor the information to the needs of the patient. Each person is an individual, and a "standard information packet" alluded to by this bill leaves little room for patient individuality.

C. Everett Koop, and the American College of Obstetrics and Gynecology, after extensively reviewing the literature, concluded that there is no solid scientific data suggesting that there are long-term negative psychological effects from an abortion. Yet paragraph 8, page 2, line 31 refers to "possible psychological effects" that have been associated with having an abortion. Why should a patient be subjected to this concept when there is no proof that it exists, and will only serve to frighten the patient with false information? Informed consent should only involve only actual scientific information, not conjecture. ("Actual scientific information" is referred to in line 26, page 2) If this reference remains in the bill, where is the comparable line referring to the possible psychological risks of adopting a baby out?

This bill is not about science, nor about medicine. This bill is not about information or informed consent. This bill is simple bias, placing more obstructions in the paths of women seeking an abortion. The suggested body of information is already available, and gathering it as suggested is a duplication of efforts. The requirements of HB 112 serve only as an obstacle intended to discourage patients from choosing a procedure that is recognized as one of the safest performed in medicine.

The persons being served are not the patients, but the legislators who wish to further obstruct abortion in Alaska.

Jan Whitefield



Medical Director, Alaska Woman's Health Services

To: House HESS Committee
From: Dr. Sharon Smith
Date: March 7, 2001
Re: HB 112

I am a family physician working in Anchorage. I care for pregnant woman, perform deliveries, and care for the children of my patients. I do not perform abortions.

I have concerns about HB 112. Specifically, the requirement that DHSS develop and make available a standard information pamphlet describing the development of an "unborn child." The bill calls for "nonjudgmental information that is accurate, scientific information." The term "unborn child" is disingenuous and inflammatory, has no scientific basis, and has no place in a medically oriented document. Furthermore, the only women who would be required to ~~review the~~ receive unnecessary information would be those who are choosing to end their pregnancies.

You know, as a physician I perform procedures and obtain informed consent prior to all of them. Obtaining informed consent responsibly was an important part of my medical training. I am, frankly, insulted that legislators are comfortable dictating how consent be obtained for a specific procedure, that the bill's language implies physicians are not already obtaining informed consent, and that you find it within your duties to single out one procedure and place onerous requirements on a safe, simple medical procedure.

Sharon Smith, MD
6203 Green Tree Circle
Anchorage, AK 99516
346-3693

COMMITTEE:HOUSE HEALTH EDUCATION & SOCIAL SERVICES	SUBJECT:HB 112-ABORTION: INFORMED CONSENT; INFORMATION

DATE: March 8, 2001

PLEASE SIGN IN

VIDEO

PLEASE PRINT: NAME & TITLE	ADDRESS (MAILING & ZIP)	PHONE	REPRESENTING (No Acronyms, Please)	DO YOU WANT TO TESTIFY ?
~~Karen Pearson~~	Div of Public Health ~~DPH DHSS~~	465-8613	350 Main Suite 503	Yes
Peter Nakamura	2346 Ka See An Dr Juneau	790 2421	Self	Yes No
~~Geran Tarr~~	~~PO Box 1273 Girdwood, AK~~	~~783-1334~~	~~self~~	~~yes~~ NO
Renee EasyCart	PO Box #22237 Juneau	586-2549	Self	yes No
~~Amber Cefalu~~	Box 21872, Juneau	586-1085	Juneau Coalition for CHOICE	~~Yes~~ No

SITE: ANCHORAGE LIO

COMMITTEE: HHES and HEDU

DATE: 3-8-2001

SUBJECT OF MEETING:

HB-112

UPDATE #:

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
~~Deatrich Stahler~~			Y – HB 112 No
Dr Sharon Smith			Y – HB 112
Dr. Jan Whitefield		AK Women's Health Center	Y – HB 112
Jennifer Rudinger		AK CLU	Y – HB 112 No
~~Hugh Fleischer~~			Y – HB 112 No

SITE: HOMER LIO

COMMITTEE: HHES

DATE: 03-08-01

SUBJECT OF MEETING:
HB112:Abortion

Update #

THE SEAL OF THE STATE OF ALASKA

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY?
Eileen L. Becker		Homer Crisis Pregnancy Center	Y- HB112 YES
Amy Bollenbach			Y- HB112 NO

SITE: Fairbanks LIO

COMMITTEE (H)HES & EDU

DATE: 3/8/01

SUBJECT OF MEETING:

HB 112

UPDATE #: 1

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Ruth Ewig			Y

SITE: *Delta Junction*

COMMITTEE: House Health Education & Social Services

Date: 3/8/01

SUBJECT OF MEETING:
Overview: Helping kids succeed/Alaska Initiative for Community Engagement
HB 43, HB 112

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
~~Jackie Blood~~			Yes – HB 112 Yes
	(All testifiers for HB 112 ONLY)		
	Page 1 of 1 COPY 1		

SITE: Mat-Su LIO

COMMITTEE:

DATE:

SUBJECT OF MEETING:

UPDATE #:

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
~~Karen Vosbergh~~			Y HB112 Yes

Testimony of Renee Gayhart
Re: HB 112
March 8, 2001
House Health, Education, and Social Services Committee

Good afternoon Mr. Chairman and members of the committee. My name is Renee Gayhart and I appreciate the opportunity to testify today in opposition to house bill 112. I am testifying on behalf of myself.

House bill 112 would require that health care professionals give information to women who are seeking an abortion in an attempt to prey on their emotions and frighten them so that they won't get an abortion.

This bill would require a health care professional to show a woman pictures of fetuses and to describe the anatomical and physiological characteristics of a fetus. This is a tactic well-known to anti-abortion extremists who ignore issues of fetal viability and try to play on the emotions of pregnant women by confronting them with pictures. The bill requires that women be told about adverse psychological effects of having an abortion, yet what about the adverse psychological effects of sitting through this biased counseling for a woman who has been raped or is a victim of incest. Incidentally, there are studies, one done by the World Health Organization, that could find no medical evidence that abortion causes psychological injury.

Leave the details of informed consent up to the people that understand the health risks of pregnancy and abortion. Abortion is being singled out for these counseling requirements because the sponsors want to outlaw abortion.

The harm from the restrictions the sponsors of this bill wish to impose are felt most by those who have the fewest resources, low income women, minors, rural women, working women without insurance or sick leave, and battered women.

Many in this legislature talk a great deal of less governmental intrusion and this would be a good time to practice what you preach. Leave these matters up to women and their doctors.

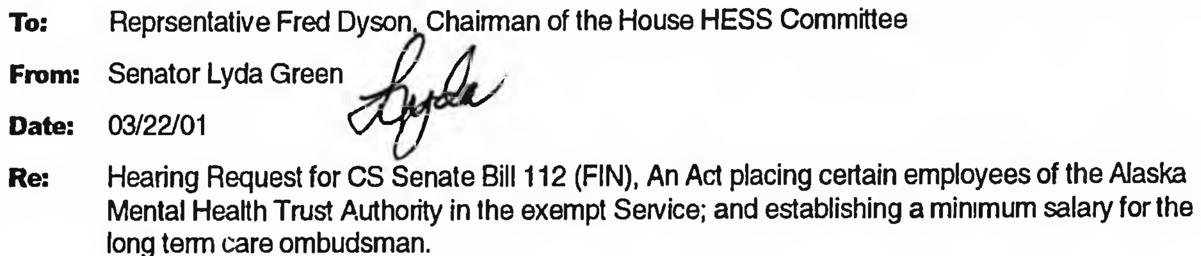
ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
(907) 465-3805 Fax

SENATOR LYDA GREEN
SENATE DISTRICT N

Memo



To: Reprsentative Fred Dyson, Chairman of the House HESS Committee

From: Senator Lyda Green

Date: 03/22/01

Re: Hearing Request for CS Senate Bill 112 (FIN), An Act placing certain employees of the Alaska Mental Health Trust Authority in the exempt Service; and establishing a minimum salary for the long term care ombudsman.

I request that CSSB 112(FIN) be scheduled for a Hearing in the House HESS Committee.

CSSB 112 (FIN) would place employees of the Alaska Mental Health Trust Authority (the Trust) in the exempt service, while establishing a minimum salary for the Long Term Care Ombudsman.

CSSB 112 (FIN) was introduced at the request of the Alaska Mental Health Trust Authority to address concerns expressed about their ability to function efficiently as a state corporation.

The Senate passed CSSB 112(FIN) with a vote of 16 yeahs, 0 Nays.

Thank you for your consideration of this request.

LG/hn

ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
(907) 465-3805 Fax

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
SENATOR LYDA GREEN, CHAIR

SPONSOR STATEMENT
SB 112

"An Act placing certain employees of the Alaska Mental Health Trust Authority in the exempt Service; establishing a minimum salary for the long term care ombudsman"

Senate Bill 112 would place employees of the Alaska Mental Health Trust Authority (the Trust) in the exempt service, while establishing a minimum salary for the Long Term Care Ombudsman.

SB 112 was introduced at the request of the Alaska Mental Health Trust Authority to address concerns expressed about their ability to function efficiently as a state corporation.

Unlike other state boards, commissions and authorities whose employees are placed in the exempt service under AS 39.25.110(11), the Alaska Mental Health Trust Authority's employees are not in the exempt service. This is despite the fact that the fiduciary duty owed to the beneficiaries by the Trust requires that employees perform at the highest levels of competency, since their actions could jeopardize the assets and/or management of the Trust.

Additionally, this legislation establishes a minimum salary for the Long Term Care Ombudsman at a Range 21. Establishing a minimum salary of the Long Term Care Ombudsman will help ensure that a qualified individual can be hired for this crucial position.

LG/hm

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 112
() Publish Date:

Revision Date/Time (Note if correction):
Title: Long-Term Care Ombudsman; Mental Health Trust Authority
Sponsor: Senate Health, Education & Social Services
Requester: Senate Health, Education & Social Services

Dept. Affected: Revenue
BRU: Mental Health Trust Authority
Component: Mental Health Trust Authority
Component Number: 1423

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type) 1094	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal: [ ]

POSITIONS						
Full-time						
Part-time						
Temporary						

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

This fiscal note reflects the placing of the Alaska Mental Health Trust Authority staff positions in the exempt service and the establishment of a minimum salary for the Long-Term Care Ombudsman.

The Alaska Mental Health Trust Authority will absorb any and all costs for the staff positions that will be placed in exempt service within the current Trust income funded budget.

The Office of the Long-Term Care Ombudsman positions being transferred to the Alaska Mental Health Trust Authority by Executive Order 102 will remain classified. The costs of establishing a minimum salary for the Long-Term Care Ombudsman will be absorbed within the current federally funded budget.

Prepared by: Jeff Jessee, Executive Director
Phone (907) 269-7960
Division: Alaska Mental Health Trust Authority
Date/Time 2/23/01 2:00 PM
Approved by: Larry Persily, Deputy Commissioner
Date Feb.23, 2001
Agency: Department of Revenue

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

SB 112 LONG-TERM CARE OMBUDSMAN; MENTAL HEALTH AUTHORITY

SECTIONAL ANALYSIS

Prepared by Aurora Hauke, Senate HESS Committee Aide

Sec.	Statute	Existing	Changes
1	AS 39.25.110 Public Officers and Employees Coverage of Personnel Exempt service	Lists positions that are exempt.	New paragraph (34) added. Chief executive officer and employees of the Alaska Mental Health Trust Authority are also exempt.
2	AS 47.30.026 Welfare, Social Services and Institutions Mental Health Mental Health Trust Authority Officers and staff	The annually elected chief officer may hire additional employees, appoint hearing officers, and contact for the services of consultants and others.	New subsection (d) added. The chief executive officer and employees hired under this section are in the exempt service.
3	AS 47.62.010(b) Welfare, Social Services and Institutions Office of the Longer Term Care Ombudsman Office established	See Executive Order 102. Hiring guidelines for the Long Term Care Ombudsman.	The LTCO will be at least a range 21.
4	Uncodified law	None.	New section CONDITIONAL EFFECT added. This act takes effect only if Executive Order 102 does.
5	Effective date		Takes effect immediately as conditioned by Sec. 4

550 West 7th Avenue, Suite 1820
Anchorage, AK 99501
Main line: (907) 269-7960
FAX: (907) 269-7966
Internet:
mhta@mhta.revenue.state.ak.us

The TRUST

The Alaska Mental Health Trust Authority

February 27, 2001

Senator Lyda Green, Chair
Senate Health, Education and Social Services Committee
State Capitol
Juneau, Alaska 99801-1182

Re: SB 112

Dear Senator Green,

This letter is in support of SB 112 that would place the employees of the Alaska Mental Health Trust Authority in the exempt service and establish a minimum salary for the Long Term Care Ombudsman.

Through oversight, the legislation creating the Alaska Mental Health Trust Authority (the Trust) made no provision regarding the category of service of either the Executive Director of the Authority or the staff. Therefore, all positions were deemed to be in the classified service by default. This has created a number of problems for the Trust and continues to be a barrier to the efficient operation of the agency.

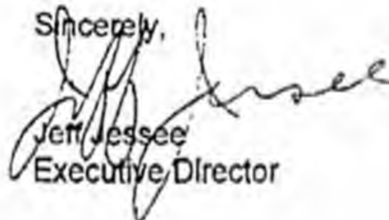
At the time the initial Board of Trustees was appointed in 1995, it was forced to petition the State Personnel Board to have the Executive Director position established as partially exempt. Without this action, the Trustees would have been seriously restricted in their ability to hire an appropriate person for this critical position. Subsequently, due to the large assets of the Trust (over $300 million and 1,000,000 acres of land) and the fiduciary duty owed to the beneficiaries, the Trust was forced to budget for a State Investment Officer position, which is already exempt by law, as a means of securing the services of someone they could be assured over time would adequately monitor the management of Trust assets by the Permanent Fund Corporation and the Department of Natural Resources. The remaining four staff are still in the classified service. This eclectic mix of employee positions in such a small office has been cumbersome and confusing at best.

The Trust is a state corporation similar in nature and function to the other boards, commissions and authorities whose employees are in the exempt service under AS 39.25.110 (11). These include, the Alaska Industrial Development and Export Authority, the Alaska Permanent Fund Corporation, the Alaska Aerospace Development Corporation, the Alaska Commission on Postsecondary Education and the Alaska Commercial Fisheries Entry Commission. The function of the Trust in developing a plan for the state and granting endowment income is extremely similar to that of the Alaska Science and Technology Foundation which is also in the exempt service under AS 39.25.110 (25). Finally, the fiduciary duty owed to the beneficiaries by the Trust requires that employees perform at the highest levels of competency and that any action that jeopardizes the assets or management of the Trust can be immediately addressed

The Trustees have agreed to accept responsibility for administering the Office of the Long Term Care Ombudsman. The Long Term Care Ombudsman is responsible for protecting the welfare of some of our most vulnerable Alaskans. Residents in the Pioneer Homes, nursing homes and community based assisted living homes often cannot speak for themselves. To mediate disputes and protect these individuals, the Long Term Care Ombudsman has extraordinary powers including the authority to subpoena confidential records and pursue legal actions if necessary. The Trustees believe that establishing a minimum salary for the Long Term Care Ombudsman is essential to ensure that a qualified individual can be found for this vitally important position. This position, as well as all others in the office, would remain in the classified service to protect them from any political pressure.

On behalf of the Trustees and the beneficiaries, thank you for considering SB 112. Please let me know if I can be of any further assistance.

Sincerely,



Jeff Jessee
Executive Director

Cc: Board of Trustees

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union
P. O. Box 201844, Anchorage, AK 99520-1844
Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

To: Members of the Alaska House
From: Jennifer Rudinger, Executive Director
Date: Friday, April 20, 2001

Re: **HB 112 – MANDATORY EXTRA "COUNSELING" FOR ABORTION**

The US Supreme Court's 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey upheld, among other restrictions, a Pennsylvania law requiring that physicians provide women with state-prepared anti-choice materials prior to the abortion procedure. The law forces a doctor to provide every woman seeking an abortion with information that is intended to discourage the procedure -- even if the information is irrelevant, unnecessary, and ultimately harmful to her health.

Such "biased counseling" laws are currently enforced in more than a dozen states. In a number of other states, these laws have been enacted but are enjoined or otherwise unenforced. Often introduced under the deceptive label of "Informed Consent" or "Women's Right to Know," biased counseling laws in fact serve to hamper women's access to abortion.

Alaska, however, is one of several states that evaluate restrictions on women's reproductive choices under the stricter standard of judicial review established by the US Supreme Court in 1973 in Roe v. Wade. Therefore, the Casey analysis and conclusion do not apply when an Alaska court reviews laws such as HB 112, and it is our opinion that HB 112 may be unconstitutional under the Alaska Supreme Court's decision in Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice, et al. in 1997.

Aside from our concerns that HB 112 may violate the Alaska Constitution, there are many reasons why the bill is bad public policy.

1. This Mandatory Extra "Counseling" Gives Women Inaccurate and Irrelevant Medical Information.

Mandatory extraneous lectures do not give women accurate or meaningful medical information. HB 112 puts words in doctors' mouths and forces them to run through a litany of conceivable pro's and con's for abortion and for all alternatives to abortion – even when those alternatives are not in the patient's best interest and may even *harm* her. Yet, women who are seeking prenatal care in order to carry a pregnancy to term are *not* forced to waste time and money listening to a diatribe about their options and alternatives to pregnancy and

childbirth, even though the mortality risk of full-term pregnancy and childbirth is more than 20 times *greater* than that of a first-trimester abortion.

2. HB 112 refers to "possible psychological effects that have been associated with having an abortion," substituting politicians' judgment for that of doctors.

This reference is misleading because no such psychological harms have been proven to exist. In fact, according to a 1987-88 investigation by the former Surgeon General of the United States, Dr. C. Everett Koop (who is no champion of choice), as well as a study by the World Health Organization, there is no medical evidence that abortion causes psychological injury. On the contrary, relief is the most common reaction to a voluntary abortion, whereas women who are forced to continue unwanted pregnancies suffer adverse and sometimes severe psychological consequences. It should be left to doctors to decide, based on their best medical judgment, what risks and benefits are relevant to their particular patients and what medical information is scientifically sound.

3. Requiring That *Physicians* Deliver These Extraneous Lectures Makes Access to Quality Reproductive Health Care More Difficult and Expensive.

HB 112 prohibits a trained counselor, nurse, or other health care practitioner from providing this mandatory lecture to the patient, requiring instead that a doctor deliver the state's message. This requirement has a direct effect on women's health. Many clinics experience serious difficulty in finding doctors willing and able to perform abortions, and the few who are available often find themselves barely able to meet the needs of their patients. By prohibiting doctors from delegating counseling and related tasks to other trained professionals, these laws make it far more difficult for clinics to provide women with the quality health care they deserve. Furthermore, since a doctor's time costs much more than that of a nurse, clinician, social worker, or counselor, the doctor-only stipulation drives up the costs of abortion and other health services provided by clinics.

4. Informed Consent Is Already Required For All Medical Procedures.

A woman must already give her informed consent before undergoing *any* surgical procedure, including abortion. The standards of the medical profession, as well as state laws, ensure that health care practitioners provide women with accurate and unbiased information regarding the risks and benefits of their various treatment options, and obtain their informed consent. HB 112 singles out abortion from all other medical procedures. Implicit in the requirement of a biased lecture is the assumption that women do not adequately think through their abortion decision and that the State must do their thinking for them. This assumption reflects a lack of respect for women's moral decision-making. In fact, virtually all women have carefully considered their decision to have an abortion by the time they arrive at the clinic. Clinics in Alaska routinely refer for additional counseling the small number of women who remain ambivalent.

5. Biased Counseling Requirements Violate Standard Medical Practice and the Doctor/Patient Relationship.

HB 112 requires a doctor to supply all of the state-mandated information to every woman in every instance in order to avoid liability. This state-imposed litany may conflict with the doctor's ethical obligation to give the best medical advice to the patient, in view of her individual circumstances. For example, it is both pointless and cruel to "inform" a victim of rape or incest that she has the "alternative" of raising the "unborn child" (as though she did not already know this), or to remind a woman carrying a fetus with impairments so severe that it could never survive outside the womb that her "unborn child" will be 20 weeks old at the time of the abortion. Indeed, the American Medical Association has resolved to oppose these types of measures, finding that "informed consent requirements [for specific medical procedures] often are not medically indicated and never are appropriate areas for codification in law." [American Medical Association, "AMA Opposition to 'Procedure Specific" Informed Consent," House of Delegates Resolution 226 (A-99).]

HB 112 is a perfect example of why legislators should not insert themselves into the business of practicing medicine. The definitions of "fertilization" and "gestational age" contained in the bill are medically inaccurate, and the definition and use of the term "unborn child" is both medically inaccurate and inflar matory.

6. Conclusion: HB 112 Endangers Women's Health and Violates Women's Constitutional Right to Reproductive Choice.

HB 112 is not created to protect women's health. The purpose is clear: this bill is designed to make a woman's very personal decision even more difficult. Fear of civil sanctions and the intrusive nature of the state-prescribed litany also serve to deter doctors from performing abortions, further exacerbating the alarming present shortage of providers in Alaska.

The AkCLU respectfully urges this body not to place any further burdens on women's rights to choose abortion. Please feel free to call on me if you have any further questions or concerns. I can be reached at (907) 258-0044 most days, from mid-morning until mid-evening.

Thank you very much for your careful consideration.

AMERICAN CIVIL LIBERTIES UNION

JR: See also the recent study described in the attached (this factsheet preceded that)

OPPOSING LAWS THAT REQUIRE WOMEN SEEKING ABORTIONS TO BE "INFORMED" OF THE "RISK" OF BREAST CANCER

The latest "scare tactic" initiated by anti-choice groups is to link abortion to breast cancer. Seizing upon scant evidence in a 1994 research study, they have mounted a vigorous advertising and legislative campaign to convince the public that having an abortion increases a woman's chance of contracting breast cancer. The study, published in the Journal of the National Cancer Institute (JNCI),[1] reported a small statistical connection between abortion and breast cancer. Although cancer research experts have characterized the study as inconclusive and methodologically problematic, anti-abortion activists have eagerly wielded it as a new way to frighten women and restrict their reproductive choices.

Opponents of choice have persuaded legislators in several states to introduce or enact bills that require physicians to inform women seeking abortions that abortion increases a woman's risk of breast cancer. Since this "warning" directly contradicts expert medical research, it can only be viewed as a politically inspired scare tactic; it is not motivated by a genuine concern for women's health. Here are some "talking points" that you can use to oppose such requirements when they are proposed as freestanding bills or as specific provisions in broader biased counseling bills (deceptively labeled by their anti-choice sponsors, "Informed Consent" or "Women's Right to Know" bills):

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."[2]

- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."[3]

- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.[4]

- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.[5]

- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."[6]

• A 1996 article in the Journal of the American Medical Association evaluating the association between pregnancy terminations and risk of breast cancer concluded, "Our data suggest that the risk of breast cancer associated with any pregnancy termination is likely to be small, if it exists at all."[7]

• The California Medical Association convened a task force to review all of the literature on abortion and breast cancer. The task force found the evidence to be inconclusive. "Some studies reported an adverse effect, some no effect, and some a positive effect. . . . [E]vidence is insufficient to support claims that induced abortion has an effect on the later development of breast cancer." This position was adopted by the American College of Obstetricians and Gynecologists (ACOG).[8]

• A widely noted 1997 study of more than 1.5 million women in Denmark, where abortion histories are corroborated by a government sponsored medical registry, and no chance of reporting bias exists, concluded that "induced abortions have no overall effect on the risk of breast cancer." In a New England Journal of Medicine editorial accompanying the Danish research, Dr. Patricia Hartge of the National Cancer Institute said of the study, "[It] provides important new evidence to resolve a controversy that previous investigations have been unable to settle. . . . In short, a woman need not worry about the risk of breast cancer when facing the difficult decision of whether to terminate a pregnancy."[9]

February 1997

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1. Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White, and Noel S. Weiss, "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion," Journal of the National Cancer Institute, Vol. 86, No. 21, November 2, 1994.

2. National Cancer Institute, Department of Health and Human Services, Risk of Breast Cancer Associated with Abortion, Washington, DC, February 13, 1996.

3. American Cancer Society, "Abortion and Breast Cancer" Fact Sheet, Document 002039, January 5, 1996.

4. Lynn Rosenberg, "Induced Abortion and Breast Cancer: More Scientific Data Are Needed," Journal of the National Cancer Institute, Vol. 86, No. 21, November 2, 1994.

5. Supra note 2; Karin B. Michels and Walter C. Willett, "Does Induced or Spontaneous Abortion Affect the Risk of Breast Cancer?," Epidemiology, Vol. 7, No. 5, September 1996. A contrasting opinion is offered by Joel Brind, Vernon M. Chinchilli, Walter B. Severs, Joan Summy-Long, "Induced Abortion as An Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-Analysis," Journal of Epidemiology and Community Health, Vol. 50, No. 5, October 1996.

6. Karin B. Michels, Chung-cheng Hsieh, Dimitrios Trichopoulos, and Walter C. Willett, "Abortion and Breast Cancer Risk in Seven Countries," Cancer Causes and Controls, Vol. 6, 1995.

7. Polly A. Newcomb, Barry E. Storer, Matthew P. Longnecker, Robert Mittendorf, E. Robert Greenberg, and Walter C. Willett, "Pregnancy Termination in Relation to Risk of Breast Cancer," Journal of the American Medical Association, Vol. 275, No. 4, January 24, 1996.

8. "Statement on Links Between Induced Abortion and Subsequent Breast Cancer," ACOG Newsletter, September 1995.

9. Mads Melbye, Jan Wohlfahrt, Jorgen H. Olsen, Morten Frisch, Tine Westergaard, Karin Helweg-Larsen, and Per Kragh Andersen, "Induced Abortion and the Risk of Breast Cancer," New England Journal of Medicine, Vol. 336, No. 2, January 9, 1997.

Alaska State Legislature
Written Testimony Form

Please enter into the record my testimony to the HHESS Committee on
(Committee Name)

4/19/2001 dated HB 112.
(bill/subj)

Page 1 of 2
Testimony on 2

Testifier Signature ____________________

Representing: (Optional) ____________________

Address ____________________

Phone Number ____________________

From Cordova LIO Fax 424-5462

Jim E. & Teresa J. Holley
P.O. Box 2246
Cordova, AK 99574
(907) 424-5988
April 18, 2001

To Whom It May Concern:

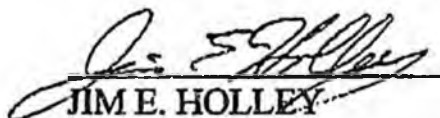
First we'd like to say that we are sorry that we are unable to provide this testimony via teleconference; however, as registered Alaskan voters, we urge you to pass:

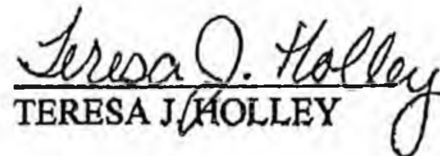
> **HOUSE BILL NO. 112;** ***"An Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency".***

Twenty-two years ago a high school friend of ours had an abortion. She was not informed of the potential risks involved with having an abortion. She returned to school regretting the decision she made. Five years after the abortion, she married and had a baby. The baby died shortly after birth of SIDS. To this day, she still blames herself for the deaths of her two children. She feels that had she been more informed as a teenager, she would have chosen a different path rather than abortion and instead of being childless today, she would have at least one of her children with her. The uninformed consent she gave twenty-two years ago, haunts her daily.

For the sake of those who are considering choosing abortion, we feel that they should be made aware of the potential medical and emotional costs that this decision will possibly bring to their future. For their sake, please vote yes on House Bill No. 112.

Sincerely,


JIM E. HOLLEY


TERESA J. HOLLEY

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union
P. O. Box 201844, Anchorage, AK 99520-1844
Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

To: Members of the Alaska House
From: Jennifer Rudinger, Executive Director
Date: Friday, April 20, 2001

Re: **HB 112 – MANDATORY EXTRA "COUNSELING" FOR ABORTION**

The US Supreme Court's 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey upheld, among other restrictions, a Pennsylvania law requiring that physicians provide women with state-prepared anti-choice materials prior to the abortion procedure. The law forces a doctor to provide every woman seeking an abortion with information that is intended to discourage the procedure -- even if the information is irrelevant, unnecessary, and ultimately harmful to her health.

Such "biased counseling" laws are currently enforced in more than a dozen states. In a number of other states, these laws have been enacted but are enjoined or otherwise unenforced. Often introduced under the deceptive label of "Informed Consent" or "Women's Right to Know," biased counseling laws in fact serve to hamper women's access to abortion.

Alaska, however, is one of several states that evaluate restrictions on women's reproductive choices under the stricter standard of judicial review established by the US Supreme Court in 1973 in Roe v. Wade. Therefore, the Casey analysis and conclusion do not apply when an Alaska court reviews laws such as HB 112, and it is our opinion that HB 112 may be unconstitutional under the Alaska Supreme Court's decision in Valley Hospital Association, Inc. v. Mat-Su Coalition for Choice, et al. in 1997.

Aside from our concerns that HB 112 may violate the Alaska Constitution, there are many reasons why the bill is bad public policy.

1. This Mandatory Extra "Counseling" Gives Women Inaccurate and Irrelevant Medical Information.

Mandatory extraneous lectures do not give women accurate or meaningful medical information. HB 112 puts words in doctors' mouths and forces them to run through a litany of conceivable pro's and con's for abortion and for all alternatives to abortion – even when those alternatives are not in the patient's best interest and may even *harm* her. Yet, women who are seeking prenatal care in order to carry a pregnancy to term are *not* forced to waste time and money listening to a diatribe about their options and alternatives to pregnancy and

5. Biased Counseling Requirements Violate Standard Medical Practice and the Doctor/Patient Relationship.

HB 112 requires a doctor to supply all of the state-mandated information to every woman in every instance in order to avoid liability. This state-imposed litany may conflict with the doctor's ethical obligation to give the best medical advice to the patient, in view of her individual circumstances. For example, it is both pointless and cruel to "inform" a victim of rape or incest that she has the "alternative" of raising the "unborn child" (as though she did not already know this), or to remind a woman carrying a fetus with impairments so severe that it could never survive outside the womb that her "unborn child" will be 20 weeks old at the time of the abortion. Indeed, the American Medical Association has resolved to oppose these types of measu es, finding that "informed consent requirements [for specific medical procedures] often are not medically indicated and never are appropriate areas for codification in law." [American Medical Association, "AMA Opposition to 'Procedure Specific" Informed Consent," House of Delegates Resolution 226 (A-99).]

HB 112 is a perfect example of why legislators should not insert themselves into the business of practicing medicine. The definitions of "fertilization" and "gestational age" contained in the bill are medically inaccurate, and the definition and use of the term "unborn child" is both medically inaccurate and inflammatory.

6. Conclusion: HB 112 Endangers Women's Health and Violates Women's Constitutional Right to Reproductive Choice.

HB 112 is not created to protect women's health. The purpose is clear: this bill is designed to make a woman's very personal decision even more difficult. Fear of civil sanctions and the intrusive nature of the state-prescribed litany also serve to deter doctors from performing abortions, further exacerbating the alarming present shortage of providers in Alaska.

The AkCLU respectfully urges this body not to place any further burdens on women's rights to choose abortion. Please feel free to call on me if you have any further questions or concerns. I can be reached at (907) 258-0044 most days, from mid-morning until mid-evening.

Thank you very much for your careful consideration.

AMERICAN CIVIL LIBERTIES UNION

JR: See also the recent study described in the attached (& this factsheet preceded that)

OPPOSING LAWS THAT REQUIRE WOMEN SEEKING ABORTIONS TO BE "INFORMED" OF THE "RISK" OF BREAST CANCER

The latest "scare tactic" initiated by anti-choice groups is to link abortion to breast cancer. Seizing upon scant evidence in a 1994 research study, they have mounted a vigorous advertising and legislative campaign to convince the public that having an abortion increases a woman's chance of contracting breast cancer. The study, published in the Journal of the National Cancer Institute (JNCI),[1] reported a small statistical connection between abortion and breast cancer. Although cancer research experts have characterized the study as inconclusive and methodologically problematic, anti-abortion activists have eagerly wielded it as a new way to frighten women and restrict their reproductive choices.

Opponents of choice have persuaded legislators in several states to introduce or enact bills that require physicians to inform women seeking abortions that abortion increases a woman's risk of breast cancer. Since this "warning" directly contradicts expert medical research, it can only be viewed as a politically inspired scare tactic; it is not motivated by a genuine concern for women's health. Here are some "talking points" that you can use to oppose such requirements when they are proposed as freestanding bills or as specific provisions in broader biased counseling bills (deceptively labeled by their anti-choice sponsors, "Informed Consent" or "Women's Right to Know" bills):

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."[2]

- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."[3]

- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.[4]

- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.[5]

- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."[6]

HB112

~~HB~~ Testimony

My name is Debbie Joslin. My husband, Steven and I live in Delta Junction with our three children; Matthew, Emily and Victoria. Steven is the resource forester in our area. I am a homeschooling mom. I teach 3rd and 4th grade Sunday School at my church.

On January 15, 1999 I was 22 weeks pregnant when we drove 100 miles to Fairbanks for an ultrasound on our child. After a lengthy examination of the baby, I was told we were expecting a male child with multiple anomalies. The baby we named Isaiah John had a brain cyst, a missing or unconnected stomach and a hypoplastic left heart. We were given the name of a Perinatologist in Anchorage. A Perinatologist, as I understand it, is a doctor who specializes in unborn babies who have serious health complications. I spoke to this specialist over the phone and made arrangements to go to Anchorage and have another ultrasound. During that phone conversation she urged me to have the pregnancy terminated. The reasons she listed were that the baby would probably die anyway, the medical expenses would be too great and that my own life was probably in danger. Keep in mind, she had not examined me at this point. I made an appointment with this doctor, since I was told she was the only Perinatologist in the state. My husband and I drove 350 miles to keep that appointment, leaving Delta at 40 below zero. When we arrived for our appointment we first saw a genetic counselor who went over some family history with us and explained that they thought Isaiah had Trisomy 18, a chromosomal abnormality (an extra number 18 chromosome). She expressed surprise that we were not considering terminating the pregnancy and asked several times whether we wanted to consider terminating the pregnancy. Another ultrasound was performed by a technician and then the Perinatologist took over the exam and listed the following anomalies: Brain cyst, missing or unconnected stomach, hypoplastic left heart, eyes not properly spaced, underdeveloped chin, something wrong with spinal development, something wrong with his penis, rocker bottom feet, possibly an extra toe and fluid in the abdominal cavity and lungs. We were told the fluid indicated that Isaiah was already in congestive heart failure and that he would never make it to his due date in May. The Perinatologist told us that Isaiah would never respond to us if he were to live, we were told that all Trisomy infants were severely mentally retarded. She described a somewhat vegetative state but more probably he would be stillborn any day. She said that if he were to be born alive he would only live for a few minutes. Later they adjusted it to a few hours and then later yet they said maybe a day at most and then finally they said a few days. We agreed to an amniocentesis to determine whether Isaiah did actually have Trisomy 18. Our hope was that he would not, and we could begin to make plans for heart surgery. She told us doctors will not operate on Trisomy infants since they ALL die in infancy anyway.

You can imagine what heavy hearts we had as we drove back to Delta. The plans and dreams I had had for my son were shelved as we instead discussed his funeral. Within a few days I got a call from the genetic counselor with the preliminary test results which showed Isaiah had Trisomy 13. I asked how that differed from Trisomy 18 and she said it was worse. She asked again about termination and I told her again that we were not interested in that. Almost immediately I got a call from my doctor in Fairbanks who asked

me about termination. I told her (again) that I was not interested in that. She told me that since my life was in danger and I had chosen to continue with the pregnancy, she could no longer be my doctor as she was a general practitioner and not qualified to handle such a case. I began seeing the osteopath doctor in Delta and an OB/GYN in Fairbanks. I told them what I had been told about the baby and about my own health. The OB/GYN doctor told me he could not understand why I had been told my life was in danger. He treated me during the remainder of the pregnancy and I never had any complications or problems. Only the usual complaints pregnant women suffer from.

A couple of weeks after the preliminary results, the genetic counselor called with the final results from Isaiah's amniocentesis. It was final - Isaiah had Trisomy 13. She asked me again about termination and I told her no again. I then asked her out of curiosity what she would do if I did say yes. She got very excited and told me that "there is the most wonderful clinic in Kansas". I asked if she meant Dr Tiller's clinic and she said "yes, do you know him"? "No, I told her, but I know about him". She offered to have other women who had had abortions call me but I declined. Sensing that I was not interested in pursuing this any further she told me in a very apologetic voice that "there is a parent support group, but well....they are rather positive". She made it sound as though positive was a bad thing to be. She then went on to tell me that she had information on the group including an 800 number as well as pamphlets and books in her office that gave detailed information about Trisomy 18, 13 and related disorders including pictures. I called S.O.F.T. (Support Organization for Trisomy 18, 13 and Related Disorders) right away and found that they were indeed positive - but realistic. I told the woman over the phone about Isaiah's diagnosis and she told me that probably they were right but there was a chance he could live. She talked to me about the other "parents" and I remember asking her, "parents, you mean they have children?" "Yes, some did,"she said. "How old". I was told that they varied but there were a few children who were teenagers and even a couple of adults. The lady took my name and address and told me she would send me a family packet right away. I also requested the books they had available; Trisomy 13, a Guideline for Families and Care of the Infant and Child with Trisomy 18 or 13. These were the books the genetic counselor had described, the very ones she had in her office. While the information was heartbreaking, it also offered some hope and some help. Two things we hadn't had much of. Not only did some of these children live - they played and smiled and laughed and talked and learned things and showed affection and responded to love and affection.

We located a wonderful pediatrician in Fairbanks who agreed that Isaiah's chances were not good but she was willing to do what she could to help him. We made the decision to hire her and made plans to deliver our baby in Fairbanks. On May 10, only 11 days before his due date, Isaiah John Joslin was born at Fairbanks Memorial Hospital. He weighed 6 lbs 1 oz and was 18 1/4 inches long. Isaiah was a pretty baby with lots of bright red hair. Isaiah had difficulty breathing when first born but as the doctors and nurses checked him over they could find no sign of the problems seen earlier on three different ultrasounds. The brain cyst, stomach problem and hypoplastic heart were all missing as were all of the other problems earlier noted. However, Isaiah suffered from a ventricular septal defect

(VSD) - a hole in his heart. Although very serious, it was a far cry from the problems he had had earlier. Isaiah required oxygen and a nasal gastric tube for feeding. Because of the hole in his heart he was too weak to nurse and had to be fed with a tube. Isaiah looked so normal that even the nursing staff agreed we should retest him. Test results again showed Isaiah to have Trisomy 13. He stayed in the hospital for 12 days and then came home where we cared for him for 20 days before he left us to go to be with the LORD in heaven. Those were some of the hardest but sweetest days of my life.

I am telling you this story so you can understand why I stand before you today and ask that you pass ~~[illegible]~~. HB112

After talking to other doctors and doing a great deal of research and reading about Trisomy infants and because of my own personal experience, I believe my life was never in any danger. Yet, this undue burden was placed on me at a time when I already had plenty to worry about. I believe this was done to try and convince me to have the abortion.

I was told that ALL Trisomy infants die. I now know that somewhere between 90 and 95% of all Trisomy infants die before one year of age. That doesn't leave much room for hope I realize but it is quite different than saying they ALL die.

I was not told about the parent support group (S.O.F.T.) for over two weeks not until they had finally given up on talking me into an abortion. Well, you may say they were not sure your child had Trisomy until the final results were in. Perhaps, but they were sure enough that they continually brought up termination. I drove 350 miles to see the doctor and was never shown the written information about this disorder that they had right there..

Though they were careful to tell me every negative thing they could about the baby, I was never told of any of the risks of having an abortion. There was never any mention made of the risk to my health, either physical or emotional from having the abortion.

I believe the doctors who repeatedly brought up termination probably meant well. The problem comes in where they apparently believed that their professional status, or their medical degrees placed them in a position to know better than me what was best for me, my family and my baby. That simply is not true.

Giving life to Isaiah was hard on our family. But it wasn't TOO hard. It was expensive. But it wasn't TOO expensive. It was hard on the other children. But it wasn't TOO hard on my other children. Giving life to Isaiah blessed our family, including the other children. Because of his heart condition Isaiah was always lethargic and sleepy and tired acting but he was never in pain. The equipment which monitored his oxygen saturation rate showed that whenever we held him or showed affection to him, Isaiah was aware of it. His saturation levels would soar when he was being loved on. My daughter, Emily who is five loves to recount the story of how Isaiah's oxygen saturation level was in the 60s the night before he died. I laid him in Emily's arms and immediately his saturation level rose to 100. There seems to be a feeling out there that a successful life is one that is free from pain or

suffering or trials and that isn't true. Isaiah's life was successful. We loved him and he loved us.

We have been comforted and encouraged even since Isaiah's death by reading of other families with Trisomy children in the S.O.F.T. newsletter. The letters and testimonials are all expressions of the love each family has for their infant or child. Many of them include pictures of their precious children, most of them deceased but some still living. Some of them telling stories of medical professionals pressing them to have abortions are very similar to our experience. Without exception every family expressed love and gratitude for the time they had had with their children, no matter how short.

Uniform written information should include basic facts regarding fetal development and the risks associated with continuing the pregnancy versus terminating the pregnancy. Crisis pregnancies come in many different forms. For some women it can be as simple as finding out about WIC, others are not even aware that the child's father is legally responsible for helping to provide support. Over 90% of all babies diagnosed prenatally with Downs Syndrome are aborted. Could it be that those women don't know about the parent support groups out there? Information on adoption agencies should be as readily available as information on abortion. There is a wealth of information out there and it would be a great help to doctors to have a booklet they could hand out to their patients.

Of course I would like for every mother to make the same decision I did but I realize that won't happen. But every mother deserves to have all of the information pertinent to her situation so that she can make an intelligent informed decision. I stand before you today and say that if you vote against ~~HB339~~ HB112 you are saying, in effect, that women are not competent enough to be trusted with the facts regarding the health of their own bodies and that of their unborn children. A "no" vote says that you have no compassion for families and believe that doctors are better suited to make decisions for women and their unborn babies.

A "yes" vote for ~~HB339~~ HB112 sends an entirely different message. A vote *for* informed consent says that you have respect for the intelligence of women and believe that they have the right to be trusted with the information necessary to make decisions for themselves. I trust and hope that this body of legislators will prove themselves to be in favor of women's rights.

Thank you.

Debbie Joslin
Box 377
Delta Junction, AK 99737

(907) 895-4565

Ms. Cyndi L Saunders,
6400 Woodmont Dr
Anchorage, AK 99516

346-8226

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

I encourage you to vote for HB 112.

Email Address

Mr. Dean P Eisberg,
19829 Samalga Cir
Eagle River, AK 99577

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

I am asking the legislature to stop funding abortions with state money that hasn't been appropriated for abortions. Don't allow the courts to legislate how state money is spent.

Email Address

Mr. James E Preston,
PO Box 394
Homer, AK 99603

235-8906

Distribution	Affiliation	Reg Voter
60		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

Please support HB 112, Abortion: Informed Consent; Information. I do not like my tax dollars used for abortion. I also do not like judges legislating.

Email Address

Mrs. Janice E Preston,
PO Box 394
Homer, AK 99603

235-8906

Distribution	Affiliation	Reg Voter
60		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

Please support HB 112, Abortion: Informed Consent; Information. I do not like my tax dollars used for abortion. I also do not like judges legislating.

Email Address

Ms. Mary A Patania,
1327 Airport Heights Dr
Anchorage, AK 99508

278-1736

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

I support HB 112 to disclose information before abortion for the woman's health. I believe in separation of power that the legislature allocates money and not the court system. The court has a different function of executing the laws which the legislature enacts. The funds come from the legislature.

Email Address

Ms. Laura M Jackson,
6939 Windsor Pl
Anchorage, AK 99502

786-7755

Distribution	Affiliation	Reg Voter
60		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/05/2001	N	HB 112	Supports	

Doctors are required to inform patients of ramifications of choices regarding all medical procedures. This should certainly include the procedures involved in abortions.

Email Address

Mr Manus R McKeehan,
400 Irish Ln
Fairbanks, AK 99712

488-5550

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/06/2001	N			OIL & GAS

Re the Natural Gas Line: I would like you to make sure that the Fairbanks North Star Borough communities have access to the natural gas pipeline. I am also in favor of drilling in the Arctic Natural Wildlife Refuge.

Email Address lmckeehan@gci.com

Stanley D Tucker,
1001 Dellwood Dr
Wasilla, AK 99654

373-7139

Distribution	Affiliation	Reg Voter
11		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/06/2001	N	HB 112	Supports	

Please support HB 112. Thanks

Email Address

Mr Ronald D Rasmussen,
4000 Cushman St
Fairbanks, AK 99701

452-4000

Distribution	Affiliation	Reg Voter
34		Y

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			BUDGET

Division of Forestry: I strongly urge you to support the Division of Forestry's $280,000 increment calledovercoming limits to value - added timber sales". Sustainable forestry depends upon proper registration. The timber sale program has provided millions to the State Treasury. It is only right that some of these funds return to benefit the industry."

Email Address

Ms. Barbara A Johnson,
631 W 32nd Ave #133
Anchorage, AK 99503

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

Please support HB 112, requiring women be given full disclosure as too physical and psychological risk of abortion before choosing an abortion and information requiring fetal development. thank you for supporting pre-born life.

Email Address

Ms. Marvel G Lloyd,
Hc85 Box 9814
Eagle River, AK 99577

694-9179

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I urge your to vote for HB 122, because I feel for any optional medical procedure the patient should always be making an informed decision by knowing all the possible negative affects that the procedure might cause.

Email Address

Madonna R Singleton,
PO Box 4166
Palmer, AK 99645

746-6806

Distribution	Affiliation	Reg Voter
10		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I strongly support HB 112. Thanks

Email Address

Robert H Singleton,
PO Box 4166
Palmer, AK 99645

746-6806

Distribution	Affiliation	Reg Voter
10		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

I strongly support HB 112. Thanks

Email Address

Ms. Lapriel C Stephan,
PO Box 112114
Anchorage, AK 99511

276-5733

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HJR 12	Supports	

I agree with With Representative Fred Dyson, that hunting and fishing and trapping are part of our heritage and must be preserved. I think your doing a good job.

Email Address

Ms Charis G Berry,
PO Box 1121
Valdez, AK 99686

835-2898

Distribution	Affiliation	Reg Voter
40		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/08/2001	N	HB 112	Supports	

Please look at this bill. Please make sure all women are given full information about what abortion is and what it means.

Email Address

Ms. Geraldine I Boye,
52557 Geraldine St
Kenai, AK 99611

776-5419

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			ABORTION

Stress the separation of powers and in abortion especially. That the state is still funding it irritates me as they haven't asked my permission to do that. I don't think the courts are supposed to legislate. Please remember we need to be on the side of life.

Email Address

Mr. Dave N Syren,
1004 Beech Ln
Anchorage, AK 99501

274-9046

Distribution	Affiliation	Reg Voter
60		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N	HB 112	Supports	

I am in support of HB 112 and feel we need to have continued separation of powers in all decisions, especially relating to abortion.

Email Address

Mrs. Renate Kennedy,
326 Wedgewood Dr #E29
Fairbanks, AK 99701

452-1045

Distribution	Affiliation	Reg Voter
43		V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	N			BUDGET

There is a tremendous need for substance abuse treatment throughout our community I work in this field and feel this workforce is understated and under paid. I could make $10,000/year more if I left this field, but I understand how it might impact our community.

Email Address Renate@gci.net

Ms. Rayetta L Calhoun,
1254 Loon Ln
North Pole, AK 99705

Distribution	Affiliation	Reg Voter
41	Ralph	V

Date POM Sent	Constituency	Bill Number	Response	Subject
03/07/2001	C			BUDGET

We can no longer do more for less. Jobs are plentiful and it is easier to do work somewhere else and get paid more. Please fund the substance abuse programs so staff can get adequate pay.

Email Address Rayetta@mail.com

March 8, 2001

House HESS Committee
State Capitol
Juneau, AK 99801-1182

Dear Mr. Chairman and Members of the Committee:

My name is Deatrich Sitchler, and I reside at 520 Glacier Bay Circle #B, Anchorage, AK 99508. I am writing to you to urge you to **oppose HB 112**. I understand that the bill is currently in the House HESS Committee, on which you sit. Please do everything in your power to stop this bill from becoming law.

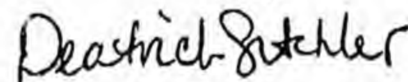
I would like to share with you my personal reasons why this bill would be detrimental to many women. At the age of 14, I was diagnosed with hemophilia, a disease affecting the blood. As a result of this condition, it is medically dangerous for me to carry a pregnancy to term because the loss of blood during delivery could be potentially fatal to me. I am in a long-term committed relationship, and my partner and I are very careful, but as you know, no form of birth control is 100% effective. Were I to accidentally become pregnant, it may be in my best medical interest to terminate the pregnancy rather than carry the pregnancy to term.

I strongly feel that this is a decision between my partner and me, with the advice and consultation of my doctor. The government has no place in this personal, painful choice I would have to make. Furthermore, my partner and I would find it very painful to have to look at pictures of healthy fetuses in a brochure or to have to listen to a litany of "alternatives" to abortion – alternatives that are not actually in *our* best interest and that could actually threaten my life – before we could be deemed capable of consenting to an abortion. I might not fall under the "medical necessity" exception to HB 112 because having the abortion <u>at that very moment</u> would probably not be a life-saving measure or an emergency situation. Therefore, I would be subject to this extra "counseling" which would be wholly irrelevant to my individual circumstances.

I remind you that this decision would already be very painful for me, and that I would be terminating my pregnancy to save my life. Why should extra hurdles be placed before me that are not placed before any other patient seeking any other medical treatment?

My boyfriend and I live together at the above address. We both urge you to oppose HB 112.

Very truly yours,



Deatrich M. Sitchler

To: House HESS Committee
From: Dr. Sharon Smith
Date: March 7, 2001
Re: HB 112

I am a family physician working in Anchorage. I care for pregnant woman, perform deliveries, and care for the children of my patients. I do not perform abortions.

I have concerns about HB 112. Specifically, the requirement that DHSS develop and make available a standard information pamphlet describing the development of an "unborn child." The bill calls for "nonjudgmental information that is accurate, scientific information." The term "unborn child" is disingenuous and inflammatory, has no scientific basis, and has no place in a medically oriented document. Furthermore, the only women who would be required to review the information would be those who are choosing to end their pregnancies.

You know, as a physician I perform procedures and obtain informed consent prior to all of them. Obtaining informed consent responsibly was an important part of my medical training. I am, frankly, insulted that legislators are comfortable dictating how consent be obtained for a specific procedure, that the bill's language implies physicians are not already obtaining informed consent, and that you find it within your duties to single out one procedure and place onerous requirements on a safe, simple medical procedure.

Sharon Smith, MD
6203 Green Tree Circle
Anchorage, AK 99516
346-3693

March 7, 2001

Rep. Fred Dyson

Rep. Peggy Wilson

Rep. John Coghill, Jr.

Rep. Vic Kohring

Rep. Gary Stevens

Rep. Sharon Cissna

Rep. Reggie Joule

I recently read House Bill No.112 proposed by Representatives Coghill and Dyson. I must object to this bill on multiple grounds. This bill is a thinly veiled attempt squarely aimed at making it more difficult for women of Alaska to receive abortions. It contains biased language throughout, and indirectly suggests placing new limitations on the availability of the abortion procedure.

The bill claims to be about informed consent. As physicians, we are quite familiar with informed consent. If there is a complication of a procedure and informed consent was not obtained, we are painfully aware of the consequences. Getting proper informed consent before an abortion is very high on my list of priorities. Contrary to what some people may think, there is no monetary gain in performing abortions to a physician who does both prenatal care and abortion. If a patient carries a pregnancy to term, our practice will see a much larger revenue stream than if the patient has an abortion. There is no incentive on our part to encourage abortion over an ongoing pregnancy.

The bill starts in a biased manner by saying that it is meant to "ensure informed consent before an abortion may be performed, except in the cases of medical emergency." A pregnancy has several possible outcomes including carrying and delivery, abortion, adoption, miscarriage, and ectopic pregnancy and others. There is no mention of giving informed consent to women regarding carrying a pregnancy to delivery, or giving the pregnancy up for adoption. In my practice as a physician, I perform abortions as well as multiple other procedures including both office and hospital procedures. The legislature has not chosen to pass a bill on how I obtain consent from a person for a C-Section, or hysterectomy – both of which carry far more risk to the patient than an abortion. Clearly, the abortion is being singled out, but not for medical reasons. This bill relates to politics and beliefs, not medicine or the safety of Alaska women.

Throughout the bill the term "unborn child" is used. A review of the 23rd edition of Stedman's medical dictionary reveals that the term "unborn" or phrase "unborn child" are not recognized. There are medical terms such as blastocyst, morula, embryo, fetus, and several others terms referring to the "conceptus." The term "unborn child" is included to incite only emotion. On page 2, line 25 the term "nonjudgmental" is used when the decidedly judgmental phrase "unborn child" is used in the very same sentence, a contradiction of terms.

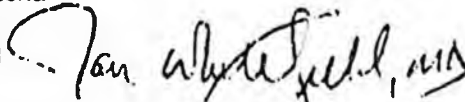
In pages 1 line 1 through 3, line 23 a "standard pamphlet of information" is described, again using biased terms defined by the legislators, not terms recognized in science. Paragraph (7), page 2, lines 19-27 describes in detail the pictures that need to be included in this pamphlet. Why are these to be included? Are these meant to "educate" the patient regarding the fetal development when she is deciding whether to carry a pregnancy rather than to have an abortion? If so, where are the parallel photographs describing the complications of abortion as well as the complications

of carrying a pregnancy to term? Of what value are these pictures? When I counsel patients regarding an ongoing pregnancy or an abortion, should a patient ask me for drawings or photographs of a fetus at various stages of development, I have an encyclopedia containing the information, and I go over it with the patient, but I tailor the information to the needs of the patient. Each person is an individual, and a "standard information packet" alluded to by this bill leaves little room for patient individuality.

C. Everett Koop, and the American College of Obstetrics and Gynecology, after extensively reviewing the literature, concluded that there is no solid scientific data suggesting that there are long-term negative psychological effects from an abortion. Yet paragraph 8, page 2, line 31 refers to "possible psychological effects" that have been associated with having an abortion. Why should a patient be subjected to this concept when there is no proof that it exists, and will only serve to frighten the patient with false information? Informed consent should only involve only actual scientific information, not conjecture. ("Actual scientific information" is referred to in line 26, page 2.) If this reference remains in the bill, where is the comparable line referring to the possible psychological risks of adopting a baby out?

This bill is not about science, nor about medicine. This bill is not about information or informed consent. This bill is simple bias, placing more obstructions in the paths of women seeking an abortion. The suggested body of information is already available, and gathering it as suggested is a duplication of efforts. The requirements of HB 112 serve only as an obstacle intended to discourage patients from choosing a procedure that is recognized as one of the safest performed in medicine.

The persons being served are not the patients, but the legislators who wish to further obstruct abortion in Alaska.

Jan Whitefield 

Medical Director, Alaska Woman's Health Services

Subject: **TESTIMONY--HB112**
Date: Sun, 22 Apr 2001 10:31:30 -0800
From: "R. Holmes Johnson" <drbob@keaconnect.net>
To: Representative_Fred_Dyson@legis.state.ak.us

Fred Dyson, Representative
State of Alaska
State Capitol
Juneau, Alaska 99801-1182

Dear Mr. Dyson,

When I had to leave before testifying at the Saturday teleconference on HB112, the LIO in Kodiak forwarded an article of mine that was published in the Kodiak Mirror when I was in practice. The "going public" in the initial paragraph refered to picketing that had just begun and therefore removed the need for secrecy. I was quite happy to "tell it like it is" to correct many misconceptions created by opponents of abortion.

I would urge you to read the article since it establishes my experience and thus qualifies me to testify on this proposed legislation.

HB112 is an unnecessary bill. It needn't have been introduced at all since: a) the Alaska Department of Health presently distributes much information on pregnancy and abortrion, since; b) *informed consent* has been reiterated so many times that no sane phyisian fails to explain whatever procedure is being considered and to obtain signed consent, and since; c) abortion should not be singled out as the *only procedure* in Alaska to be subject to such mandatory "extra" counseling.

Though making a studied effort toward objectivity, the details which serve as an impediment to free choice (of what one wants to know), and the use of the term *unborn child* in place of the proper term *fetus*, make it fairly obvious that this bill was written by those who do not approve abortion!

I heard testimony on SB91 a few days ago by a woman who quoted unbelievable complications of abortion, particularly serious psychological problems. Dr. C. Everett Koop, Surgeon General under President Reagan, himself *not in favor of abortion*. did an exhaustive study of abortion and found *no evidence* of psychological effects. My own experience supports Dr. Koop. This suggests that those who feel abortion is *murder* are so biased that they transmit this to those whom they interview and suceed in creating severe guilt feelings would be, indeed, complications, *but not of abortion.*

Please keep in mind that a woman, now, has the right to ask any question at all of her physician and he has the obligation to answer that question to the best of his ability. To have someone else, particularly legislators, dictate what she must know, is an insult to her intelligence and, furthermore, overlooks individual differences and individual needs.

In summary, this bill is redundant and should not have been introduced at all. It places an unnecessary impediment to the free exercise of choice which has been the legal right of women since Roe vs. Wade. Had it always been their legal right, we would not have seen the *serious complications* that *were* a result of back alley abortionists. To add impediments to free choice, as has already been done in a number of ways, is to chip away at one effective and necessary form of population control.

Realize that I am retired and have nothing to gain personally! I write in defense of women who

become unexpectedly pregnant who should be free to choose what they want to know about their options as well as which, among them, to select. This bill interferes with that freedom and should be buried!

Sincerely,

Dr. Bob Johnson,
drbob@keaconnect.net
Phone 907--486-5171
Box 945 Kodiak 99615

Alaska State Legislature

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Representative John Coghill

Sponsor Statement

HB 112

Since the early 1970s, Alaska regulations have required physicians to advise patients seeking an abortion of the "medical implications and the possible emotional and physical sequelae of the procedure." (12 AAC 40.070). However, Alaska's informed consent regulation lacks specificity and is not uniform in its application.

HB 112 elevates Alaska's current informed consent requirement from regulation to statute. This legislation would ensure that a patient is given the appropriate information about an abortion procedure without obstructing a physician's ability to tailor information to the individual needs of the patient.

HB 112 also requires that the Department of Health and Social Services develop a pregnancy informational pamphlet to be made available to the public. The pamphlet would list factual, nonbiased information about pregnancy and abortion, as well as pregnancy and abortion alternative resources, and state services available to pregnant women in Alaska.

HB 112 reinforces the current ethical standards by protecting them from possible systematic abuse in the future, putting a statutory safeguard into place for both women and physicians.

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Representative John Coghill

Sectional analysis - HB 112

Section 1: Creates an information pamphlet that is designed for pregnant women which describes average fetal development and lists both non-profit and state pregnancy and pregnancy alternative resources and options.

Section 2: Amends AS.18.16.010 ("Abortions") to state that an abortion may not be performed unless the provisions of section 4 (AS 18.16.060) have been satisfied.

Section 3: Amends AS 18.16.010 ("Abortions") to include a subsection that states that, except in situations of medical emergency, if an abortion is performed in violation of section 4 (AS 18.16.060), the physician is civilly liable for compensatory and punitive damages.

Section 4: Amends AS 18.16.010 to include a section addressing informed consent requirements. An abortion may not be performed in this state unless the physician or referring physician orally informs the patient of

- The name of the physician performing the procedure.
- Gestational estimate of pregnancy at the time of the procedure.
- Nature and risks of undergoing or not undergoing the procedure, as pertinent to the patient's circumstances and medical history.

Written consent must be obtained from the patient confirming that the required information has been provided.

Section 5: Provides a severability clause. In the event that one or more of these provisions is found to be unconstitutional, the remaining provisions would continue in full force and effect.

CURRENT STANDARD:

ALASKA ADMINISTRATIVE CODE - ABORTION/INFORMED CONSENT

2 AAC 40.070

INFORMED CONSENT.

Unless otherwise provided in 12 AAC 40.060, a written informed consent shall be obtained from the patient or from any other person whose consent is required before termination of a pregnancy. Such written informed consent shall be on the patient's chart. The patient and other persons whose consent is required shall be advised of the medical implications and the possible emotional and physical sequelae of the procedure.

History -

Eff. 12/20/70, Register 36; am 8/29/73, Register 47

Authority -

AS 08.64.105
Sec. 08.64.105. Regulation of abortion procedures.

The board shall adopt regulations necessary to carry into effect the provisions of AS 18.16.010 and shall define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for facilities, equipment, and care of patients in the performance of an abortion.

CONCEPT BEHIND HB 112: REFINE AND ELEVATE ALASKA'S CURRENT ABORTION INFORMED CONSENT STANDARD

EXAMPLE:

AS 18.16. REGULATION OF ABORTIONS
AS.18.16.010. Abortions.

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

(1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on an unmarried, unemancipated woman under 17 years of age, consent has been given as required under AS 18.16.020 or a court has authorized the minor to consent to the abortion under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 17 years of age is unemancipated;* and

(4) the woman is domiciled or physically present in the state for 30 days before the abortion.

HB 112 WOULD INSERT:

(a) Except in the case of a medical emergency, a person may not knowingly perform or induce an abortion without the voluntary and informed consent of the woman on whom the abortion is to be performed or induced.

(b) Consent to an abortion is voluntary and informed when all of the following are true:

- (1) before the abortion procedure, the physician who is to perform the abortion or the referring physician has orally informed the woman of the
  - (A) name of the physician who will perform the procedure;
  - (B) gestational estimation of the pregnancy at the time the abortion is to be performed; and
  - (C) nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a voluntary and informed decision of whether to undergo the procedure;
- (2) before the abortion, the woman certifies in writing that the information required under (1) of this subsection has been provided; and
- (3) the physician who is to perform the abortion or a representative of the physician receives a copy of the written certificate required under (2) of this subsection and retains a copy in the physician's file.

(c) The information required in (b)(1) of this section shall be provided to the woman individually and in a private setting to protect the woman's privacy, maintain the confidentiality of the woman's decision, ensure that the information focuses on the woman's individual circumstances, and ensure that the woman has an adequate opportunity to ask questions.

*Parental Consent/Judicial Waiver struck down - Planned Parenthood of Alaska, Inc. v. State, No. 3AN-97-6014 CI (10/5/98)

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Representative John Coghill

"INFORMED CONSENT FOR ABORTION" LAWS IN THE UNITED STATES

- 30 states, including Alaska, currently have laws detailing informed consent requirements for abortion procedures.

  AL, AK, CA, CT, DE, FL, ID, IN, KS, KY, LA, ME, MA, MI, MN, MS, MT, NE, NV, ND, OH, PA, RI, SC, SD, TN, UT, VA. WI

- 21 states have introduced legislation concerning this issue in 2001 to both initiate laws and to update current laws.

- Alaska is one of 12 states that have legislation in 2001 that would update the current state laws on abortion informed consent.

- Separate medical informed consent laws for abortion procedures have been upheld at the Federal level (U.S. Supreme Court *Casey*). 7 states currently have their laws enjoined due to state court rulings. The central issue behind these injunctions being that the laws also required a waiting period, which was ruled unconstitutional under the individual state constitutions.

- The determining factor for federal constitutionality of informed consent laws is the judgment of whether or not the laws pose an undue burden to a woman seeking an abortion.

  Note: Alaska's abortion laws are held to the more strict interpretation of Roe v. Wade, not the recent U.S. Supreme Court ruling in *Casey*.

TESTIMONY OF

VINCENT M. RUE, PH.D.
INSTITUTE FOR PREGNANCY LOSS
STRATHAM, NEW HAMPSHIRE

REGARDING
HB 112
BEFORE THE HOUSE
HESS COMMITTEE

JUNEAU, ALASKA

MARCH 2, 2001

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 112 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: (l) "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.

In the United States today, the following elements of informed consent have been mandated in a number of states: (l) 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.

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."

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.

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: (1) 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.

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."

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."

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 stress. There is considerable pressure on the woman to make a decision as quickly as possible. Women who make 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 contributory 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 112 is a step in the right direction to help remedy these known deficiencies. HB 112 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

REFERENCES

Angelo, J. (1992) Psychiatric sequelae of abortion: The many faces of Post-Abortion Grief. *Linacre Quarterly*, 59:2, 69-80.

Bagarozzi, D. (1993) Post traumatic stress disorders in women following abortion: Some considerations and implications for marital/couple therapy. *International Journal of Family and Marriage* 1:51-68.

Barnard, C. (1990) *The Long Term Psychosocial Effects of Abortion.* Institute for Pregnancy Loss. Stratham, New Hampshire.

Breslau, N., Davis, G., Andreski, P. & Peterson, E. (1991) Traumatic events & posttraumatic

stress disorder in an urban population of young adults. *Archives of General Psychiatry* **48:** 216-222.

Congleton, G. and Calhoun, L. (1993) Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations. *International Journal of Social Psychiatry* **39**:255-265.

Conklin, M. and O'Connor, B. (1995) Beliefs about the fetus as a moderator of postabortion psychological well-being. *Journal of Social Psychiatry* **39**: 76-81.

Foy, D., Osato, S., Houskamp, B. & Neuman, D. (1992) Etiology of posttraumatic stress disorder. In P. Saigh (ed.), *Posttraumatic Stress Disorder* (pp. 28-49). Boston: Allyn & Bacon.

Franco, K. et al. (1989) Anniversary reactions and due date responses following abortion. *Psychotherapy and Psychosomatics 52:151-154.*

Gilchrist, A., Hannaford, P., Frank, P., and Kay, C. (1995) Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry 167:243-248.*

Gissler, M., Hemminki, E., and Lönnqvist, J. (1996) Suicides after pregnancy in Finland, 1987-94: Register linkage. *British Medical Journal* **313**:1-11.

Ney, P. & Wickett, A. (1989) Mental health and abortion: Review and analysis. *Psychiatric Journal of the University of Ottawa,* 14:4, 506-516.

Reardon, D. ((1988). Aborted Women: Silent No More. Westchester, Ill.: Crossway.

Reardon, D. & Ney, P. (2000) Abortion and subsequent substance abuse. *American Journal of Drug and Alcohol Abuse.* 26:1, 61-75.

Rue, V. (1995) Post-Abortion Syndrome: A Variant of post-traumatic stress disorder. In P. Doherty (ed.) *Post-Abortion Syndrome: Its Wide Ramifications.* Dublin: Four Courts Press, 15-28.

Rue, V. et al. (forthcoming) Abortion & Trauma: Controversy, Diagnosis & Treatment. Unpublished manuscript.

Soderberg, H., Janzon, L. & Sjoberg, N. (1998) Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmo, Sweden. *European Journal of Obstetrics & Gynecology, 79, 173-178*

Speckhard, A. (1997) Traumatic death in pregnancy: The significance of meaning and attachment. In Figley, C., Bride, B. & Mazza, N. (Eds.) *Death & Trauma: The Traumatology of Grieving.* Washington, D.C.: Taylor & Francis, 67-100.

Speckhard, A. & Rue, V. (1992) Postabortion syndrome: An emerging public health concern. *Journal of Social Issues*, 48 95-120.

Torre-Bueno, A. (1996) *Peace after abortion.* San Diego: Pimpernel Press.