SB

49

(FILE 2)

<TARGET><BILL>SB 49</BILL><SUBJECT>SB 49 (FILE 2)</SUBJECT><COMM>SFIN28</COMM></TARGET>

SB 49

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SPONSOR SUBSTITUTE FOR SENATE BILL NO. 49

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-EIGHTH LEGISLATURE - FIRST SESSION

BY SENATORS COGHILL, Olson, Kelly, Dyson, Micciche, Dunleavy, Giessel

Introduced: 2/15/13
Referred: Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 **"An Act defining 'medically necessary abortion' for purposes of making payments**
2 **under the state Medicaid program."**

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

4 *** Section 1.** AS 47.07 is amended by adding a new section to read:
5 **Sec. 47.07.068. Payment for abortions.** (a) The department may not pay for
6 abortion services under this chapter unless the abortion services are for a medically
7 necessary abortion or the pregnancy was the result of rape or incest. Payment may not
8 be made for an elective abortion.
9 (b) In this section,
10 (1) "abortion" has the meaning given in AS 18.16.090;
11 (2) "elective abortion" means an abortion that is not a medically
12 necessary abortion;
13 (3) "medically necessary abortion" means that, in a physician's
14 objective and reasonable professional judgment after considering medically relevant

1 factors, an abortion must be performed to avoid a threat of serious risk to the life or
2 physical health of a woman from continuation of the woman's pregnancy;
3 (4) "serious risk to the life or physical health" includes, but is not
4 limited to, a serious risk to the pregnant woman of
5 (A) death; or
6 (B) impairment of a major bodily function because of
7 (i) diabetes with acute metabolic derangement or severe
8 end organ damage;
9 (ii) renal disease that requires dialysis treatment;
10 (iii) severe pre-eclampsia;
11 (iv) eclampsia;
12 (v) convulsions;
13 (vi) status epilepticus;
14 (vii) sickle cell anemia;
15 (viii) severe congenital or acquired heart disease, class
16 IV;
17 (ix) pulmonary hypertension;
18 (x) malignancy if pregnancy would prevent or limit
19 treatment;
20 (xi) kidney infection;
21 (xii) congestive heart failure;
22 (xiii) epilepsy;
23 (xiv) seizures;
24 (xv) coma;
25 (xvi) severe infection exacerbated by pregnancy;
26 (xvii) rupture of amniotic membranes;
27 (xviii) advanced cervical dilation of more than six
28 centimeters at less than 22 weeks gestation;
29 (xix) cervical or cesarean section scar ectopic
30 implantation;
31 (xx) any pregnancy not implanted in the uterine cavity;

1 (xxi) amniotic fluid embolus; or
2 (xxii) another physical disorder, physical injury, or
3 physical illness, including a life-endangering physical condition caused
4 by or arising from the pregnancy that places the woman in danger of
5 death or major bodily impairment if an abortion is not performed.

2

ALASKA STATE LEGISLATURE

SENATOR JOHN COGHILL

State Capitol, Room 119, Juneau, AK 99801-1182 (907) 465-3719
301 Santa Claus Lane, Suite 3B, North Pole, AK 99705 (907) 488-5725

SB 49: An Act defining "medically necessary abortion" for purposes of making payments under the state Medicaid program.

Sponsor Statement

Senate Bill 49 ("SB 49") specifically brings clarity to the term "medically necessary abortion" for the purposes of making payments under Medicaid.

In 2001, the Alaska Supreme Court determined the state must pay for medically necessary abortions for participants in the Medicaid program.[1] Since 2001, the term "medically necessary abortion" has acquired a constitutional component of *unknown scope*. The relatively few Alaska cases involving abortion rights do not provide guidance as to how broadly the term "medically necessary abortion" is to be construed.

SB 49 answers that issue. SB 49, based on recommendations and expert testimony from medical professionals, reasonably provides a neutral definition for a "medically necessary abortion."

I urge you to support SB 49.

---

[1] See *State, Department of Health and Social Services v. Planned Parenthood of Alaska*, 28 P.3d 904 (Alaska 2001).

3

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SENATOR JOHN COGHILL

SECTIONAL ANALYSIS

SB 49: "An Act defining 'medically necessary abortion' for purposes of making payments under the state Medicaid program."

Section 1: AS 47.07 is amended by adding a new section:

AS 47.07.068 shall read:

This section shall neutrally define "medically necessary abortions" for the purpose of making payments under Medicaid.

This section shall clearly distinguish between "medically necessary abortions" and "elective abortions."

Medicaid does not fund elective procedures (such as a facelift).

Medicaid also shall not fund elective abortions.

Medicaid only funds medically necessary procedures.

Medicaid shall only fund medically necessary abortions.

The definition was crafted after giving careful consideration to existing federal foundational thresholds found in the Hyde Amendment, the language in the 2001 "Planned Parenthood Case" (State, DHSS v. Planned Parenthood, 28 P.3d 904, 915 (Alaska 2001)), and the neutral, professional recommendations of medical experts.

(a) The department shall not pay for abortions unless the services are medically necessary or the pregnancy was the result of rape or incest. Payment shall not be made for elective abortions.

(b) (1) "Abortion" shall be as defined in AS 18.16.090.

(2) “Elective abortion” means an abortion that is not medically necessary.
(3) “Medically necessary abortion” means, in a physician’s objective and reasonable professional judgment, after considering neutral medically relevant factors, that an abortion must be performed to avoid a threat of serious risk to the life or physical health of a woman from continuation of the woman’s pregnancy;
(4) “Serious risk to the life or physical health” includes, but is not limited to, a serious risk to the pregnant woman of:

(A) death; or

(B) impairment of a major bodily function because of

(i-xxii) the conditions listed.

4

7 of 100 DOCUMENTS

FEDERAL REGISTER

Vol. 75, No. 059

Presidential Documents

PRESIDENT OF THE UNITED STATES

Executive Order 13535 of March 24, 2010

Title 3--

The President

Title3--

The President

Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act

Part IV

View PDF of Federal Register Print Version

75 FR 15599

DATE: Monday, March 29, 2010

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the "Patient Protection and Affordable Care Act" (Public Law 111-148), I hereby order as follows:

Section. 1. *Policy.* Following the recent enactment of the Patient Protection and Affordable Care Act (the "Act"), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds arenot used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this order is to establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors--Federal officials, State officials (including insurance regulators) and health care

providers--are aware of their responsibilities, new and old.

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, *42 U.S.C. 300a-7*, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Numerous executive agencies have a role in ensuring that these restrictions are enforced, including the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the Office of Personnel Management.

Sec. 2. *Strict Compliance with Prohibitions on Abortion Funding in Health Insurance Exchanges.* The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014. The Act also imposes strict payment and accounting requirements to ensure that Federal funds are not used for abortion services in exchange plans (except in cases of rape or incest, or when the life of the woman would be endangered) and requires State health insurance commissioners to ensure that exchange plan funds are segregated by insurance companies inaccordance with generally accepted accounting principles, OMB funds management circulars, and accounting guidance provided by the Government Accountability Office.

I hereby direct the Director of the OMB and the Secretary of HHS to develop, within 180 days of the date of this order, a model set of segregation guidelines for State health insurance commissioners to use when determining whether exchange plans are complying with the Act's segregation requirements, established in section 1303 of the Act, for enrollees receiving Federal financial assistance. The guidelines shall also offer technical information that States should follow to conduct independent regular audits of insurance companies that participate in the health insurance exchanges. In developing these model guidelines, the Director of the OMB and the Secretary of HHS shall consult with executive agencies and offices that have relevant expertise in accounting [*15600] principles, including, but not limited to, the Department of the Treasury, and with the Government Accountability Office. Upon completion of those model guidelines, the Secretary of HHS should promptly initiate a rulemaking to issue regulations, which will have the force of law, to interpret the Act's segregation requirements, and shall provide guidance to State health insurance commissioners on how to comply with the model guidelines.

Sec. 3. *Community Health Center Program.* The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program. Existing law prohibitsthese centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), as a result of both the Hyde Amendment and longstanding regulations containing the Hyde language. Under the Act, the Hyde language shall apply to the authorization and appropriations of funds for Community Health Centers under section 10503 and all other relevant provisions. I hereby direct the Secretary of HHS to ensure that program administrators and recipients of Federal funds are aware of and comply with the limitations on abortion services imposed on CHCs by existing law. Such actions should include, but are not limited to, updating Grant Policy Statements that accompany CHC grants and issuing new interpretive rules.

Sec. 4. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect: (i) authority granted by law or Presidential directive to an agency, or the head thereof; or (ii) functions of the Director of the OMB relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at

law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees or agents, or any other person.

/S/ Barack Obama

THE WHITE HOUSE,

Washington, March 24, 2010.

[FR Doc. 2010-7154 Filed 3-26-10; 1:00 pm]

BILLING CODE 0000-00-X

4a

GUTTMACHER INSTITUTE
STATE POLICIES IN BRIEF As of FEBRUARY 1, 2013

State Funding of Abortion Under Medicaid

BACKGROUND: First implemented in 1977, the Hyde Amendment, which currently forbids the use of federal funds for abortions except in cases of life endangerment, rape or incest, has guided public funding for abortions under the joint federal-state Medicaid programs for low-income women. At a minimum, states must cover those abortions that meet the federal exceptions. Although most states meet the requirements, one state is in violation of federal Medicaid law, because it pays for abortions only in cases of life endangerment. Some states use their own funds to pay for all or most medically necessary abortions, although most do so as a result of a specific court order.

HIGHLIGHTS:

- 32 states and the District of Columbia follow the federal standard and provide abortions in cases of life endangerment, rape and incest.
  - 2 of these states also provide state funds for abortions in cases of fetal impairment.
  - 3 of these states also provide state funds for abortions that are necessary to prevent grave, long-lasting damage to the woman's physical health.
- 1 state provides abortions only in cases of life endangerment, in apparent violation of the federal standard.
- 17 states use state funds to provide all or most medically necessary abortions.
  - 4 of these states provide such funds voluntarily.
  - 13 of these states do so pursuant to a court order.

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CONTINUED

STATE FUNDING OF ABORTION UNDER MEDICAID

STATE	GENERALLY FOLLOWS THE FEDERAL STANDARD, FUNDS IN CASES OF:		FUNDS ALL OR MOST MEDICALLY NECESSARY ABORTIONS
	Life Endangerment, Rape and Incest	Other Exceptions	
Alabama	X		
Alaska			Court order
Arizona			Court order
Arkansas	X		
California			Court order
Colorado	X		
Connecticut			Court order
Delaware	X		
Dist. of Columbia	X		
Florida	X		
Georgia	X		
Hawaii			Voluntarily
Idaho	X		
Illinois			Court order
Indiana	X	Physical health	
Iowa	X		
Kansas	X		
Kentucky	X		
Louisiana	X		
Maine	X		
Maryland			Voluntarily
Massachusetts			Court order
Michigan	X		
Minnesota			Court order
Mississippi	X	Fetal impairment	
Missouri	X		
Montana			Court order
Nebraska	X		
Nevada	X		
New Hampshire	X		
New Jersey			Court order
New Mexico			Court order
New York			Voluntarily
North Carolina	X		
North Dakota	X		
Ohio	X		
Oklahoma	X		
Oregon			Court order
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota	*		
Tennessee	X		
Texas	X		
Utah	X	Physical health	
Vermont			Court order
Virginia	X	Fetal impairment	
Washington			Voluntarily
West Virginia			Court order
Wisconsin	X	Physical health	
Wyoming	X		
TOTAL	32 + DC		17

* State only pays for abortions when necessary to protect the woman's life.

CONTINUED

FOR MORE INFORMATION:

For information on state legislative and policy activity, click on Guttmacher's Monthly State Update, for state-level policy information see Guttmacher's State Policies in Brief series, and for information and data on reproductive health issues, go to Guttmacher's State Center. To see state-specific reproductive health information go to Guttmacher's Data Center, and for abortion specific information click on State Facts About Abortion. To keep up with new state relevant data and analysis sign up for the State News Quarterly Listserv.

Sonfield A and Gold RB, *Public Funding for Family Planning, Sterilization and Abortion Services, FY1980–2010*, New York: Guttmacher Institute, 2012.

Kacanek D, et al., Medicaid funding for abortion: providers' experiences with cases involving rape, incest and life endangerment, *Perspectives on Sexual and Reproductive Health*, 42(2):79–86.

Henshaw SK et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, New York: Guttmacher Institute, 2009.

Boonstra HD, The impact of government programs on reproductive health disparities: three case studies, *Guttmacher Policy Review*, 11(3):6–12.

Sonfield A, Alrich C and Gold RB, Public funding for family planning, sterilization and abortion services, FY 1980–2006, *Occasional Report*, New York: Guttmacher Institute, 2008, No. 38.

Boonstra HD, The heart of the matter: public funding of abortion for poor women in the United States, *Guttmacher Policy Review*, 10(1):12–16.

4b

Abortion Laws

Updated February 2012

Abortion and related issues concerning fetal rights are debated each year during state legislative sessions. Laws dealing with mandatory counseling and waiting periods for abortion, state funding of abortion under Medicaid, parental involvement in abortions for minors and abortion policy in the absence of *Roe v Wade* are frequently debated on the floors of state legislatures across the country. This webpage provides charts containing information on the laws related to these topics.

For information about state laws related to abortion coverage in insurance exchanges and the Affordable Care Act, please visit NCSL's Health Reform and Abortion Coverage webpage.

Mandatory Counseling and Waiting Periods for Abortion

State	Counseling					Length of Waiting Period
		Includes Information On:				
	Counseling Required	Breast Cancer	Fetal Pain	Mental Health Impact	Ultrasound Services	
Alabama	X			X*		24 hours
Alaska	X	X*	X*	X		
Arizona	§					24 hours
Arkansas	X		X«	X		Prior day
California	X					
Connecticut	X					
Delaware	X					±
Florida	X					
Georgia	X		X	X	X	24 hours
Idaho	X			X*		24 hours
Indiana	X		X£		X	18 hours
Kansas	X	X*		X*	X	24 hours
Kentucky	X					24 hours
Louisiana	X		X	X*		24 hours
Maine	X					
Massachusetts						±
Michigan	X			X	X*	24 hours
Minnesota	X	X	X«	X		24 hours
Mississippi	X	X				24 hours
Missouri	X		X«	X	X	24 hours
Montana						±
Nebraska	X			X	X	24 hours
Nevada	X			X (emotional)		
North Carolina	X	X		X	X	24 hours
North Dakota	X					24 hours
Ohio	X					24 hours
Oklahoma	X	X*	X«	X	X	24 hours
Pennsylvania	X			X		24 hours
Rhode Island	X					
South Carolina	X				X	24 hours
South Dakota	X		X*	X*		72 hours¥
Tennessee	X#					±
Texas	X	X	X*	X*		24 hours
Utah	X		X	X	X	24 hours
Virginia	X			X		24 hours
West Virginia	X	X*		X		24 hours
Wisconsin	X			X	X	24 hours
Total	**35**	**8**	**11**	**21**	**11**	**30**

All states waive mandatory waiting period requirements in a medical emergency or when the woman's life or health is threatened. In Utah, the waiting period requirement is waived if the pregnancy is a result of rape or incest, the fetus has grave defects or the patient is younger than 15. The counseling requirement is waived in cases of ectopic pregnancy or severe fetal abnormality (Alabama) and in cases of a medical emergency (Georgia and Rhode Island).

± Permanently enjoined by court order; policy not in effect.
§ Temporarily enjoined by court order; policy not in effect.

* Included in written counseling materials although not specified by law.
« Fetal pain information is given only to women who are at least 20 weeks gestation; in Missouri at 22 weeks gestation.
Enforcement of provision of the Tennessee law requiring that a woman be told that an abortion constitutes major surgery is enjoined.
¥ A 2011 law to extend the waiting period to 72 hours and mandated in person counseling is blocked during a court case.
£ Required by law to be included in the written materials; however, the materials have not yet been updated. The provision is currently not enforced against Planned Parenthood of Indiana.

Source: Guttmacher Institute 2012

State Funding of Abortion Under Medicaid

State	Generally Follows the Federal Standard, Funds in Cases of: Life Endangerment, Rape and Incest	Other Exceptions	Funds All of Most Medically Necessary Abortions
Alabama	X		
Alaska			Court Order
Arizona			Court Order
Arkansas	X		
California			Court Order
Colorado	X		
Connecticut			Court Order
Delaware	X		
District of Columbia	X		
Florida	X		
Georgia	X		
Hawaii			Voluntarily
Idaho	X		
Illinois			Court Order
Indiana	X	Physical Health	
Iowa	X		
Kansas	X		
Kentucky	X		
Louisiana	X		
Maine	X		
Maryland			Voluntarily
Massachusetts			Court Order
Michigan	X		
Minnesota			Court Order
Mississippi	X	Fetal Abnormality	
Missouri	X		
Montana			Court Order
Nebraska	X		
Nevada	X		
New Hampshire	X		
New Jersey			Court Order
New Mexico			Court Order
New York			Voluntarily
North Carolina	X		
North Dakota	X		
Ohio	X		
Oklahoma	X		
Oregon			Court Order
Pennsylvania	X		
Rhode Island	X		
South Carolina	X		
South Dakota	*		

Tennessee	X		
Texas	X		
Utah	X	Physical Health	
Vermont			Court Order
Virginia	X	Fetal Abnormality	
Washington			Voluntarily
West Virginia			Court Order
Wisconsin	X	Physical Health	
Wyoming	X		
Total	**32 and DC**		**17**

* State only pays for abortions when necessary to protect the woman's life.

Source: Guttmacher Institute 2012

Parental Involvement in Minors' Abortions

	Required Parental Involvement		Alternatives		Exceptions	
State	**Consent**	**Notification**	**Judicial Bypass**	**Other Adult Relatives**	**Medical Emergency**	**Abuse, Assault, Incest or Neglect**
Alabama	X		X		X	
Alaska		X	X		X	X
Arizona	X		X		X	X
Arkansas	X		X		X	X
California	±					
Colorado		X	X		X	X
Delaware		X,*,¥	X,*,¥	X,¥	X,¥	
Florida		X	X		X	
Georgia		X	X		X	
Idaho	X		X		X	X
Illinois		§	§	§	§	§
Indiana	X		X		X	
Iowa		X	X	X	X	X
Kansas	Both parents		X		X	
Kentucky	X		X		X	
Louisiana	X		X		X	
Maryland		X*				X*
Massachusetts	X		X		X	
Michigan	X		X		X	
Minnesota		Both Parents	X		X	X
Mississippi	Both Parents		X		X	
Missouri	X		X			
Montana		±				
Nebraska	X		X		X	X
Nevada		±				
New Hampshire		X	X		X	
New Jersey		±				
New Mexico	±					
North Carolina	X		X	X	X	
North Dakota	Both Parents		X		X	
Ohio	X		X			
Oklahoma	X	X	X		X	X
Pennsylvania	X		X		X	
Rhode Island	X		X			
South Carolina	X,*		X, ¥	X, ¥	X, ¥	X, ¥
South Dakota		X	X		X	
Tennessee	X		X		X	X
Texas	X	X	X		X	
Utah	X	X	X, £		X	X, ¢
Virginia	X		X	X	X	X
West Virginia		X*	X*		X	
Wisconsin	X*		X*	X	X	X
Wyoming	X	X	X		X	
Total	**28**	**19**	**37**	**7**	**34**	**16**

Note: Except where indicated, policies require the involvement of one parent.

± Enforcement permanently enjoined by court order; policy not in effect.
§ Enforcement temporarily enjoined by court order; policy not in effect.
* Allows specified health professionals to waive parental involvement in limited circumstances.
¥ While most states laws apply to minors under 18, South Carolina's law applies to women under 17 and Delaware's law applies to women under 16.
£ The provision only applies to parental consent requirements.
¢ The provision only applies to the parental notification requirements.

Source: Guttmacher Institute 2012

Abortion Policy in the Absence of *Roe v Wade*

State	Criminalizing Abortion Except in Cases of Life Endangerment		Upholding Right to Abortion
	Abortion Ban	Abortion Ban if *Roe* Overturned	
California			X
Connecticut			X
Hawaii			X
Louisiana	±	X	
Maine			X
Maryland			X
Mississippi		X	
Nevada			X
North Dakota		§	
South Dakota		X	
Utah	±		
Washington			X
Total	**2**	**4**	**7**

± Enforcement permanently enjoined by court order; policy not in effect
§ Law allows a physician to claim an affirmative defense that the abortion was necessary to protect the life of the woman or in cases of rape or incest.

Source: Guttmacher Institute 2012

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4c

Supreme Court of Alaska.
STATE of Alaska, DEPARTMENT OF HEALTH & SOCIAL SERVICES, Karen Perdue, Commissioner, Appellant,
v.
PLANNED PARENTHOOD OF ALASKA, INC., Jan Whitefield, M.D., and Susan Lemagie, M.D., Appellees.

No. S-9109.
July 27, 2001.

Two **medical** doctors and an abortion provider filed a complaint against the Department of Health and Social Service (DHSS), seeking to enjoin enforcement of Department regulation that denied funding for **medically necessary** abortions, and requesting declaratory relief. The Superior Court, Third Judicial District, Sen K. Tan, J., granted summary judgment in favor of plaintiffs and permanently enjoined the Department from enforcing the regulation. Department appealed. The Supreme Court, Fabe, C.J., held that: (1) regulation violated Alaska's constitutional guarantee of equal protection, and (2) separation of powers doctrine does not preclude a court from ordering the state to provide equal funding for women whose health is endangered by pregnancy.

Affirmed.

West Headnotes

[1] Appeal and Error 30 893(1)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k893 Cases Triable in Appellate Court
30k893(1) k. In General. Most Cited Cases

Appeal and Error 30 895(2)

30 Appeal and Error
30XVI Review
30XVI(F) Trial De Novo
30k892 Trial De Novo
30k895 Scope of Inquiry
30k895(2) k. Effect of Findings Below. Most Cited Cases

Supreme Court will review a grant of summary judgment de novo, exercising its independent judgment to determine whether the parties genuinely dispute any material facts and, if not, whether the undisputed facts entitle the moving party to judgment as a matter of law.

[2] Appeal and Error 30 840(3)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k838 Questions Considered
30k840 Review of Specific Questions and Particular Decisions
30k840(3) k. Review of Constitutional Questions. Most Cited Cases

Appeal and Error 30 856(1)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k851 Theory and Grounds of Decision of Lower Court
30k856 Grounds for Sustaining Decision Not Considered
30k856(1) k. In General. Most Cited Cases

On questions of constitutional law, Supreme Court will apply its independent judgment, and may affirm the superior court on any ground supported by the record.

[3] Constitutional Law 92 3552

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92 Constitutional Law
92XXVI Equal Protection
92XXVI(E) Particular Issues and Applications
92XXVI(E)5 Social Security, Welfare, and Other Public Payments
92k3548 Medical Assistance
92k3552 k. Abortion Funding. Most Cited Cases
(Formerly 92k242.3(1))

Health 198H ⚷480

198H Health
198HIII Government Assistance
198HIII(B) Medical Assistance in General; Medicaid
198Hk472 Benefits and Services Covered
198Hk480 k. Abortion or Birth Control. Most Cited Cases
(Formerly 356Ak241.95)

State regulation denying Medicaid funding for medically necessary abortions, except for pregnant women at risk of dying or pregnant from rape or incest, violates Alaska's constitutional guarantee of equal protection by providing medically necessary care to all indigents except women who need abortions; once the State undertook to fund medically necessary services for poor Alaskans, it could not selectively exclude women from that program merely because the threat to their health arose from pregnancy, which would affect their constitutional right to reproductive freedom, despite state's interest in providing healthcare to women who carry pregnancies to term and in protecting the fetus. Const. Art. 1, § 1; Alaska Admin. Code title 7, § 43.140.

[4] Constitutional Law 92 ⚷3043

92 Constitutional Law
92XXVI Equal Protection
92XXVI(A) In General
92XXVI(A)5 Scope of Doctrine in General
92k3038 Discrimination and Classification
92k3043 k. Statutes and Other Written Regulations and Rules. Most Cited Cases
(Formerly 92k209)

Constitutional Law 92 ⚷3050

92 Constitutional Law
92XXVI Equal Protection
92XXVI(A) In General
92XXVI(A)6 Levels of Scrutiny
92k3050 k. In General. Most Cited Cases
(Formerly 92k209)

In analyzing a challenged law under Alaska's equal protection provision, Supreme Court must first determine what level of scrutiny to apply, using Alaska's "sliding scale" standard, the Court must next examine the State's interests served by the challenged regulation and determine whether the burden placed on constitutional rights by the regulation is minimal, or whether the objective degree to which the challenged legislation tends to deter exercise of constitutional rights is significant and cannot survive constitutional challenge absent a compelling state interest, and if the State has shown that its interests justify burdening the rights of citizens, the Court must finally determine whether State has demonstrated that the means it has chosen to advance those goals are well-fitted to the ends, and that its goals could not be accomplished by less restrictive means. Const. Art. 1, § 1.

[5] Constitutional Law 92 ⚷3062

92 Constitutional Law
92XXVI Equal Protection
92XXVI(A) In General
92XXVI(A)6 Levels of Scrutiny
92k3059 Heightened Levels of Scrutiny
92k3062 k. Strict Scrutiny and Compelling Interest in General. Most Cited Cases
(Formerly 92k213.1(1))

Constitutional Law 92 ⚷3766

92 Constitutional Law
92XXVI Equal Protection
92XXVI(E) Particular Issues and Applications
92XXVI(E)18 Privacy and Sexual Matters
92k3766 k. Birth Control and Abortion. Most Cited Cases
(Formerly 92k225.1)

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A regulation that affects the constitutional right to reproductive freedom, or selectively denies a benefit to those who exercise a constitutional right, is subject to the most searching judicial scrutiny, that is, "strict scrutiny" in analyzing the regulation under Alaska's equal protection provision. Const. Art. 1, § 1.

[6] Health 198H ⚷473

198H Health
198HIII Government Assistance
198HIII(B) Medical Assistance in General; Medicaid
198Hk472 Benefits and Services Covered
198Hk473 k. In General. Most Cited Cases
(Formerly 356Ak241)

Government agency is constitutionally bound to apply neutral criteria in allocating health care benefits to poor Alaskans, even if considerations of expense, medical feasibility, or the necessity of particular services otherwise limit the health care it provides. Const. Art. 1, § 1.

[7] Constitutional Law 92 ⚷3552

92 Constitutional Law
92XXVI Equal Protection
92XXVI(E) Particular Issues and Applications
92XXVI(E)5 Social Security, Welfare, and Other Public Payments
92k3548 Medical Assistance
92k3552 k. Abortion Funding. Most Cited Cases
(Formerly 92k242.3(1))

Health 198H ⚷480

198H Health
198HIII Government Assistance
198HIII(B) Medical Assistance in General; Medicaid
198Hk472 Benefits and Services Covered
198Hk480 k. Abortion or Birth Control. Most Cited Cases
(Formerly 356Ak241.95)

State regulation denying Medicaid funding for medically necessary abortions, except for pregnant women at risk of dying or pregnant from rape or incest, fails equal protection analysis under any standard, given that under the regulation, the State grants needed health care to some Medicaid-eligible Alaskans, but denies it to others, based on criteria entirely unrelated to the Medicaid program's purpose of granting uniform and high quality medical care to all needy persons in the state. Const. Art. 1, § 1; Alaska Admin. Code title 7, § 43.140.

[8] Constitutional Law 92 ⚷3006

92 Constitutional Law
92XXVI Equal Protection
92XXVI(A) In General
92XXVI(A)2 Relationship to Similar Provisions
92k3006 k. Federal/State Cognates. Most Cited Cases
(Formerly 92k213.1(2))

Federal rational basis review for equal protection analysis is a less rigorous standard than Alaska's rational basis review. U.S.C.A. Const.Amend. 5; Const. Art. 1, § 1.

[9] Constitutional Law 92 ⚷2453

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)1 In General
92k2453 k. Determination of Constitutionality of Actions of Other Branches in General. Most Cited Cases
(Formerly 92k67)

Under Alaska's constitutional structure of government, the Judicial branch has the constitutionally mandated duty to ensure compliance with the provisions of the Alaska Constitution, including compliance by the legislature.

[10] Constitutional Law 92 ⚷2516(1)

92 Constitutional Law
92XX Separation of Powers
92XX(C) Judicial Powers and Functions
92XX(C)2 Encroachment on Legislature
92k2499 Particular Issues and Applica-

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tions
92k2516 Health
92k2516(1) k. In General. Most Cited Cases
(Formerly 92k70.1(12))

Separation of powers doctrine does not preclude a court from ordering the state to provide equal funding for women whose health is endangered by pregnancy, even if legislature's appropriations power underlies the funding.

[11] Constitutional Law 92 2330

92 Constitutional Law
92XX Separation of Powers
92XX(A) In General
92k2330 k. In General. Most Cited Cases
(Formerly 92k50)

Separation of powers doctrine and its complementary doctrine of checks and balances are implicit in the Alaska Constitution.

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Before FABE, Chief Justice, MATTHEWS, EASTAUGH, BRYNER, and CARPENETI, Justices.

OPINION

FABE, Chief Justice.

I. *INTRODUCTION*

Alaska's Medicaid program funds virtually all necessary medical services for poor Alaskans-"regardless of race, age, national origin, or economic standing" [FN1]-but it denies funding for medically necessary abortions. Alone among Medicaid-eligible Alaskans, women whose health is endangered by pregnancy are denied health care based solely on political disapproval of the medically necessary procedure. This selective denial of medical benefits violates Alaska's constitutional guarantee of equal protection. Our conclusion is supported by the majority of jurisdictions that have considered comparable restrictions on state funding of medically necessary abortions: these state courts have concluded that, under their state constitutions, government health care programs that fund other medically necessary procedures may not deny assistance to eligible women whose health depends on obtaining abortions.[FN2]

FN1. AS 47.07.010.

FN2. *See Committee to Defend Reprod. Rights v. Myers,* 29 Cal.3d 252, 172 Cal.Rptr., 866, 625 P.2d 779 (1981); *Moe v. Secretary of Admin. & Fin.,* 382 Mass. 629, 417 N.E.2d 387 (1981); *Women of Minnesota v. Gomez,* 542 N.W.2d 17 (Minn.1995); *Right to Choose v. Byrne,* 91 N.J. 287, 450 A.2d 925 (1982); *New Mexico Right to Choose/NARAL v. Johnson,* 126 N.M. 788, 975 P.2d 841 (1998), *cert. denied,* 526 U.S. 1020, 119 S.Ct. 1256, 143 L.Ed.2d 352 (1999); *Women's Health Ctr. of W. Va., Inc. v. Panepinto,* 191 W.Va. 436, 446 S.E.2d 658 (1993); *but see Renee B. v. State, Agency for Health Care Admin.,* 790 So.2d 1036 (Fla.2001); *Doe v. Department of Soc. Servs.,* 439 Mich. 650, 487 N.W.2d 166 (1992); *Rosie J. v. North Carolina Dep't of Human Resources,* 347 N.C. 247, 491 S.E.2d 535 (1997); *Hope v. Perales,* 83 N.Y.2d 563, 611 N.Y.S.2d 811, 634 N.E.2d 183 (1994); *Fischer v. Department of Pub. Welfare,* 509 Pa. 293, 502 A.2d 114 (1985).

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> A number of lower state courts have also found that funding restrictions similar to those challenged today violated their state constitutions. *See Simat Corp. v. Arizona Cost Containment System Admin.,* No. CV1999014614 (Ariz.Super. May 23, 2000); *Doe v. Maher,* 40 Conn.Supp. 394, 515 A.2d 134 (1986); *Roe v. Harris,* NO. 96977 (Idaho Dist. Feb. 1, 1994); *Doe v. Wright,* No. 91-CH-1958 (Ill.Cir. Dec. 2, 1994); *Clinic for Women v. Humphreys,* No. 49D12-9908-MI-1137 (Ind.Super. Oct. 18, 2000); *Jeannette R. v. Ellery,* No. BDV-94-811 (Mont.Dist. May 19, 1995); *Planned Parenthood Ass'n v. Department of Human Resources of Oregon,* 63 Or.App. 41, 663 P.2d 1247 (1983), *aff'd on other grounds,* 297 Or. 562, 687 P.2d 785 (1984) (declining to reach constitutional issue); *Low-Income Women of Texas v. Bost,* 38 S.W.3d 689 (Tex.App.2000); *Doe v. Celani,* No. S81-84CnC (Vt.Super. May 23, 1986); *but see Doe v. Childers,* No. 94CI02183 (Ky.Cir. Aug. 7, 1995).

This case concerns the State's denial of public assistance to eligible women whose health is in danger. It does not concern State payment for elective abortions; nor ***906** does it concern philosophical questions about abortion which we, as a court of law, cannot aspire to answer. We join the California Supreme Court in clarifying that "this case does not turn on the morality or immorality of abortion, and most decidedly does not concern the personal views of the individual justices as to the wisdom of the legislation itself or the ethical considerations involved in a woman's individual decision whether or not to bear a child." FN3 Indeed, as the California Supreme Court emphasized, "similar constitutional issues would arise if the Legislature ... funded [Medicaid] abortions but refused to provide comparable medical care for poor women who choose childbirth." FN4 The constitutional issue in this case therefore "does not involve a weighing of the value of abortion as against childbirth, but instead concerns the protection of either procreative choice from discriminatory governmental treatment." FN5 As the California court recognized, the issue presented is "not whether the state is generally obligated to subsidize the exercise of constitutional rights for those who cannot otherwise afford to do so." FN6 Rather, the issue is whether the State, having enacted a benefits program, may discriminate between recipients in the manner attempted by the Department of Health and Social Services (DHSS) today. We hold that it may not. Once the State undertakes to fund medically necessary services for poor Alaskans, it may not selectively exclude from that program women who medically require abortions.

> FN3. *Myers,* 172 Cal.Rptr. 866, 625 P.2d at 780.

> FN4. *Id.*

> FN5. *Id.*

> FN6. *Id.*

Although the State argues that courts may not enjoin unconstitutional use of the legislative appropriations power, this proposition is unsupported by case law from any jurisdiction. The legislature's spending power does not create license to disregard citizens' constitutional rights. In rejecting this part of the State's argument, we concur with every state and federal court that has considered this issue.

II. *FACTS AND PROCEEDINGS*

Alaska provides medical services for poor Alaskans primarily through the Medicaid program.FN7 Medicaid is a comprehensive health care program designed to provide medical assistance for all eligible poor persons***907** in the state.FN8 But a DHSS regulation, 7 Alaska Administrative Code (AAC) 43.140, imposes a limit on the state's health care funding: It denies Medicaid assistance for medically necessary abortions unless a pregnant woman is at risk of dying or her pregnancy resulted from rape or incest.FN9 Because DHSS offers no other funding source for abortions, 7 AAC 43.140 ensures that a woman who medically requires an abortion will receive no assistance from the state.

> FN7. *See* AS 47.07; *see also* 42 U.S.C. §§ 1396-1396v (1997).

> A second program, Chronic and Acute Medical Assistance (CAMA) complements Medicaid by providing some medical care for Alaskans who are poor but in-

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eligible for Medicaid. *See* AS 47.08.150. CAMA's predecessor, the General Relief Medical program (GRM), funded abortions for eligible women when the procedure was necessary to protect their health or when pregnancy resulted from sexual assault, sexual abuse of a minor, or incest. *See* 7 AAC 47.200(a)(4)(F) (2000); 7 AAC 47.290(8) (2000). In 1998, after nearly 30 years of government support for medically necessary abortions through GRM, the legislature stopped funding the program and enacted CAMA as a replacement. CAMA covers essentially the same services as GRM, except that it does not fund any abortions. *Compare* AS 47.08.150 *with* 7 AAC 47.200.

FN8. *See* AS 47.07.010. Medicaid relies on joint state-federal funding, with the federal government paying a portion of the state's costs. *See* 42 U.S.C. §§ 1396b(a), 1396d(b). The "Hyde Amendment" limits federal Medicaid contributions for abortions: Federal funding is available for abortions in cases of rape or incest or where the woman's life is in danger, but not for abortions necessary to protect a woman's health. *See* Pub.L. No. 106-554, §§ 508-509, 114 Stat. 2763 (2000); *Right to Choose v. Byrne,* 91 N.J. 287, 450 A.2d 925, 928-29 (1982) (discussing history of Hyde Amendment).

FN9. 7 AAC 43.140 (2000) provides in part:

(a) Payment for an abortion will, in the department's discretion, be covered under Medicaid if the physician services invoice is accompanied by certification that the

(1) life of the mother would be endangered if the pregnancy were carried to term; or

(2) pregnancy is the result of an act of rape or incest.

The range of women whose access to medical care is restricted by the regulation is broad. According to medical evidence provided to the superior court, some women-particularly those who suffer from pre-existing health problems-face significant risks if they cannot obtain abortions. Women with diabetes risk kidney failure, blindness, and preeclampsia or eclampsia-conditions characterized by simultaneous convulsions and comas-when their disease is complicated by pregnancy. Women with renal disease may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion. And pregnancy in women with sickle cell anemia can accelerate the disease, leading to pneumonia, kidney infections, congestive heart failure, and pulmonary conditions such as embolus. Poor women who suffer from conditions such as epilepsy or bipolar disorder face a particularly brutal dilemma as a result of DHSS's regulation-medication needed by the women to control their own seizures or other symptoms can be highly dangerous to a developing fetus. Without funding for medically necessary abortions, pregnant women with these conditions must choose either to seriously endanger their own health by forgoing medication, or to ensure their own safety but endanger the developing fetus by continuing medication. Finally, without state funding, Medicaid-eligible women may reach an advanced stage of pregnancy before they can gather enough money for an abortion; resulting late-term abortions pose far greater health risks than earlier procedures.

In June 1998 the plaintiffs-two **medical** doctors and **Planned Parenthood** of Alaska-filed a complaint against DHSS. They sought to enjoin enforcement of 7 AAC 43.140 and also sought a judgment declaring that the State's denial of funding for **medically necessary** abortions violates Alaska's Constitution. Superior Court Judge Sen K. Tan granted summary judgment in favor of **Planned Parenthood**. Based on this court's holding that "reproductive rights are fundamental ... [and] include the right to an abortion," [FN10] the superior court concluded that 7 AAC 43.140 impermissibly interferes with Medicaid-eligible women's constitutional rights to privacy. Because the State failed to articulate a compelling state interest for this interference, the superior court permanently enjoined DHSS from enforcing the regulation "so as to deny coverage for medically necessary abortions." The State now appeals. [FN11]

FN10. *Valley Hosp. Ass'n v. Mat-Su Coalition for Choice,* 948 P.2d 963, 969 (Alaska 1997).

FN11. For part of the time that this appeal

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was pending, DHSS continued to withhold funding for **medically necessary** abortions, despite the superior court's injunction. On **Planned Parenthood's** motion, the superior court held a show cause hearing to determine whether the Department was in contempt of court. The court heard DHSS's claim that funding was unavailable, and determined, after a "struggle", not to hold the agency in contempt. However, the court issued a new injunction to reiterate the terms of the first injunction and explicitly direct that, while DHSS retained discretion over its use of resources, it should consider state Medicaid funds available to pay for medically necessary abortions. The parties on appeal presented records from these proceedings and additional related briefing.

***908** III. *STANDARD OF REVIEW*

[1][2] We review a grant of summary judgment de novo, exercising our independent judgment to "determine whether the parties genuinely dispute any material facts and, if not, whether the undisputed facts entitle the moving party to judgment as a matter of law." FN12 On questions of constitutional law, we also apply our independent judgment. FN13 We may affirm the superior court on any ground supported by the record. FN14

FN12. *M.C. v. Northern Ins. Co. of N.Y.*, 1 P.3d 673, 674-75 (Alaska 2000).

FN13. *See Rollins v. State, Dep't of Revenue, Alcoholic Beverage Control Bd.*, 991 P.2d 202, 206 (Alaska 1999).

FN14. *See James v. McCombs*, 936 P.2d 520, 523 n. 2 (Alaska 1997); *see also Dixon v. Dixon*, 747 P.2d 1169, 1175 n. 5 (Alaska 1987).

IV. *DISCUSSION*

A. *The Challenged Regulation Violates Equal Protection.*

[3] By providing health care to all poor Alaskans except women who need abortions, the challenged regulation violates the state constitutional guarantee of "equal rights, opportunities, and protection under the law." FN15 The State, having established a health care program for the poor, may not selectively deny necessary care to eligible women merely because the threat to their health arises from pregnancy. Because we decide this case on state constitutional equal protection grounds, we do not review the superior court's privacy-based ruling. We do note, however, that our analysis today closely parallels that applied by many of the fifteen courts that have rejected similar restrictions. FN16 Although other courts' decisions have rested on a variety of state constitutional provisions, including equal protection, FN17 constitutional equal-rights-for-women clauses, FN18 due process, FN19 and privacy, FN20 the underlying logic has been the same in decision after decision: "[W]hen state government seeks to act for the common benefit, protection, and security of the people in providing medical care for the poor, it has an obligation to do so in a neutral manner so as not to infringe upon the constitutional rights of our citizens." FN21 As the Massachusetts Supreme Judicial Court observed, the constitutional principle at issue is straightforward: "It is elementary that 'when a State decides to alleviate some of the hardships of poverty by ***909** providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations.' " FN22 The State's spending discretion is limited by the constitution-"[w]hile the State retains wide latitude to decide the manner in which it will allocate benefits, it may not use criteria which discriminatorily burden the exercise of a fundamental right." FN23

FN15. Alaska Const. art. 1, § 1.

FN16. *See supra* note 2.

FN17. *See, e.g., Doe v. Maher*, 40 Conn.Supp. 394, 515 A.2d 134, 157-59 (1986); *Right to Choose v. Byrne*, 91 N.J. 287, 450 A.2d 925, 934-37 (1982); *Planned Parenthood Ass'n v. Department of Human Resources of Oregon*, 63 Or.App. 41, 663 P.2d 1247, 1257-61 (1983), *aff'd on other grounds*, 297 Or. 562, 687 P.2d 785 (1984); *see also Committee to Defend Reprod. Rights v. Myers*, 29 Cal.3d 252, 172 Cal.Rptr. 866, 625 P.2d 779 (1981).

FN18. *See, e.g., New Mexico Right to Choose/NARAL v. Johnson*, 126 N.M. 788,

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975 P.2d 841, 850-57 (1998); *Doe v. Maher*, 515 A.2d at 159-62.

FN19. *See, e.g.*, *Moe v. Secretary of Admin. & Fin.*, 382 Mass. 629, 417 N.E.2d 387, 398-99 (1981); *Doe v. Maher*, 515 A.2d at 146-57.

FN20. *See, e.g.*, *Women of Minnesota v. Gomez*, 542 N.W.2d 17, 26-32 (Minn.1995); *Women's Health Ctr. of W. Va., Inc. v. Panepinto*, 191 W.Va. 436, 446 S.E.2d 658, 664-66 (1993).

FN21. *Panepinto*, 446 S.E.2d at 667; *see also Myers*, 172 Cal.Rptr. 866, 625 P.2d at 781 (addressing the narrow question "whether the state, having enacted a general program to provide medical services to the poor, may selectively withhold such benefits from otherwise qualified persons because such persons seek to exercise their constitutional right of procreative choice in a manner which the state does not favor and does not wish to support" and holding that it may not); *Gomez*, 542 N.W.2d at 28 (defining the "relevant inquiry" as "whether, having elected to participate in a medical assistance program, the state may selectively exclude from such benefits otherwise eligible persons solely because they make constitutionally protected health care decisions with which the state disagrees," and concluding that the state may not); *Byrne*, 450 A.2d at 937 ("[W]e hold that the State may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent."); *Johnson*, 975 P.2d at 856 ("[C]ourts very rarely require the government to fund its citizens' exercise of their constitutional rights.... But that is not to say that when the Department elects to provide medically necessary services to indigent persons, it can do so in a way that discriminates against some recipients on account of their gender.").

FN22. *Moe*, 417 N.E.2d at 401 (quoting *Maher v. Roe*, 432 U.S. 464, 469-70, 97 S.Ct. 2376, 53 L.Ed.2d 484 (1977)).

FN23. *Id.*

[4] Alaska's constitutional equal protection clause mandates "equal treatment of those similarly situated;" [FN24] it protects Alaskans' right to non-discriminatory treatment more robustly than does the federal equal protection clause.[FN25] In analyzing a challenged law under Alaska's equal protection provision, we first determine what level of scrutiny to apply, using Alaska's "sliding scale" standard.[FN26] The "weight [that] should be afforded the constitutional interest impaired by the challenged enactment" is "the most important variable in fixing the appropriate level of review." [FN27] Second, we examine the State's interests served by the challenged regulation.[FN28] If the burden placed on constitutional rights by the regulation is minimal, then the State need only show that its objectives were legitimate for the regulation to survive an equal protection challenge. [FN29] But if "the objective degree to which the challenged legislation tends to deter [exercise of constitutional rights]" [FN30] is significant, the regulation cannot survive constitutional challenge unless it serves a compelling state interest.[FN31] Finally, if the State shows that its interests justify burdening the rights of citizens, for the regulation to survive constitutional challenge the State must demonstrate that the means it has chosen to advance those goals are well-fitted to the ends, and that its goals could not be accomplished by less restrictive means.[FN32]

FN24. *Alaska Pacific Assurance Co. v. Brown*, 687 P.2d 264, 271 (Alaska 1984).

FN25. *See* *State v. Anthony*, 810 P.2d 155, 157 (Alaska 1991).

FN26. *See* *Matanuska-Susitna Borough Sch. Dist. v. State*, 931 P.2d 391, 396 (Alaska 1997).

FN27. *Id.* (quoting *Alaska Pacific Assurance Co.*, 687 P.2d at 269).

FN28. *See id.*; *State v. Ostrosky*, 667 P.2d 1184, 1192 (Alaska 1983).

FN29. *See id.*

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FN30. *Alaska Pacific Assurance Co.*, 687 P.2d at 271.

FN31. *See Matanuska-Susitna Borough Sch. Dist.*, 931 P.2d at 396 (quoting *Alaska Pacific Assurance Co.*, 687 P.2d at 269-70).

FN32. *See id.* at 396-97.

[5] The regulation at issue in this case affects the exercise of a constitutional right, the right to reproductive freedom.[FN33] Therefore, the regulation is subject to the most searching judicial scrutiny, often called "strict scrutiny." [FN34] We have explained in the past that such scrutiny is appropriate where a challenged enactment affects "fundamental rights," including "the exercise of intimate personal choices." [FN35] This court has specified that the right to reproductive freedom "may be legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest." [FN36]

FN33. *See Valley Hosp. Ass'n v. Mat-Su Coalition for Choice*, 948 P.2d 963, 968-69 (Alaska 1997).

FN34. *See State v. Ostrosky*, 667 P.2d 1184, 1192 (Alaska 1983).

FN35. *Id.*

FN36. *Valley Hosp.*, 948 P.2d at 969.

Judicial scrutiny of state action is equally strict where the government, by selectively denying a benefit to those who exercise a constitutional right, effectively deters the exercise of that right. In *Alaska Pacific Assurance Co. v. Brown,* we held the State to a "very high" burden to justify a statute that reduced workers' compensation benefits paid to workers who exercised their constitutional right to leave the state.[FN37] We concluded that the challenged regulation did not meet this high standard and thus violated equal protection.[FN38] Like the regulation at issue today, ***910** the challenged statute in *Alaska Pacific Assurance Co.* did not forbid individual exercise of constitutional rights; rather, it limited the government benefits distributed to the class of individuals who exercised that right.[FN39] As we explained in that case, we look to the real-world effects of government action to determine the appropriate level of equal protection scrutiny: "The suspicion with which this court will view infringements upon [constitutional rights] depends upon ... the objective degree to which the challenged legislation tends to deter [the exercise of those rights]." [FN40]

FN37. 687 P.2d at 273-74.

FN38. *See id.* We have since applied more relaxed scrutiny where "[t]he infringement on [the] right to travel is relatively small and would not be likely to deter a person from traveling." *Church v. State, Dep't of Revenue*, 973 P.2d 1125, 1131 (Alaska 1999). In this case the likelihood of deterring exercise of the right is very high: The State's own statistics and the findings of the superior court indicate that, under the challenged regulation, some women "will have no choice but to go forward with the pregnancy." We therefore follow *Alaska Pacific Assurance Co.* in applying strict scrutiny.

FN39. *See* 687 P.2d at 266-67.

FN40. *Id.* at 271.

[6] We reached a similar conclusion in *Alaska Gay Coalition v. Sullivan,* holding that the Municipality of Anchorage could not constitutionally withhold a public benefit based on a potential recipient's beliefs and public expression.[FN41] The municipality had undertaken to publish a guidebook to public and private organizations in Anchorage, but excluded the Alaska Gay Coalition from the book.[FN42] We held that this exclusion violated the Coalition's constitutional rights to equal protection under the law.[FN43] We explained:

FN41. 578 P.2d 951, 960 (Alaska 1978).

FN42. *Id.*

FN43. *Id.*

When the Municipality decided to publish a limited informational guide to public and private local resources, it did not thereby assume the obligation of providing space to every possible group.... Had the

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Municipality deleted groups at random or used criteria not related to the nature of the particular organizations, constitutional violations may not have resulted. In deleting the Alaska Gay Coalition ... however, appellees denied that group access to a public forum based solely on the nature of its beliefs. In so doing, they violated appellant's constitutional rights to ... equal protection under the law.[FN44]

FN44. *Id.*

Similarly, in the instant case, the State's obligations do not depend on whether the State has undertaken to provide limitless health care services to all poor Alaskans. Rather, DHSS is constitutionally bound to apply neutral criteria in allocating health care benefits, even if considerations of expense, medical feasibility, or the necessity of particular services otherwise limit the health care it provides to poor Alaskans.

The State argues in this case that it does not provide all necessary medical care to indigent Alaskans. For support, it cites 7 AAC 43.385, a regulation that excludes from Medicaid coverage such services as medically unnecessary inpatient treatment,[FN45] beautifying cosmetic surgery, [FN46] and transplants of organs other than kidney, cornea, skin, and bone marrow.[FN47] This regulation has not been challenged, and the issue has not been thoroughly briefed by the parties, but the restrictions appear to relate to medical necessity, cost, and feasibility-all politically neutral criteria. Such spending limits are irrelevant to the constitutional issue raised by the State's denial of coverage for medically necessary abortions. As the United States Supreme Court noted in *Shapiro v. Thompson:*

FN45. 7 AAC 43.385(2), (6), (9), (11) & (12).

FN46. 7 AAC 43.385(4).

FN47. 7 AAC 43.385(17).

We recognize that the State has a valid interest in preserving the fiscal integrity of its programs. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes of its citizens.[FN48]

FN48. 394 U.S. 618, 633, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969).

Like *Alaska Pacific Assurance Co., Alaska Gay Coalition* establishes that under Alaska's equal protection provision the government***911** may not allocate state benefits so as to deter citizens' exercise of constitutional rights.

In this case, it is undisputed that 7 AAC 43.140 deters women from obtaining abortions. The State itself stated that eliminating public assistance for medically necessary abortions would cause about thirty-five percent of women who would otherwise have obtained abortions to instead carry their pregnancies to term, despite the associated threat to their health. Under *Alaska Pacific Assurance Co.,* such a restriction warrants the highest degree of judicial scrutiny.

In the seminal *Shapiro v. Thompson* decision, the United States Supreme Court also strictly scrutinized-and ultimately held unconstitutional-state programs that denied benefits to citizens based on their exercise of constitutional rights.[FN49] *Shapiro* invalidated state laws that denied welfare benefits to persons who had moved into the jurisdiction within the past year.[FN50] The Court found that "the prohibition of benefits ... creates a classification which constitutes an invidious discrimination denying [new residents] equal protection of the laws." [FN51] The Court held that states could not constitutionally tailor their benefits programs to deter immigration from other states: "If a law has no other purpose ... than to chill the assertion of constitutional rights by penalizing those who choose to exercise them, then it [is] patently unconstitutional." [FN52]

FN49. 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969), *partly rev'd on other grounds,* Edelman v. Jordan, 415 U.S. 651, 670-71, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974).

FN50. *See id.* at 621, 89 S.Ct. 1322.

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FN51. *Id.* at 627, 89 S.Ct. 1322.

FN52. *Id.* at 631, 89 S.Ct. 1322 (internal quotations omitted) (alteration in original) (quoting *United States v. Jackson*, 390 U.S. 570, 581, 88 S.Ct. 1209, 20 L.Ed.2d 138 (1968)). This precedent was not discussed in the U.S. Supreme Court's later decision, in *Harris v. McRae*, that the Hyde Amendment was permissible under the federal constitution. 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). But in *Valley Hospital*, we explained that Alaska's broader constitutional protection at times mandates parting ways with federal precedent. *See* 948 P.2d at 969. In that case, we rejected the plurality opinion of *Planned Parenthood v. Casey*, 505 U.S. 833, 877-78, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992), in order to declare that a woman's right to an abortion is fundamental. *See Valley Hosp.*, 948 P.2d at 969. We now join the majority of state courts in concluding that the federal Supreme Court's decision in *McRae* provides inadequate protection under our state constitution.

[7][8] Although *Shapiro* and *Alaska Pacific Assurance Co.* applied strict scrutiny to reject restrictions like the one at issue in this case, 7 AAC 43.140 would fail equal protection analysis under any standard. Under the regulation, the State grants needed health care to some Medicaid-eligible Alaskans, but denies it to others, based on criteria entirely unrelated to the Medicaid program's purpose of granting uniform and high quality medical care to all needy persons of this state.[FN53] Thus, even if 7 AAC 43.140 did not affect constitutional privacy rights and we applied our most deferential standard of review, the regulation still could not withstand equal protection challenge. Under Alaska's rational basis standard, [FN54] differential treatment of similarly situated people is permissible only if the distinction between the persons "rest[s] upon some ground of difference having a fair and substantial relation to the object of the legislation." [FN55] DHSS provides necessary medical care to all Medicaid-eligible Alaskans except women who medically require abortions. This differential treatment lacks a fair and substantial relation to the object of the Medicaid program, and therefore violates equal protection.[FN56]

FN53. In the "Purpose" section of the Medicaid statute, the legislature "declare[s] as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing." AS 47.07.010.

FN54. *See* *Sonneman v. Knight*, 790 P.2d 702, 705 (Alaska 1990) (using term "rational basis" to describe lowest standard of review under Alaska's sliding scale).

FN55. *Isakson v. Rickey*, 550 P.2d 359, 362 (Alaska 1976) (quoting *State v. Wylie*, 516 P.2d 142, 145 (Alaska 1973)). *Isakson* establishes that Alaska's rational basis review is more rigorous than that of the United States Supreme Court. *Id.*

FN56. We note that the United States Supreme Court reached the opposite conclusion regarding the analogous federal regulation in *Harris v. McRae*, 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). However, as noted above, federal rational basis review is a less rigorous standard than Alaska's rational basis review. *See Isakson*, 550 P.2d at 362. We have explained that Alaska's broader constitutional protection at times mandates parting ways with federal precedent. *See Valley Hospital*, 948 P.2d at 969. The United States Supreme Court in *Harris v. McRae* did not consider the discriminatory allocation of government benefits cases, *Shapiro v. Thompson*, 394 U.S. 618, 634, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969) and *United States Department of Agriculture v. Moreno*, 413 U.S. 528, 93 S.Ct. 2821, 37 L.Ed.2d 782 (1973), discussed in this opinion.

***912** The United States Supreme Court reached a similar conclusion in *Shapiro:* although the Court invalidated states' differential treatment of similarly situated welfare recipients under strict scrutiny, it also noted that the differentiation would be deemed "irrational and unconstitutional" even under federal rational basis review.[FN57] In *United States Department of Agriculture v. Moreno*, the United States Supreme Court invalidated a similar restriction under rational basis scrutiny alone.[FN58] The Court found no rational

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basis for a statute denying food stamps to unrelated persons who shared a household; it therefore concluded that the statute violated equal protection.[FN59]

FN57. *Shapiro,* 394 U.S. at 638, 89 S.Ct. 1322.

FN58. 413 U.S. at 538, 93 S.Ct. 2821.

FN59. *See id.* The Court noted legislative history indicating congressional intent to exclude "so[-]called 'hippies' and 'hippie communes' " from the food stamp program. *Id.* at 534, 93 S.Ct. 2821. But it concluded:

> The challenged classification clearly cannot be sustained by reference to this congressional purpose. For if the constitutional conception of "equal protection of the laws" means anything, it must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot constitute a legitimate government interest. As a result, [a] purpose to discriminate against hippies cannot, in and of itself and without reference to [some independent] considerations in the public interest, justify the [challenged] amendment.

Id. at 534-35, 93 S.Ct. 2821 (internal quotations omitted, third alteration added).

Lower court decisions have applied this principle to states' allocation of health care benefits, and concluded that "classification [among recipients] must be based upon some difference between the classes which is pertinent to the purpose for which the legislation is designed." [FN60] A California court found that the state violated equal protection by paying for attendant services by spouses of elderly and blind aid recipients, but denying payment for the same services by the spouses of otherwise disabled aid recipients. [FN61] And New York's highest court held that equal protection was violated by a statute that "effectively provide[d] ... that the aged, disabled, and blind are entitled to less public assistance than other needy persons." [FN62]

FN60. *Vincent v. State,* 22 Cal.App.3d 566, 572, 99 Cal.Rptr. 410 (Cal.App.1971).

FN61. *See id.*

FN62. *Lee v. Smith,* 43 N.Y.2d 453, 402 N.Y.S.2d 351, 352, 373 N.E.2d 247, 248 (1977); *see also* *White v. Beal,* 555 F.2d 1146, 1149-50 (3d Cir.1977) (finding equal protection issue sufficient to support jurisdiction, but not deciding on equal protection grounds, where remedial eye-care was available only if a person's visual impairment resulted from eye disease or pathology); *County of Orange v. Ivansco,* 67 Cal.App.4th 328, 337-38, 78 Cal.Rptr.2d 886 (1998) (finding equal protection violation where parents supporting noncustodial children received different benefits depending on the children's eligibility for AFDC); *but see* *Moreno v. Draper,* 70 Cal.App.4th 886, 888-89, 83 Cal.Rptr.2d 82 (1999) (analyzing same regulation as in *County of Orange* and finding no equal protection violation).

DHSS's differential treatment of Medicaid-eligible Alaskans violates equal protection under rational basis review as surely as it does under strict scrutiny. Under any standard of review, "the State may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent." [FN63]

FN63. *Right to Choose v. Byrne,* 91 N.J. 287, 450 A.2d 925, 937 (1982).

Because 7 AAC 43.140 infringes on a constitutionally protected interest, the State bears a high burden to justify the regulation.[FN64] Unless the State asserts a compelling state interest, the statute will necessarily fail constitutional scrutiny.[FN65] The State has failed to demonstrate such an interest in this case. It primarily defends 7 AAC 43.140 on ***913** the grounds that "medical and public welfare interests ... are served by the legislature's decision to fund childbirth." But the regulation does not relate to funding for childbirth, and the State's decision to fund prenatal care and other pregnancy-related services has not been challenged. Indeed, a woman who carries her pregnancy to term and a woman who terminates her pregnancy exercise the same fundamental right to reproductive choice.

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Alaska's equal protection clause does not permit governmental discrimination against either woman; both must be granted access to state health care under the same terms as any similarly situated person. The State's undisputed interest in providing health care to women who carry pregnancies to term has no effect on the State's interest in providing medical care to Medicaid-eligible women who, for health reasons, require abortions.

FN64. *See* Matanuska-Susitna Borough School Dist. v. State, 931 P.2d 391, 396-97 (Alaska 1997) (outlining State's burden for justifying regulations); *Valley Hosp. Ass'n v. Mat-Su Coalition for Choice,* 948 P.2d 963, 971 (Alaska 1997) ("Since the right is fundamental, it cannot be interfered with unless the interference is justified by a compelling state interest.").

FN65. *See* Matanuska-Susitna Borough Sch. Dist., 931 P.2d at 396-97.

The State also asserts an interest in minimizing health risks to mother and child, and submits that these interests are often closely aligned. But those interests are not aligned in precisely the situation contemplated by 7 AAC 43.140's Medicaid exclusion: when pregnancy threatens a woman's health. Under the U.S. Supreme Court's analysis in *Roe v. Wade,* the State's interest in the life and health of the mother is paramount at every stage of pregnancy. [FN66] And in Alaska, "[t]he scope of the fundamental right to an abortion ... is similar to that expressed in *Roe v. Wade.*" [FN67] Thus, although the State has a legitimate interest in protecting a fetus, at no point does that interest outweigh the State's interest in the life and health of the pregnant woman.[FN68]

FN66. 410 U.S. 113, 163-64, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973).

FN67. *Valley Hospital,* 948 P.2d at 969.

FN68. *Accord* *Byrne,* 450 A.2d at 935 (holding, based on *Roe,* that "at no point in pregnancy may [the state's interest in protection of potential life] outweigh the superior interest in the life and health of the mother").

Because the State has not asserted an interest sufficiently compelling to justify denying medically necessary care to women who need abortions, we need not consider the means-ends fit of the challenged regulation. We conclude that 7 AAC 43.140 violates equal protection under the Alaska Constitution.

B. *The Separation of Powers Doctrine Cannot Shield Unconstitutional Legislation.*

[9] The State argues that by holding the Medicaid program to constitutional standards, the superior court effected an appropriation of funds in violation of the separation of powers between branches of government. We disagree. Under Alaska's constitutional structure of government, "the judicial branch ... has the constitutionally mandated duty to ensure compliance with the provisions of the Alaska Constitution, including compliance by the legislature." [FN69] The superior court had not only the power but the duty to strike the challenged restriction and any underlying legislation if it found them to violate constitutional rights; the same duty mandates our decision today.

FN69. *Malone v. Meekins,* 650 P.2d 351, 356 (Alaska 1982); *see also* *Marbury v. Madison,* 5 U.S. (1 Cranch) 137, 177, 2 L.Ed. 60 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is.").

[10][11] The separation of powers doctrine and its complementary doctrine of checks and balances are implicit in the Alaska Constitution. [FN70] In light of the separation ***914** of powers doctrine, we have declined to intervene in political questions, which are uniquely within the province of the legislature.[FN71] But under the same doctrine, we "cannot defer to the legislature when infringement of a constitutional right results from legislative action"; legislative intent is not paramount when that intent conflicts with the constitution.[FN72] And the mere fact that the legislature's appropriations power underlies Medicaid funding cannot insulate the program from constitutional review. As the California Supreme Court observed in rejecting nearly identical restrictions on abortion funding, the State's claim would remove all constitutional restraints from legislative exercise of the spending power:

FN70. *See* State v. Dupere, 709 P.2d 493, 496 (Alaska 1985), *modified,* 721 P.2d 638

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(Alaska 1986) ("The separation of powers doctrine must be considered along with the complementary doctrine of checks and balances."); *Alaska State-Operated Sch. Sys. v. Mueller*, 536 P.2d 99, 103 (Alaska 1975); *Public Defender Agency v. Superior Court*, 534 P.2d 947, 950 (Alaska 1975).

> The United States Supreme Court recently discussed the division of powers within the federal system of government. *See United States v. Morrison*, 529 U.S. 598, 120 S.Ct. 1740, 146 L.Ed.2d 658 (2000). It reiterated the duty of courts to limit acts of legislation when those acts conflict with rights guaranteed by the Constitution, explaining that the framers of the Constitution divided power among the three branches of government
>
> so that the Constitution's provisions would not be defined solely by the political branches nor the scope of legislative power limited only by public opinion and the legislature's self-restraint. It is thus a permanent and indispensable feature of our constitutional system that the ... judiciary is supreme in the exposition of the law of the Constitution.
>
> *Id.* at 1753 n. 7, 120 S.Ct. 1740 (internal quotations and citations omitted).

FN71. *See Abood v. League of Women Voters*, 743 P.2d 333, 338 (Alaska 1987); *Malone*, 650 P.2d at 356-57.

FN72. *Valley Hosp. Ass'n v. Mat-Su Coalition for Choice*, 948 P.2d 963, 972 (Alaska 1997).

There is no greater power than the power of the purse. If the government can use it to nullify constitutional rights, by conditioning benefits only upon the sacrifice of such rights, the Bill of Rights could eventually become a yellowing scrap of paper.[FN73]

FN73. *Committee to Defend Reprod. Rights v. Myers*, 29 Cal.3d 252, 172 Cal.Rptr. 866, 625 P.2d 779 (1981).

Legislative exercise of the appropriations power has not in the past, and may not now, bar courts from upholding citizens' constitutional rights. Indeed, constitutional legal rulings commonly affect state programs and funding. Many of the most heralded constitutional decisions of the past century have, as a practical matter, effectively required state expenditures. In *Green v. County School Board*, the United States Supreme Court ordered effective desegregation of public schools; [FN74] in *Gideon v. Wainwright*, it required funding of counsel for indigent criminal defendants; [FN75] and in *Shapiro v. Thompson*, it required states to give newcomers to the jurisdiction equal welfare benefits.[FN76] In each of these cases, a judicial decision upholding constitutional rights required state expenditures to support those rights. As appellee doctors and **Planned Parenthood** point out, the funding implications and separation of powers issue in this case would be identical if the State relied on other suspect **criteria**, such as race, to deny Medicaid benefits. Following the State's argument, the exclusion of one ethnic group-or inclusion only of other specified groups-within legislative Medicaid appropriations would be immunized from constitutional review, merely because the legislature had exercised its spending power. We emphatically reject such a claim. Like the Supreme Court decisions listed above, today's holding is squarely within the authority of the court, not in spite of, but *because* of, the judiciary's role within our divided system of government.

FN74. 391 U.S. 430, 88 S.Ct. 1689, 20 L.Ed.2d 716 (1968).

FN75. 372 U.S. 335, 83 S.Ct. 792, 9 L.Ed.2d 799 (1963).

FN76. 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969), *partly rev'd on other grounds*, *Edelman v. Jordan*, 415 U.S. 651, 670-71, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974).

Our conclusion that the separation of powers doctrine supports today's decision is firmly supported by twenty-one other courts that have considered a state's exclusion of medically necessary abortions from state-funded health care programs.[FN77] The State has not identified a single state or federal case holding

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that the separation of powers precludes a court from ordering the state to provide equal funding for women whose health is endangered by pregnancy.[FN78] Courts that have explicitly considered separation of powers challenges to holdings like the one we reach today have dismissed the challenges in no uncertain terms. The Massachusetts Supreme Judicial Court, for example, wrote:

FN77. *See supra* note 2.

FN78. A single justice in a concurring opinion stated that the judiciary may not, under the equal protection clause of Michigan's constitution, require legislative funding for medically necessary abortion. *Doe v. Department of Soc. Servs.,* 439 Mich. 650, 487 N.W.2d 166, 182-83 (1992) (Levin, J., concurring). To our knowledge, his is the sole dissenting voice on this issue.

> [W]e have never embraced the proposition that merely because a legislative action involves an exercise of the appropriations power, it is on that account immunized against judicial review. [We reject] the ***915** argument that either the doctrine of separation of powers or the political question doctrine requires that result. Without in any way attempting to invade the rightful province of the Legislature to conduct its own business, we have a duty, certainly since *Marbury v. Madison,* to adjudicate a claim that a law and the actions undertaken pursuant to that law conflict with the requirements of the Constitution. "This," in the words of Mr. Chief Justice Marshall, "is of the very essence of judicial duty." [FN79]

FN79. *Moe v. Secretary of Admin. & Fin.,* 382 Mass. 629, 417 N.E.2d 387, 395 (1981) (internal citations omitted); *see also* *Committee to Defend Reprod. Rights v. Cory,* 132 Cal.App.3d 852, 183 Cal.Rptr. 475, 478 (1982) ("When there is an unconstitutional restriction in an existing appropriation, it offends no constitutional principle to direct that the disputed payments be made from funds already appropriated for the same general purpose."); *Clinic for Women, Inc. v. Humphreys,* No. 49D12-9908-MI-1137, Slip Op. at 12 (Ind.Super., Oct. 18, 2000) ("If the challenged enactments violate the state Constitution, the Court can grant relief even if doing so means that state funds will be spent in a manner not explicitly approved by the Legislature. The Court has the power to shape appropriate remedies and the Legislature has a duty to appropriate funds to meet its constitutional obligations."); *Low-Income Women v. Bost,* 38 S.W.3d 689, 702 (Tex.App.2000) ("The relief sought by Low-Income Women-funding medically necessary abortions-cannot be characterized as a new appropriation. They do not ask for a new appropriation of funds to the Medical Assistance Program. Rather, they seek declaratory and injunctive relief against unconstitutional restrictions placed on the use of funds already appropriated pursuant to a pre-existing law authorizing funds to be used for health care under the program.").

We agree with this articulation of the court's fundamental powers and duties.

A federal case, *State of Georgia v. Heckler,* also directly supports our conclusion.[FN80] In that case, the state of Georgia sought reimbursement from the federal Department of Health and Human Services (HHS) for money spent by the state to fund medically necessary abortions. Although the Court of Appeals for the Eleventh Circuit ultimately denied Georgia's claim, it emphatically rejected HHS's argument that because Congress had not appropriated money for medically necessary abortions, a district court could not compel HSS to pay the claims.[FN81] As the Eleventh Circuit court noted, the statute could preclude payment only if an interpreting court so determined.[FN82] "There is no doubt," the *Heckler* court concluded, "that if this Court decided that these payments were legally required, HHS would be authorized to make them." [FN83]

FN80. 768 F.2d 1293 (11th Cir.1985).

FN81. *See id.* at 1295-96.

FN82. *See id.* at 1296.

FN83. *Id.*

We agree with the Eleventh Circuit: It is legally

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indisputable that a trial court order requiring state compliance with constitutional standards does not violate the separation of powers doctrine.

V. *CONCLUSION*

The manner in which the State allocates public benefits is subject to constitutional limitation under Alaska's equal protection provision. The State, having undertaken to provide health care for poor Alaskans, must adhere to **neutral criteria** in distributing that care. It may not deny **medically necessary** services to eligible individuals based on **criteria** unrelated to the purposes of the public health care program. Moreover, the DHSS regulation in this case discriminatorily burdens the exercise of a constitutional right. Because we conclude that denial of Medicaid assistance to poor women who **medically** require abortions violates equal protection, we AFFIRM the decision of the superior court.

Alaska,2001.
State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.
28 P.3d 904

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Alaska Statutes.
Title 18. Health, Safety, and Housing
Chapter 16. Regulation of Abortions
Section 90. Definitions.

previous: Section 60. Informed Consent Requirements.
next: Chapter 18. Hospice and Home Care Programs

AS 18.16.090. Definitions.

In this chapter,

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

(A) save the life or preserve the health of the unborn child;

(B) deliver the unborn child prematurely to preserve the health of both the pregnant woman and the woman's child; or

(C) remove a dead unborn child;

(2) "unemancipated" means that a woman who is unmarried and under 17 years of age has not done any of the following:

(A) entered the armed services of the United States;

(B) become employed and self-subsisting;

(C) been emancipated under AS 09.55.590 ; or

(D) otherwise become independent from the care and control of the woman's parent, guardian, or custodian.

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Testimony of Priscilla K. Coleman, Ph.D.

SENATE BILL NO. 49
LEGISLATURE OF THE STATE OF ALASKA

1. My name is Dr. PRISCILLA K. COLEMAN. I am a developmental psychologist and a Professor of Human Development and Family Studies at Bowling Green State University in Ohio, where I have been employed full-time for the past 11 years. I have published over 50 peer-reviewed scientific articles, of which 37 are on the psychology of abortion. Based on my expertise and the fact that I have published more peer-reviewed studies on abortion and mental health than any other researcher in the world, I am often called upon to serve as a content expert in state and civil cases involving abortion. I have given presentations in parliament houses in Great Britain, Northern Ireland, New South Wales, and Queensland. Finally, I am on the editorial boards for five international medical journals.

2. Over the course of my professional career, I have spent more than 20 years conducting research, publishing the results of studies, analyzing the research of others, and performing systematic reviews of the literature for publication in peer-reviewed journals. The opinions expressed in my testimony are based upon my education, professional experience, the psychological research I have personally conducted, and my extensive and ongoing review of the abortion and mental health literature.

3. I can say with a reasonable degree of scientific and medical certainty that abortion is a substantial contributing factor in women's mental health problems. Abortion is a particularly risky choice for women with pre-existing mental illness. There is no empirical evidence documenting mental-health benefits to women with or without pre-existing mental illness, and there is an abundance of literature documenting the

association between abortion(s) and declining mental health status. Therefore, I am of the opinion that abortion is never justified based on mental health grounds and abortion should not be paid for by the state of Alaska due to the presence of any form of mental illness in women.

4. The formal study of the psychology of induced abortion has garnered considerable momentum over the past several decades and the scientific rigor of the published studies has increased dramatically. Potential negative psychological and relational consequences of induced abortion and risk factors for such consequences have been the two primary focal areas in the literature. Paralleling the expansion of research, both in terms of the quantity and quality of studies published, there has been growing awareness in the medical community of the need for evidence-based practice.

5. The overwhelming preponderance of scientific evidence published world-wide indicates that abortion is a substantial contributing factor in women's mental health problems, including depression and death from suicide. Other well-established psychological difficulties associated with abortion include anxiety, substance use disorders, and relationship problems.

6. The scientific evidence is published in leading peer-reviewed journals in psychology and medicine, and there are now dozens of large scale, prospective studies incorporating different types of comparison groups (unintended pregnancy delivered, other forms of perinatal loss, etc.) and other control techniques, effectively fortifying the level of confidence in the results derived. Exhibit A provides a list of the most methodologically sophisticated studies on abortion and mental health published over the

last several decades; whereas Exhibit B provides an assessment of the causal evidence linking abortion to various mental health problems.

8. Exhibit C contains a report of a meta-analysis I conducted titled "Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009". This paper was published in the British Journal of Psychiatry on September 1, 2011. A meta-analysis is a specific form of systematic literature review wherein quantitative data from multiple published studies are converted to a common metric and combined statistically to derive an overall measure of the effect of an exposure such as abortion. This methodology gives the results more statistical power (due to the increased sample size) and much more credibility than the results of any individual empirical study or narrative review, such as the one conducted by the American Psychological Association in 2008. In a meta-analysis, the contribution or weighting of any particular study to the final result is based on objective scientific criteria (sample size and strength of effect), as opposed to an individual's opinion of what constitutes a strong study.

9. After applying methodologically-based selection criteria and extraction rules to minimize bias, the sample consisted of 22 studies, 36 measures of effect, and 877,297 participants (163,880 experienced an abortion). Results revealed that women who aborted experienced an 81% increased risk for mental health problems. When compared specifically to unintended pregnancy delivered, women were found to have a 55% increased risk of experiencing mental health problem.

10. Separate effects were calculated based on the type of mental health outcome with the results revealing the following: the increased risk for anxiety disorders was 34%; for depression it was 37%; for alcohol use/abuse it was 110%; for marijuana use/abuse it was

220%; and for suicide behaviors it was 155%. Calculation of a composite Population Attributable Risk (PAR) statistic revealed that 10% of the incidence of mental health problems was directly attributable to abortion.

11. Very stringent inclusion criteria were used to avoid bias. Every strong study was included and weaker studies were excluded based on the criteria. Specifically, among the rules for inclusion were sample size of 100 or more participants, use of a comparison group, and employment of controls for variables that may confound the effects such as demographics, exposure to violence, prior history of mental health problems, etc.

12. The British Journal of Psychiatry is considered one of the top psychiatry journals in the world. Specifically, it has a very high Impact Factor (5.947) and it is currently the 3rd most-cited general psychiatry journal in the world (based on ISI rankings). Submitted papers are extensively scrutinized by well-respected scientists and the results of studies published are trusted by practitioners around the globe. This review offers the largest quantitative estimate of mental health risks associated with abortion available in the world.

13. The literature on risk-factors for adverse post-abortion psychological consequences is well-developed. There is undisputed opinion among researchers and even among many abortion providers that risk factors for poor adjustment include the following: prior mental health problems, difficulty with the decision, emotional investment in the pregnancy, timing during adolescence or being unmarried, involvement in unstable or violent relationships, conservative views of abortion and/or religious affiliation, second trimester abortions, and feelings of being forced into abortion by one's partner, others, or by life circumstances (Allanson, & Astbury, 2001; Bracken, 1978;

Bracken et al., 1974; Campbell et al., 1988; Cozzarelli et al., 1994; Kero et al., 2004; Lewis, 1997; Lyndon et al., 1996; Osofsky & Osofsky, 1972; Osofsky et al., 1973; Remennick & Segal, 2001; Russo & Denious, 2001). Internalized beliefs regarding the humanity of the fetus, moral, religious, and ethical objections to abortion, and feelings of bereavement/loss also frequently distinguish those who suffer profoundly (see Coleman et al., 2005 for a review).

14. Hern (1990), a well-known abortion provider, emphasized the central role of pre-abortion counseling in evaluating women's mental status, circumstances, and abortion readiness while stressing the importance of developing a supportive relationship between the counselor and patient to prevent complications.

15. For the purpose of litigation in South Dakota (HB 1217), I completed a search of the professional literature for studies published between 1972 and 2011, documenting personal, demographic, situational, and relational factors that increase the likelihood of women experiencing post-abortion psychological problems. Over 400 abstracts of articles were read to assess relevance, 258 articles were ordered and examined closely, and a final list of 119 articles on risk factors for psychological difficulties was developed. I identified 12 risk factors documented in a minimum of 10 peer-reviewed journal articles. The risk factors are listed below. As indicated, at the top of the list are factors related to pre-abortion emotional and psychological disturbance.

1) ***Character traits indicative of emotional immaturity, emotional instability, or difficulties coping*** including low self-esteem, low self-efficacy, problems describing feelings, being withdrawn, avoidant coping, blaming oneself for difficulties etc. (42 studies)

2) ***Pre-abortion mental health/psychiatric problems*** (35 studies)

3) ***Decision ambivalence or difficulty, doubt once decision was made, or high degree of decisional distress*** (29 studies)

4) ***Conflicted, unsupportive relationships with others*** (28 studies)

5) ***Conflicted, unsupportive relationship with father of child*** (24 studies)

6) ***Desire for the pregnancy, psychological investment in the pregnancy, belief in the humanity of the fetus and/or attachment to fetus*** (21studies)

7) ***Repeat or second trimester abortion*** (19 studies)

8) ***Timing during adolescence or younger age*** (18 studies)

9) ***Religious, frequent church attendance, personal values conflict with abortion*** (18 studies)

10) ***Negative feelings and attitudes related to the abortion*** (16 studies)

11) ***Pressure or coercion to abort*** (10 studies)

12) ***Indicators of poor quality abortion care*** (feeling misinformed/inadequate counseling, negative perceptions of staff, etc.) (10 studies)

In summary, there is never, in my opinion, justification for abortion on mental health grounds. Moreover, there is a preponderance of evidence suggesting that an abortion will exacerbate pre-existing mental illness, in addition to carrying significant potential to initiate mental illness in women without a prior history. Based on the fact that there is no scientific evidence documenting that women suffering from mental illness are best served by the provision of abortion services when facing an unintended pregnancy, I

do not believe that public funds should be used for this purpose.

Priscilla K. Coleman, Ph.D.
Professor of Human Development and Family Studies
Bowling Green State University
Bowling Green, OH 43403

6a

Exhibit A

Bibliography of Peer-Reviewed Studies on Abortion and Mental Health

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6b

Exhibit B

Evidence for a Causal Association between Abortion and Mental Health Problems

I. Background for understanding causality when studying human behavior

Due to the inherent complexity of human psychological health outcomes, such as depression and suicidal behavior, identification of a single, precise causal agent applicable to all cases is not possible. Every mental health problem is determined by numerous physical and psychological characteristics, background, and current situational factors subject to individual variation. Further, any one cause (e.g. abortion) is likely to have a variety of effects (e.g., anxiety, depression, suicidal behavior) based on the variables involved.

A ***risk factor*** refers to any variable that has been established to increase the likelihood of an individual experiencing an adverse outcome. Risk factor data are used in medicine and psychology for the explicit purposes of understanding etiology, warning patients of risks associated with various medical interventions, and development of effective prevention and intervention protocols to maximize health.

Assessment of degree of risk is often expressed in terms of ***absolute risk,*** which relates to the chance of developing a disease over a time-period (e.g., a 10% lifetime risk of suicide) or in terms of ***relative risk,*** which is a comparison of the probability of an adverse outcome in two groups. For example, abortion would be considered an increased risk for suicide if the relative risk is significantly higher for women who abort compared to women who give birth or never have children.

Determination of causality technically requires an experimental design in which there is random assignment of large groups to expected cause conditions (e.g., abortion, no abortion/delivery, no abortion/no pregnancy). However, as is true with numerous variables of interest in psychology and medicine, it is not ethical nor is it practically feasible to implement such a study. When scientists are not able to control or manipulate the variable of interest, risk factors for negative outcomes are established over time through the two primary scientific steps described below.

1. **Analysis of each individual study.** Each individual study published in a peer-reviewed journal is examined to assess the quality of evidence

suggestive of a causal link between abortion and negative outcomes. The following three criteria are applied when the variable of interest such as abortion can not be manipulated.

a. Abortion must be shown to precede the mental health problem (referred to as *time precedence*). This is typically accomplished with longitudinal or prospective data collection in which testing occurs over an extended period of time following the abortion.

b. Differences in abortion history (abortion, no abortion) must be systematically associated with differences in mental health status (*covariation*).

c. Finally, all plausible alternative explanations for associations between abortion and mental health must be ruled out using a method of control. Typically third variables predictive of both the choice to abort and mental health (e.g. income, previous psychological problems, exposure to domestic violence etc.) are statistically removed from the analyses. Identifying, measuring, and statistically controlling for known predictors of abortion would go a long way to help establish causality; however there are many other means for achieving the same goal of infusing control. Additional control techniques include: (1) matching groups on all variables known to be related to abortion and the outcome measures; (2) measuring potential confounding variables and introducing them as additional variables to assess their independent effects; (3) identifying and selecting homogeneous populations to draw the pregnancy outcome groups.

2. Integrative analysis. After evaluating individual studies for causal evidence linking abortion to decrements in mental health, scientists assess the consistency and magnitude of associations between abortion and particular mental health problems across all available studies. This integrative process represents the second step for determining whether or not abortion is a substantial contributing factor for severe depression and other mental health problems.

a. *Consistency* refers to repeated observation of an association between abortion and mental health across several studies using different people, places, and circumstances tested at distinct points in time. When results become generalized in this manner, the probability that an association would be due to chance is dramatically reduced.

b. *Magnitude* (or strength of effect) refers to whether the associations between abortion and various mental health problems are slight, moderate, or strong. Strong associations across various studies are more likely causal than slight or modest associations. This point has been illustrated with the high risk ratios for the association between exposure levels of smoking and incidence of lung cancer.

II. Causal Evidence from Research on the Mental Health Risks of Abortion

The tables below provide an overview of the studies related to abortion and suicide ideation and suicide, abortion and substance use/abuse, abortion and depression, and abortion and anxiety. The arrangement of the data in the tables offers guidance regarding the extent to which the conditions for causality have been met

Table 1: Scientific Studies Identifying Abortion as a Risk Factor in Suicidal Behavior.

Study	Time sequence	Co-variation	Controls and Other Strengths	Results/Magnitude of effect
1. Fergusson, D. M. et al. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry*, 47, 16-24.	√	√	Pregnancy delivered and never pregnant used as comparison groups. Controlled for demographic, family of origin, history of abuse, partner, personality, and mental health history variables. National sample, high retention, low concealment, thorough assessments of outcomes.	27% of women who aborted reported suicidal ideation. The risk was 4X greater for women who aborted compared to never pregnant women and more than 3X greater for women who delivered.
2. Fergusson, D.M. et al. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study, *The British Journal of Psychiatry, 193*, 444-451.	√	√	Pregnancy delivered and never pregnant used as comparison groups. Controlled for demographic, family of origin, history of abuse, partner, personality, mental health history, exposure to adverse events variables and pregnancy intendedness. National sample, high retention, low concealment, thorough assessments of outcomes.	61% increased risk of suicide ideation associated with abortion.
3. Gilchrist, A. C. et al. (1995). Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry* 167, 243.	√	√	Compared women who were refused abortion and women who chose abortion but changed their minds. Pregnancy intendedness controlled.	Among women with no history of psychiatric illness, the rate of deliberate self-harm was significantly higher (70%) after abortion than childbirth.
4. Gissler, M. et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal*, 313, 1431 4.	√	√	Compared women who aborted to those who delivered, miscarried, and the general population. Large study population Use of medical claims data: ICD-8 codes.	Suicide rate was nearly 6X greater among women who aborted compared to women who delivered.
5. Gissler, M. et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health*, 15, 459-463.	√	√	Compared women who aborted, delivered, miscarried, and were not pregnant. Large study population Use of medical claims data: ICD-8 codes. Distinguished level of risk associated with suicide and other forms of death.	Abortion was associated with a 6X higher risk for suicide compared to birth.
6. Reardon, D.C. et al. (2002). Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. *Southern Medical Journal*, 95,834-41.	√	√	Use of homogenous population. Controlled for prior psychiatric history, age, and eligibility for state medical coverage. Large sample.	Suicide risk was 154% higher among women who aborted compared to those who delivered.

7. Rue, V.M. et al. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Medical Science Monitor* 10, SR 5-16.	√	√	Controlled for stressors pre-and post-abortion, demographic and psycho-social variables (including abuse and parental divorce, etc.). Women specifically asked if they believed the abortion was the cause.	36.4% of the American women and 2.8% of the Russian women respectively reported suicidal ideation.
8. Mota, N.P. et al (2010). Associations between abortion, mental disorders, and suicidal behaviors in a nationally representative sample. *The Canadian Journal of Psychiatry, 55* (4), 239-246.		√	Nationally representative sample. Controlled for the experience of interpersonal violence and demographic variables.	When compared to women without a history of abortion, those who had an abortion had a 59% increased risk for suicide ideation.

Table 2: Scientific Studies Identifying Abortion as a Risk Factor in Depression.

Study	Time sequence	Co-variation	Controls and Other Strengths	Results/Magnitude of effect
1. Coleman, P. K. et al. (2002). State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years. *American Journal of Orthopsychiatry, 72,* 141-152.	√	√	Homogeneous population. Controls for pre-pregnancy psycho-logical difficulties, age, and months of eligibility. Large sample. Used actual claims data, eliminating the concealment problem. Avoids recruitment, retention problems, and simplistic forms of assessment.	Across the 4-yrs, the abortion group had 40% more claims for neurotic depression than the delivery group.
2. Coleman, P. K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. *The Journal of Youth and Adolescence, 35,* 903-911.	√	√	Nationally representative, diverse sample. Exclusive focus on unwanted pregnancies aborted and delivered. Implemented controls for several demographic, psychological, and familial variables.	After implementing controls, adolescents with an abortion history, when compared to those with a birth history, were: 5X more likely to seek counseling for psychological or emotional problems and 4X more likely to report frequent sleep problems, a common symptom of depression.
3. Coleman, P. K. et al. (2009), Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. *Journal of Psychiatric Research, 43, 770-776.*		√	Controlled 22 different demographic, history, and personal/situational variables mostly related to adverse life events. Nationally representative sample. Thorough assessments of psych outcomes by trained professionals. PAR statistic calculated.	After implementing controls, an abortion increased the risk of developing Major Depression with Hierarchy by 42.5%. Abortion was linked to 4.3% of the incidence of Major Depression with Hierarchy.
4. Cougle, J., et al. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. *Medical Science Monitor, 9,* CR105-112	√	√	Controlled for prior psychological state, age, race, marital status, divorce history, education, and income (stratification by ethnicity, current marital status, and history of divorce). Nationally representative, racially - diverse sample. Extended time frame.	Women whose 1st pregnancies ended in abortion were 65% more likely to score in the "high-risk" range for clinical depression. (White: 79% higher risk; married: 116% higher risk; 1st marriage didn't end in divorce: 119% higher risk).
5. Dingle, K., et al. (2008). Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study. *The British Journal of Psychiatry, 193,* 455-460.	√	√	Controlled for maternal and familial factors, pre-existing behavior problems and substance misuse, and demographic factors.	Young women reporting an abortion history had almost twice the risk for 12 month depression compared to women who did not report an abortion.
6. Fergusson, D. M. et al. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47,* 16-24.	√	√	Pregnancy delivered and never pregnant used as comparison groups. Controlled for demographic, family of origin, history of abuse, partner, personality, and mental health history variables. National sample, high retention, low concealment, thorough assessments of outcomes.	42% of the women who had aborted reported major depression by age 25.

7. Fergusson, et al. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study, *The British Journal of Psychiatry, 193,* 444-451.	√	√	Pregnancy delivered and never pregnant used as comparison groups. Controlled for demographic, family of origin, history of abuse, partner, personality, pregnancy intendedness, and mental health history variables. National sample, high retention, low concealment, thorough assessments of outcomes.	Major depression: 31% increased risk associated with abortion.
8. Harlow, B. L. et al. (2004). Early life menstrual characteristics and pregnancy experiences among women with and without major depression: the Harvard Study of Mood and Cycles. *Journal of Affective Disorders, 79,* 167-176.	√	√	Employed demographic controls (age, age at menarche, educational attainment, and history of marital disruption). Population-based sample. 73.5% response rate.	Compared to women with no history of induced abortion, those with two or more were 2-3X more likely to have a lifetime history of major depression.
9. Major, B. et al. (2000). Psychological responses of women after first trimester abortion. *Archives of General Psychiatry, 57,* 777-84.	√	√	Controlled for demographic characteristics, medical complications, and prior mental health.	Two years post-abortion, 20% were depressed. Younger age and having more children pre-abortion predicted more negative post-abortion outcomes.
10. Pedersen W. (2008). Abortion and depression: A population-based longitudinal study of young women. *Scandinavian Journal of Public Health, 36* (4):424-8.	√	√	Controlled for parental education level, parental smoking habits, parental support, and prior history of depression. Large national sample	Women with an abortion history were nearly 3X as likely as their peers without an abortion experience to report significant depression.
11. Pope, L. M. et al. (2001). Post-abortion psychological adjustment: Are minors at increased risk? *Journal of Adolescent Health, 29,* 2-11.	√	√	Compared current sample results with those reported in other studies using similar samples.	19% experienced moderate to severe levels of depression 4 weeks post-abortion.
12. Reardon, D. C., & Cougle, J. (2002). Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A cohort Study. *British Medical Journal, 324,* 151-152.	√	√	Confined analyses to unintended pregnancy aborted or delivered. Nationally representative sample. Controlled for the following: prior psychiatric state, family income. Education, race, age at first pregnancy. Stratified by marital status.	The percentage of women who carried to term considered to be in the high-risk range for depression was 22.7% compared to 27.3% of women who aborted (OR=1.54). Among married women, the percentage of women who carried to term considered to be in the high-risk range for depression was 17.3% compared to 26.2% of women who aborted (OR=2.38).
13. Reardon, D. C. et al. (2003). Psychiatric admissions of low-income women following abortion and childbirth. *Canadian Medical Association Journal,* 168, 1253-1256.	√	√	Homogeneous population. Controls for pre-pregnancy psycho-logical difficulties, age, and mos. of eligibility. Large sample. Used actual claims data, eliminating the concealment problem. Avoids recruitment and retention problems, and simplistic forms of assessment.	Across the 4-yrs, the abortion group more claims for depressive disorders compared to the birth group, with the percentages equaling 90%, 110%, and 200% for depressive psychosis, single and recurrent episode, and bipolar disorder respectively.
14. Rees, D. I. & Sabia, J. J. (2007) The relationship between abortion and depression: New evidence from the Fragile Families and Child Wellbeing Study. *Medical Science Monitor, 13(*10), 430-36.	√	√	A number of controls were incorporated: race, ethnicity, age, education, household income, number of children, prior depression.	Women who had an abortion were at a significantly higher risk for reporting symptoms of Major Depression compared to women who had not become pregnant. After adjusting for controls, abortion was associated with more than a two-fold increase in the likelihood of having depressive symptoms at second follow-up.
15. Schmiege, S., & Russo, N. F. (2005). Depression and unwanted first pregnancy: Longitudinal cohort study. *British Medical Journal.*	√	√	Employed controls to only some analyses *with no explanation.* The analyses in Table 3 of the article do not incorporate controls for variables identified as significant predictors of abortion (higher education and income and smaller family size). This is highly	Percent of women exceeding the depression cut-off after an abortion: Married white women:16% Married black women: 24% Unmarried black women: 38% Among the unmarried, white women, 30% of those in the abortion group had

			problematic since lower education and income and larger family size predicted depression. Without the controls, the delivery group will have more depression variance erroneously attributed to pregnancy resolution.	scores exceeding the clinical cut-off for depression, compared to 16% of the delivery group. Statistical significance is likely to have been achieved with the controls instituted.
16. Söderberg et al. (1998). Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden. European *Journal of Obstetrics and Gynecology and Reproductive Biology 79,* 173-8.	√	√	Utilized a case control data analysis strategy. Extensive semi-structured interview methodology.	50-60% of the women experienced emotional distress of some form (e.g., mild depression, remorse or guilt feelings, a tendency to cry without cause, discomfort upon meeting children), classified as severe in 30% of cases.
17. Mota, N.P. et al (2010). Associations between abortion, mental disorders, and suicidal behaviors in a nationally representative sample. *The Canadian Journal of Psychiatry, 55* (4), 239-246.		√	Nationally representative sample. Controlled for the experience of interpersonal violence and demographic variables.	When compared to women without a history of abortion, those who had an abortion had a 61% increased risk for Mood Disorders

Table 3: Scientific Studies Identifying Abortion as a Risk Factor in Anxiety.

Study	Time sequence	Co-variation	Controls and Other Strengths	Results/Magnitude of effect
1. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2004). Psychological impact on women of miscarriage versus induced abortion: A 2 year follow-up study. *Psychosomatic Medicine, 66,* 265-271.	√	√	Number of children Marital status Vocational status	10 days after the pregnancy ended, 30% of those who had an abortion scored high on measures of avoidance or intrusion, which includes symptoms such as flashbacks and bad dreams. 2 years after the pregnancy ended, nearly 17% of 80 women who had an abortion scored highly on a scale measuring avoidance symptoms, compared with about 3% of those who miscarried.
2. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). Reasons for induced abortion and their relation to women's emotional distress: a prospective, two-year follow-up study. *General Hospital Psychiatry, 27,* 36-43.	√	√	Marital status Psychiatric history	Male pressure on women to abort was significantly associated with negative abortion-related emotions in the two years following an abortion. Pre-abortion psychiatric history was not significantly related to immediate negative abortion related emotion or with negative emotional responses measured at 2 years out. 23.8% of the sample scored high on The Impact of Events Scale (a measure of stress reactions after a traumatic event) 10 days after the abortion, 13.3% at 6 months, and 1.4% after 2 years.
3. Coleman, P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009), Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. *Journal of Psychiatric Research. 43, 770– 776.*		√	Twenty two different demographic, history, and personal/situational variables mostly related to adverse life events.	For PTSD, Agoraphobia with or without Panic Disorder, Agoraphobia without Panic Disorder, a history of abortion when compared to no history was associated with an 81.6%, 1.24.6%, and a 1.32% increased risk respectively after implementing statistical controls. Calculation of population attributable risks indicated that abortion was implicated in 8.3% of the incidence of PTSD, 12.3% of the incidence of Agoraphobia with/or without Panic, and 13.0% of Agoraphobia without Panic.

4. Coleman, P.K., & Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. *Journal of Social and Clinical Psychology, 17,* 425-442.	√	√	Gender: Compared men and women with abortion experience. Time elapsed since abortion	Anxiety increased after the abortion: female: 13.3%; male: 9.7%
5. Cougle, J., Reardon, D. C., Coleman, P. K., & Rue, V. M. (2005).Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. *Journal of Anxiety Disorders, 19, 137-142*	√	√	All women were experiencing an unintended pregnancy Stratification by ethnicity, current marital status, and age.	The odds of experiencing subsequent Generalized Anxiety were 34% higher among women who aborted compared vs. delivered. Greatest differences among the following demographic groups: Hispanic: 86% higher risk, Unmarried at time of pregnancy: 42% higher risk; under age 20: 46% higher risk.
6. Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. *Journal of Obstetrics and Gynecology, 5,* 504-509.	√	√	Used a matched control group	Previous abortion was significantly associated with anxiety among the pregnant women
7. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. Journal of Child Psychology and Psychiatry, 47, 16-24.	√	√	Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, prior history of suicide ideation, living with parents, living with partner	39% of post-abortive women suffered from anxiety disorders by age 25.
8 Fergusson, D.M., Horwood, J. H., & Boden, J. M. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study, The British Journal of Psychiatry, 193, 444-451.	√	√	Controls: childhood socio-economic circumstances, childhood family functioning, parental adjustment, abuse in childhood, individual characteristics, educational achievement, adolescent adjustment, lifestyle and related factors such as exposure to adverse events, and pre-abortion mental health.	Anxiety Disorder: 113% increased risk associated with abortion.
9. Lauzon, P., Roger-Achim, D., Achim, A., & Boyer, R. (2000). Emotional distress among couples. involved in first trimester abortions. Canadian Family Physician, 46, 2033-2040.	√	√	Random sample of the general population of reproductive age used a s the control group	Before the abortion, 56.9% of women and 39.6% of men were much more distressed than their respective controls. Three weeks after the abortion, 41.7% of women and 30.9% of men were still highly distressed.
10. Major,B.,& Gramzow, R. H. (1999).Abortion As stigma: Cognitive and emotional implications of concealment. Journal of Personality and Social Psychology,77, 735-745.	√	√		Two years after abortion: Intrusive thoughts - quite a bit: 3% - some intrusive thoughts: 62%
11. Mota, N.P. et al (2010). Associations between abortion, mental disorders, and suicidal behaviors in a nationally representative sample. *The Canadian Journal of Psychiatry, 55* (4), 239-246.		√	Nationally representative sample. Controlled for the experience of interpersonal violence and demographic variables.	When compared to women without a history of abortion, those who had an abortion had a 61% increased risk for social phobia.
12. Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? Journal of Adolescent Health, 29, 2-11.	√	√	Compared current results with those in other studies using similar samples.	Impact of Events Scale – Intrusion Subscale Score = 13.46, which is similar to adults experiencing a recent parental bereavement.
13. Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. Medical Science Monitor 10, SR 5-16.	√	√	Controls for severe stress symptoms prior to the abortion, other stressors pre-and post-abortion, several demographic variables, psycho-social variables (harsh discipline, abuse, parental divorce, etc).	The percentages of Russian and U.S. women who experienced 2 or more symptoms of arousal, 1 or more symptom of re-experiencing the trauma, and 1 or more experience of avoidance (consistent with DSM-IV diagnostic criteria for PTSD) were equal to 13.1% and 65% respectively.

14. Sivuha, S. Predictors of Posttraumatic Stress Disorder Following Abortion in a Former Soviet Union Country. Journal of Prenatal & Perinatal Psych & Health,17, 41-61 (2002).		√		35% of women had some posttraumatic consequences of abortion (elevated avoidance, intrusion, or hyper-arousal scores) 46% of women had evidence of PTSD, exceeding the cut-offs for intrusion and avoidance subscales. 22% of women experienced PTSD, exceeding the cut-offs on all 3 subscales.
15. Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. British Journal of Obstetrics and Gynecology, 105, 1288-1295.	√	√		1 month post-abortion: Cases of anxiety: 27%
16. Suliman et al. (2007) Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia vs. intravenous sedation. BMC Psychiatry, 7 (24), p.1-9.	√	√	Baseline levels of depression, state anxiety, self-esteem, and functional disability.	The percentages of women experiencing PTSD symptoms after abortion were 17.5% and 18.2% at one and three months respectively.
17. Williams, G. B. (2001). Short-term grief after an elective abortion. Journal of Obstetrics, Gynecologic, and Neonatal Nursing, 30, 174-183.	√	√	Controlled for other forms of loss and psychiatric history. Control group with no abortion history.	History of elective abortion associated with more grief in terms of loss of control, death anxiety, and dependency than controls.
18. Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. British Journal of Obstetrics and Gynecology, 98, 396-399.	√	√		Clinically significant feelings of anxiety at 1 month post-abortion by 10% of the sample.

Table 4: Scientific Studies Identifying Abortion as a Risk Factor in Substance Use/Abuse.

Study	Time sequence	Co-variation	Controls and Other Strengths	Results/Magnitude of effect
1. Amaro H., Zuckerman B, & Cabral H. (1989). Drug use among adolescent mothers: profile of risk. *Pediatrics, 84,* 144-151.	√	√	Other forms of perinatal loss as comparison groups	Adolescent drug users when compared to nonusers were significantly more likely to report a history of elective abortion (33% vs. 16.3%). No associations were identified between drug use and parity or other forms of perinatal loss (miscarriage /stillbirth).
2. Coleman, P. K. (2006). Resolution of Unwanted Pregnancy During Adolescence Through Abortion versus Childbirth: Individual and Family Predictors and Consequences. *Journal of Youth and Adolescence.*	√	√	Demographic, educational, psychological, and family variables found to predict the choice to abort Exclusive focus on unwanted pregnancies	After implementing controls, adolescents with an abortion history, when compared to adolescents who had give birth were 6 times more likely to use marijuana.
3. Coleman., P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009), Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. *Journal of Psychiatric Research. 43, 770– 776.*		√	Controlled for twenty two different demographic, history, and personal/situational variables mostly related to adverse life events.	Abortion was related to an increased risk for substance abuse disorders after statistical controls were instituted. An induced abortion was specifically associated with a 105%, 134%, 70.9%, 104% increased risk for Alcohol Abuse with or without Dependence, Alcohol Dependence, Drug Abuse with or without Dependence, and Drug Dependence respectively. Calculation of population attributable risks indicated that abortion was implicated in 9% of the incidence of

				Alcohol Abuse with/or without Dependence, 12.5% of the incidence of Alcohol Dependence, 7.1% of the incidence of Drug Abuse with/or without Dependence, and 10.4% of the incidence of Drug Dependence.
4. Coleman, P. K., & Maxey, D. C., Spence, M. Nixon, C. (2009). The choice to abort among mothers living under ecologically deprived conditions: Predictors and consequences. *International Journal of Mental Health and Addiction7, 405-422.*	√	√	Controls for the following variables: mother and father married at baseline, mother considered an abortion during first pregnancy, and relationship with father got worse or remained the same after first pregnancy confirmed, and 11 variables related to paternal involvement in the care of the child born at baseline.	Women who chose abortion when compared to women who delivered a second child were more likely to report recent heavy use of alcohol (239% increased risk) and cigarette smoking (99% increased risk).
5. Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). History of induced abortion in relation to substance use during subsequent pregnancies carried to term. *American Journal of Obstetrics and Gynecology, 187,* 1673-1678.	√	√	Results were stratified by potentially confounding factors (marital status, income, ethnicity, and time elapsed since a prior abortion or birth)	Compared with women who had previously given birth, women who aborted were significantly more likely to use marijuana (929%), various elicit drugs (460%), and alcohol (122%) during their next pregnancy. Differences relative to marijuana and use of any elicit drug were more pronounced among married and higher income women and when more time had elapsed since the prior pregnancy. Differences relative to alcohol use were most pronounced among the white women and when more time had elapsed since the prior pregnancy.
6. Coleman, P. K., Reardon, D. C., & Cougle, J. (2005) Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. *British Journal of Health Psychology, 10, 255-268.*	√	√	Other forms of loss Age Marital status Trimester in which prenatal care was sought Education Number in household	No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. A prior history of abortion was associated with a significantly higher risk of using marijuana (201%), cocaine-crack (198%), cocaine-other than crack (406%), any illicit drugs (180%), and cigarettes (100%).
7. Dingle, K., Alta, R., Clavarino, A. et al. (2008). Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study. *The British Journal of Psychiatry, 193,* 455-460.	√	√	Controlled for maternal and familial factors, pre-existing behavior problems and substance misuse, and demographic factors.	Young women reporting an abortion history had almost 3 times a greater risk of experiencing a lifetime illicit drug use disorder (not including marijuana) and twice the risk for an alcohol use disorder compared to women who did not report an abortion.
8. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47,* 16-24.	√	√	Those who delivered and were never pregnant used as comparison groups. Controlled for maternal education, childhood sexual abuse, physical abuse, neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, suicide ideation, living with parents, living with partner	6.8% indicated alcohol dependence, and 12.2% were abusing drugs. By age 25.
9. Fergusson, D.M., Horwood, J. H., & Boden, J. M. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study, *The British Journal of Psychiatry, 193,* 444-451.	√	√	Controls: Measures of childhood socio-economic circumstances, childhood family functioning, parental adjustment, exposure to abuse in childhood, individual characteristics, educational achievement, adolescent adjustment, lifestyle and related factors which included exposure to adverse events, and pre-abortion mental health.	Alcohol dependence: 188% increased risk associated with abortion Illicit drug dependence: 185% increased risk associated with abortion.

10. Hope, T. L., Wilder, E. I., & Watt, T. T. (2003). The relationships among adolescent pregnancy, pregnancy resolution, and juvenile delinquency, *Sociological Quarterly,44,* 555-76.	√	√	Controls for a wide range of socioeconomic and demographic variables likely to influence juvenile delinquency.	Compared to adolescents who ended their pregnancies through abortion, those who keep their babies experienced a dramatic reduction in smoking and marijuana use
11. Pedersen, W. (2007). Addiction. Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study, 102 (12), 1971-78.	√	√	Controls for social background, parental and family history, smoking, alcohol and drug use, conduct problems, depression, schooling, and career variables. Comparison groups included those who had never been pregnant and those who delivered.	Elevated rates of substance use (nicotine dependence: 400% increased risk; alcohol problems: 180% increased risk; Cannabis use: 360% increased risk: and other illegal drugs: 670% increased risk) compared to other women
12. Reardon, D. C., Coleman, P. K., & Cougle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. *Am. Journal of Drug and Alcohol Abuse, 26, 369-383.*	√	√	Age Ethnicity Marital status Income Education Pre-pregnancy self-esteem and locus of control	Compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and 149% more likely to use cocaine in the past 30 days (only approached significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. Except for less frequent drinking, the delivery group was not significantly different from the no pregnancy group.
13. Reardon D.C., Ney, P.G. (2002) Abortion and subsequent substance abuse. *American Journal of Drug and Alcohol Abuse, 26*, 61-75.	√	√	Controlled for substance use prior to the abortion and age	Women who aborted a first pregnancy were 5 times more likely to report subsequent substance abuse than women who carried to term and 4 times more likely to report substance abuse compared to those who had a non-voluntary pregnancy loss
14. Yamaguchi D, & Kandel D. (1987). Drug use and other determinants of premarital pregnancy and its outcome: A dynamic analysis of competing life events. *Journal of Marriage and the Family, 49,* 257-270.	√	√		The use of illicit drugs other than marijuana was 6.1 times higher among women with a history of abortion when compared to women without a history.
15. Mota, N.P. et al (2010). Associations between abortion, mental disorders, and suicidal behaviors in a nationally representative sample. *The Canadian Journal of Psychiatry, 55* (4), 239-246.		√	Nationally representative sample. Controlled for the experience of interpersonal violence and demographic variables.	The increased risk for alcohol abuse, alcohol dependence, drug abuse, drug dependence, and any substance use disorder were equal to 261%, 142%, 313%, 287%, and 280% respectively.

6c

Exhibit C

Coleman, P.K. (Sept 1, 2011). Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009. British Journal of Psychiatry.

National Right to Life

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The complete text of the current Hyde Amendment

Public Law 111-8
H.R. 1105, Division F, Title V, General Provisions

SEC. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term `health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

SEC. 508. (a) The limitations established in the preceding section shall not apply to an abortion--

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

To go to the Abortion in Health Care index, click here.
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Bill Text
112th Congress (2011-2012)
H.R.2055.ENR

H.R.2055

Consolidated Appropriations Act, 2012 (Enrolled Bill [Final as Passed Both House and Senate] - ENR)

(transfer of funds)

Sec. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations provided in this Act. Such transferred balances shall be used for the same purpose, and for the same periods of time, for which they were originally appropriated.

Sec. 502. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

Sec. 503. (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Sec. 504. The Secretaries of Labor and Education are authorized to make available not to exceed $28,000 and $20,000, respectively, from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $5,000 from the funds available for `Federal Mediation and Conciliation Service, Salaries and Expenses'; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed $5,000 from funds available for `National Mediation Board, Salaries and Expenses'.

Sec. 505. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state--

(1) the percentage of the total costs of the program or project which will be financed with Federal money;

(2) the dollar amount of Federal funds for the project or program; and

(3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

Sec. 506. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion .

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion .

(c) The term `health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 507. (a) The limitations established in the preceding section shall not apply to an abortion --

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure

by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term `health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Sec. 508. (a) None of the funds made available in this Act may be used for--

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term `human embryo or embryos' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. 509. (a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. 510. None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

Sec. 511. None of the funds made available in this Act may be obligated or expended to enter into or renew a contract with an entity if--

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Table 18: Number of Induced Terminations by Method of Payment and Age: Alaska Occurrence, 2011

Payment Type	Total	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45+	Not Stated
Cash	249	0	10	29	87	53	40	18	10	0	2
Insurance	107	0	5	9	31	24	21	9	7	0	1
Medicaid	623	6	44	79	223	163	66	32	8	0	2
Multiple Payment Sources	21	0	0	4	6	2	5	4	0	0	0
Other/Not Stated	627	1	21	71	214	156	73	69	15	2	5
Total	1,627	7	80	192	561	398	205	132	40	2	10

Table 19: Induced Terminations by Method of Payment and Percentage by Age: Alaska Occurrence, 2011

Payment Type	Total	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45+	Not Stated
Cash	15.3	0.0	12.5	15.1	15.5	13.3	19.5	13.6	25.0	0.0	20.0
Insurance	6.6	0.0	6.3	4.7	5.5	6.0	10.2	6.8	17.5	0.0	10.0
Medicaid	38.3	85.7	55.0	41.1	39.8	41.0	32.2	24.2	20.0	0.0	20.0
Multiple Payment Sources	1.3	0.0	0.0	2.1	1.1	0.5	2.4	3.0	0.0	0.0	0.0
Other/Not Stated	38.5	14.3	26.3	37.0	38.1	39.2	35.6	52.3	37.5	100.0	50.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

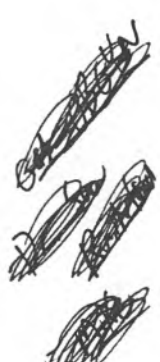

Table 20: Induced Terminations by Age and Percentage by Method of Payment: Alaska Occurrence, 2011

Payment Type	Total	<15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45+	Not Stated
Cash	100.0	0.0	4.0	11.6	34.9	21.3	16.1	7.2	4.0	0.0	0.8
Insurance	100.0	0.0	4.7	8.4	29.0	22.4	19.6	8.4	6.5	0.0	0.9
Medicaid	100.0	1.0	7.1	12.7	35.8	26.2	10.6	5.1	1.3	0.0	0.3
Multiple Payment Sources	100.0	0.0	0.0	19.0	28.6	9.5	23.8	19.0	0.0	0.0	0.0
Other/Not Stated	100.0	0.2	3.3	11.3	34.1	24.9	11.6	11.0	2.4	0.3	0.8
Total	100.0	0.4	4.9	11.8	34.5	24.5	12.6	8.1	2.5	0.1	0.6

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ARTICLES

Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives

By Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh and Ann M. Moore

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CONTEXT: *Understanding women's reasons for having abortions can inform public debate and policy regarding abortion and unwanted pregnancy. Demographic changes over the last two decades highlight the need for a reassessment of why women decide to have abortions.*

METHODS: *In 2004, a structured survey was completed by 1,209 abortion patients at 11 large providers, and in-depth interviews were conducted with 38 women at four sites. Bivariate analyses examined differences in the reasons for abortion across subgroups, and multivariate logistic regression models assessed associations between respondent characteristics and reported reasons.*

RESULTS: *The reasons most frequently cited were that having a child would interfere with a woman's education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%). Nearly four in 10 women said they had completed their childbearing, and almost one-third were not ready to have a child. Fewer than 1% said their parents' or partners' desire for them to have an abortion was the most important reason. Younger women often reported that they were unprepared for the transition to motherhood, while older women regularly cited their responsibility to dependents.*

CONCLUSIONS: *The decision to have an abortion is typically motivated by multiple, diverse and interrelated reasons. The themes of responsibility to others and resource limitations, such as financial constraints and lack of partner support, recurred throughout the study.*

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Public discussion about abortion in the United States has generally focused on policy: who should be allowed to have abortions, and under what circumstances. Receiving less attention are the women behind the statistics—the 1.3 million women who obtain abortions each year[1]—and their reasons for having abortions. While a small proportion of women who have abortions do so because of health concerns or fetal anomalies, the large majority choose termination in response to an unintended pregnancy.[2] However, "unintended pregnancy" does not fully capture the reasons and life circumstances that lie behind a woman's decision to obtain an abortion. What personal, familial, social and economic factors lead to the decision to end a pregnancy?

The research into U.S. women's reasons for having abortions has been limited. In a 1985 study of 500 women in Kansas, unreadiness to parent was the reason most often given for having an abortion, followed by lack of financial resources and absence of a partner.[3] In 1987, a survey of 1,900 women at large abortion providers across the country found that women's most common reasons for having an abortion were that having a baby would interfere with school, work or other responsibilities, and that they could not afford a child.[4] Since 1987, little research in this area has been conducted in the United States, but studies done in Scandinavia and worldwide have found several recurring motivations: economic hardship, partner difficulties and unreadiness for parenting.[5] An extensive literature (both quantitative and qualitative) examines how women make the decision to have an abortion or a birth.[6] Here, we focus on women who have already made the decision to have an abortion.

Why revisit this topic? One compelling reason is that the abortion rate declined by 22% between 1987 and 2002,[7] and another is that the demographic characteristics of reproductive-age women in general and of abortion patients in particular have changed since 1987. For example, the proportion of abortion patients who have already had one or more children has increased, as have the proportions who are aged 30 or older, who are nonwhite and who are cohabiting. In addition, between 1994 and 2000, the proportion of women having abortions who were poor increased.[8] Because social and demographic characteristics may be associated with motivations for having an abortion, it is important to reassess the reasons why women choose to terminate a pregnancy.

A better understanding of these motivations can inform public opinion and prevent or correct misperceptions. Likewise, a fuller appraisal of the life circumstances within which women decide to have an abortion bears directly on the issue of public funding for abortions and provides evidence of how increasing legal and financial constraints on access to abortion may affect women's lives.

METHODS

Our study included a quantitative component (a structured survey) and a qualitative component (in-depth interviews), which together provide a more comprehensive examination of women's reasons for having abortions. The survey instrument, the interview guide and implementation protocols were approved by our organization's institutional review board. We also make comparisons to nationally representative surveys of abortion patients fielded in 1987 and 2000, and to a 1987 survey of reasons for abortion.[9]

Quantitative Component

The design of the structured questionnaire was modeled after the one used in the 1987 U.S. study,[10] and we kept the wording as similar as possible to the language of that survey. Our eight-page questionnaire covered in detail the reasons why the respondent chose to terminate her pregnancy. The first question was open-ended: "Please describe briefly why you are choosing to have an abortion now. If you have more than one reason, please list them all, starting with the most important one first." Nearly eight in 10 respondents provided at least one answer.

The next 12 questions asked about reasons for deciding to have an abortion. If the woman answered affirmatively to any of the first three ("Having a baby would dramatically change my life," "Can't afford a baby now" and "Don't want to be a single mother or having relationship problems"), she was asked which of a set of specific subreasons were relevant. Multiple responses were allowed, and a space was provided to write in reasons that were not listed.* The questionnaire then had a space for reasons that did not fit into any of the categories provided. Finally, women were asked about their demographic and social characteristics.

We purposively sampled 11 facilities from the universe of known abortion providers that perform 2,000 or more abortions per year; such facilities performed 56% of all abortions in the United States in 2000.[11] Our sample was chosen to be broadly representative, rather than strictly statistically representative, of all large providers. We included at least one facility in each of the nine major geographic divisions defined by the U.S. Census Bureau, and chose facilities that represented a variety of city sizes, patient characteristics and state abortion policies (such as waiting periods, parental consent regulations and use of state Medicaid funds). Most were clinics or private practices; one was a hospital. Of the 11 sites originally chosen, one clinic declined to participate and was replaced by a similar facility.

The questionnaire was pretested at a clinic that was not part of the sample to assess how well women understood the informed consent process and the survey questions.

Staff at the selected facilities asked women arriving for a pregnancy termination to participate in the survey and, if they agreed, to fill out the questionnaire by themselves and return it to a staff member in a sealed envelope.† The questionnaire was available in English and Spanish. Participation was voluntary, and no identifying information about the respondents was collected.

The fielding period ranged from one to six weeks, depending on each facility's caseload. We established a minimum response rate of 50% of all abortion clients seen by each facility during its sampling period for the data to be considered representative of the women at that facility. The overall response rate was 58%, and facility rates ranged from 50% to 76%, because some women declined participation and some staff had minor difficulties adhering to the protocol. Fielding ran from December 2003 until March 2004, and 1,209 abortion patients completed the questionnaire.

Qualitative Component

We also conducted in-depth interviews with 38 women at four sites. The interview guide included all of the same topics as the survey. The selected sites were hospital-based and freestanding, in different regions of the country and in states with differing restrictions on access to and Medicaid reimbursement for abortion services. The sites were also chosen to represent varying city sizes and to capture a cross section of abortion patients. In three of these facilities, the structured survey had also been distributed. Staff at the study clinics offered all abortion patients a chance to participate; recruitment was not based on social or demographic characteristics.

Members of the study team interviewed respondents during their medical visit, typically before the procedure. Women were informed that the interviews would be recorded, and they provided verbal consent. The interviews lasted 30–60 minutes and were anonymous. The qualitative component was limited to fluent English speakers. Women were compensated $25 in cash for their participation. The interview period began at the end of the structured survey period and continued for two months.

Data Analysis

We used chi-square tests to examine differences in reasons for abortion across demographic subgroups. Multivariate logistic regression models refined our understanding of the variables associated with each reason. In addition, we conducted a factor analysis of the closed-ended and write-in reasons and subreasons to identify logical groupings.

The 1987 study purposely oversampled women having abortions at 16 weeks of gestation or later. We therefore weighted figures for 1987 to reflect the true distribution of abortions by gestation for all U.S. women. Given that the 2004 survey was not nationally representative, individual cases were not weighted. Because the sampling design involved 11 primary sampling units, we used statistical techniques that accounted for the clustered design to calculate

*In 1987, the question about ability to afford a baby did not offer specific subreasons, but asked women to write in subreasons. The most common responses were used to create the options for the 2004 version. Hence, comparisons of subreasons between 1987 and 2004 for this question are not valid.

†The facilities were free to alter this recommended process to best fit their client flow; most had respondents complete the survey as they waited for their procedure, but some facilities asked women to participate after their procedure and recovery period were over.

TABLE 1. Percentage of women in various surveys of abortion patients, by selected characteristics, 1987–2004

Characteristic	Structured survey, 2004 (N=1,209)	In-depth interviews, 2004 (N=38)	Nationwide survey, 2000 (N=10,683)	Structured survey, 1987 (N=1,900)	Nationwide survey, 1987 (N=9,480)
Age ≤19	20	24	19	28	25
Age 20–29	57	53	56	54	55
Never-married	72	76	67	67	63
Has children	59	71	61	42	48
<200% of federal poverty level†	60	68	57	50	55
≥some college	53	u	57	53	u
Black	31	45	32	26	26
Hispanic	19	11	20	7	13
<9 weeks' gestation	61	39	u	55	50
<13 weeks' gestation	85	58	u	87	86

†The 2004 study used the federal poverty level in 2003. *Note:* u=unavailable. *Sources:* **Nationwide survey, 2000**—RK Jones, JE Darroch and SK Henshaw, 2002 (see reference 8). **Structured survey, 1987**—reference 4. **Nationwide survey, 1987**—SK Henshaw and J Silverman, 1988 (see reference 8).

accurate standard errors. We conducted all analyses using Stata version 8.2. All associations discussed were significant at p<.05 or less.

Of the 1,209 respondents, 4% gave no reasons and were excluded from most analyses. Higher proportions of these women than of the others were nonwhite and had children. In addition, nonresponse was 12–14% for age, parity, marital status, race and employment, and 26% for income, causing the Ns for the multivariate models to be lower than those for the univariate and bivariate tabulations.

The audiocassettes of the in-depth interviews were professionally transcribed, and the research team listened to every tape while reviewing the transcription. Errors were corrected, and any information that could potentially identify respondents was removed. The edited transcripts were systematically coded using categories based on the project focus as well as related ideas emerging from the data. All coding was done by one author and checked for validity by another. We used the software N6 for coding and data analysis.

RESULTS

Respondents' Characteristics

Respondents to the structured survey of reasons for abortion were not substantially different from a nationally representative sample of abortion patients surveyed in 2000[12] in terms of age, marital status, parity, income, education, race or gestation (Table 1). Twenty percent were 19 or younger, and 57% were in their 20s. Seventy-two percent had never been married, and 59% had had at least one child. Some 60% were below 200% of the federal poverty line, including 30% who were living in poverty (not shown). More than half had attended college or received a college degree. Thirty-one percent of respondents were black, and 19% were Hispanic. (Four percent completed the questionnaire in Spanish.) Sixty-one percent were at fewer than nine weeks of gestation, and 85% were at fewer than 13 weeks.

However, the characteristics of abortion patients had changed between 1987 and 2000, and these changes were reflected in the 1987 and 2004 surveys of reasons for abortion. For example, the proportion who were mothers increased from 48% to 61% in the nationally representative surveys carried out in 1987 and 2000; a similar increase (from 42% to 59%) was seen between the 1987 and 2004 surveys of reasons. The median age of respondents was 23.0 in the 1987 survey of reasons and 24.1 in 2004 (not shown). Fifty percent of women were below 200% of the federal poverty level in the 1987 survey of reasons, while in 2004, 60% were below this level. Also, the proportion who were Hispanic rose from 7% in 1987 to 19% in 2004.

The in-depth interview respondents were slightly older than the structured survey respondents; more than half were 25 or older (not shown). More than two-thirds had children, and two-thirds were living below 200% of the federal poverty level (with half at or below the poverty line—not shown). Marital status was similar between the two samples. Nearly half were black, and the proportion who were Hispanic was only 11%. Furthermore, almost half of the interview respondents were in their second trimester; a possible explanation for this overrepresentation is that these women were usually in the clinic on two consecutive days for their abortion procedures, and therefore were more likely to be available to participate in the interviews.

Reasons for Abortion

• *Reasons in 2004.* Among the structured survey respondents, the two most common reasons were "having a baby would dramatically change my life" and "I can't afford a baby now" (cited by 74% and 73%, respectively—Table 2). A large proportion of women cited relationship problems or a desire to avoid single motherhood (48%). Nearly four in 10 indicated that they had completed their childbearing, and almost one-third said they were not ready to have a child. Women also cited possible problems affecting the health of the fetus or concerns about their own health (13% and 12%, respectively).* Respondents wrote in a number of specific health reasons, from chronic or debilitating conditions such as cancer and cystic fibrosis to pregnancy-specific concerns such as gestational diabetes and morning sickness.

The most common subreason given was that the woman could not afford a baby now because she was unmarried (42%). Thirty-eight percent indicated that having a baby would interfere with their education, and the same proportion said it would interfere with their employment. In a related vein, 34% said they could not afford a child because they were students or were planning to study.

In the in-depth interviews, the three most frequently stated reasons were the same as in the structured survey: the dramatic impact a baby would have on the women's lives or the lives of their other children (32 of 38 respondents), financial concerns (28), and their current relationship or fear of single motherhood (21). Nine women cited health concerns for themselves, possible problems affecting the

*Women's reasons for abortion may vary by type of facility. For example, women who undergo abortions at hospitals may be more likely than others to have sought an abortion for health reasons. However, administrators at participating sites noted that local hospitals often refer women seeking abortions for fetal or maternal health reasons to their facilities. Thus, underreporting of health reasons, while possible, is likely not substantial.

health of the fetus or both as a reason for terminating the pregnancy.

• *Changes in reasons, 1987–2004.* Several questions were identical or virtually identical on the 1987 and 2004 surveys of reasons for abortion and are thus comparable (Table 2). The proportions of women giving four of the five most common reasons for abortion in 2004 were similar to those in 1987. Roughly equal proportions of women in both surveys indicated that a baby would dramatically change their lives, that they could not afford a baby now, that they did not want to be a single mother or had problems with their relationship, and that they were not ready for a child or another child. While some of these proportions showed statistically significant differences, in our assessment they were not substantial, because the percentage changes were small.

However, the proportion of women indicating that they had completed their desired childbearing increased substantially (and significantly) between 1987 and 2004, from 28% to 38%. To assess whether this shift was due to a change in mothers' propensity to give this reason (in addition to the change in population composition described earlier), we stratified this analysis by both survey year and whether the woman had any children. The findings showed that mothers in 2004 were more likely to report this reason than were mothers in 1987 (not shown). Thus, the overall increase likely reflected both a rise in the proportion of abortion patients who were already mothers and an increased tendency of mothers to give this reason. The proportion of women indicating that having children or other dependents was a reason not to have another child increased from 22% to 32% between 1987 and 2004. This change, however, appeared to be due solely to the change in population composition (not shown). The proportion of women who cited a physical problem with their health also increased over the period.

On the other hand, smaller proportions of women in 2004 than in 1987 said that having a baby would interfere with their job or career (38% vs. 50%), that they were not mature enough (22% vs. 27%), that their husband or partner wanted them to have an abortion (14% vs. 24%), and that they and their partner could not or did not want to get married (12% vs. 30%). In both surveys, 1% indicated that they had been victims of rape, and less than half a percent said they became pregnant as a result of incest.

• *Most important reasons.* In both 1987 and 2004, unreadiness for a child or another child and inability to afford a baby were each mentioned by about one-quarter of women as their most important reason for having an abortion (Table 3, page 114).* The proportion indicating that they had completed their childbearing, that they had others depending on them or that their children were grown increased over this period, from 8% to 19%. In contrast, the proportions reporting fear of single motherhood or relationship problems, and reporting that a child would interfere with school or career, both declined, as did the percentage describing themselves as not mature enough or too young.

Seven percent of women cited health concerns for themselves or possible problems affecting the health of the fetus as their most important reason in 2004, about the same as in 1987. Only half a percent of women indicated that their partners' or their parents' desire for an abortion was the most important reason behind their decision.

• *Number of reasons given.* Of the 1,160 women who gave at least one reason, 89% gave at least two and 72% gave at least three; the median number of reasons given was four, and some women gave as many as eight reasons out of a possible 13 (not shown). Among women who gave at least two reasons, the most common pairs of reasons were inability to afford a baby and interference with school or work; inability to afford a baby and fear of single motherhood or relationship problems; and inability to afford a baby and having completed childbearing or having other people dependent on them.

In-depth interview respondents gave an average of five reasons (range, 1–10) for why they were ending their pregnancy. However, women's responses often did not fit the categories of the structured survey; the reasons tended to overlap between the domains of unplanned pregnancy, financial instability, unemployment, single motherhood and current parenting responsibilities. For example, one 25-

TABLE 2. Percentage of women reporting that specified reasons contributed to their decision to have an abortion, 2004 and 1987

Reason	2004 (N=1,160)	1987 (N=1,900)
Having a baby would dramatically change my life	74	78*
Would interfere with education	38	36
Would interfere with job/employment/career	38	50***
Have other children or dependents	32	22***
Can't afford a baby now	73	69
Unmarried	42	na
Student or planning to study	34	na
Can't afford a baby and child care	28	na
Can't afford the basic needs of life	23	na
Unemployed	22	na
Can't leave job to take care of a baby	21	na
Would have to find a new place to live	19	na
Not enough support from husband or partner	14	na
Husband or partner is unemployed	12	na
Currently or temporarily on welfare or public assistance	8	na
Don't want to be a single mother or having relationship problems	48	52*
Not sure about relationship	19	na
Partner and I can't or don't want to get married	12	30***
Not in a relationship right now	11	12
Relationship or marriage may break up soon	11	16*
Husband or partner is abusive to me or my children	2	3
Have completed my childbearing	38	28**
Not ready for a(nother) child†	32	36
Don't want people to know I had sex or got pregnant	25	33*
Don't feel mature enough to raise a(nother) child	22	27*
Husband or partner wants me to have an abortion	14	24***
Possible problems affecting the health of the fetus	13	14
Physical problem with my health	12	8**
Parents want me to have an abortion	6	8
Was a victim of rape	1	1
Became pregnant as a result of incest	<0.5	<0.5

*p<.05. **p<.01. ***p<.001. †This was a write-in response in 2004 and 1987. *Note:* na=not applicable, because survey questions were not comparable. *Source:* **1987**—reference 4.

*We grouped some reasons slightly differently in Tables 2 and 3 to combine reasons that are conceptually similar. For example, women who indicated that they had children or other dependents were grouped with those who said they had completed their childbearing.

TABLE 3. Percentage distribution of women having an abortion, by their most important reason for having the abortion, 2004 and 1987

Reason	2004 (N=957)	1987 (N=1,773)
Not ready for a(nother) child†/timing is wrong	25	27
Can't afford a baby now	23	21
Have completed my childbearing/have other people depending on me/ children are grown	19	8***
Don't want to be a single mother/am having relationship problems	8	13***
Don't feel mature enough to raise a(nother) child/feel too young	7	11**
Would interfere with education or career plans	4	10***
Physical problem with my health	4	3
Possible problems affecting the health of the fetus	3	3
Was a victim of rape	<0.5	1
Husband or partner wants me to have an abortion	<0.5	1
Parents want me to have an abortion	<0.5	<0.5
Don't want people to know I had sex or got pregnant	<0.5	1***
Other	6	1
Total	100	100

**p<.01. ***p<.001. †This was a write-in response in 2004 and 1987. *Source:* 1987—reference 4.

year-old woman, separated from her husband, said:

"Neither one of us are really economically prepared. For myself, I've been out of work for almost two years now, I just started, you know, receiving benefits from DSS and stuff. And with my youngest child being three years old, and me...constantly applying for jobs for a while now,...if I got a job, I'm going to have to go on maternity leave. And with [the father],...let's just say, with four children, I don't think he needs another one."–*Mother of two, below the poverty line*

Factors Related to Reasons for Abortion

This study also examined the relationship between various social and demographic characteristics and reasons for having an abortion. These analyses included all women who mentioned each reason; they are not restricted to women's most important reasons. In several cases, we have grouped two reasons on the basis of their similarity and the factor analysis of related reasons.

• *Interference with school or career, and unreadiness for a child or another child.* Higher proportions of younger women, of women with no children and of never-married women identified interference with education or work and unreadiness for a child or another child as reasons for having an abortion, compared with their respective counterparts (Table 4). Even among older women and women who had children, however, about one-third cited disruption of schooling or work. A higher proportion of more educated women than of less educated women gave this reason.

Nulliparity was the most important correlate of reporting interference with education or work as a reason for choosing abortion, after other variables were controlled for. Women who had children were less likely than women with no children to give these reasons (odds ratios, 0.2–0.3). In addition, women aged 30 and older were much less likely than those aged 17 and younger to cite educational or career interference (0.1).

Having no children was also the key predictor of reporting unreadiness for a child or another child: Women with children had reduced odds of citing this reason (odds ratios, 0.3–0.4). The fact that the odds ratios for women with one, two, and three or more children are similar suggests that unreadiness is more strongly linked to initiating childbearing than to limiting the number of children.

Fewer than half of the interview respondents said that having a baby now would keep them from fulfilling their goals or that they were not ready to have a(nother) child. The majority of these women were young and nulliparous; their aspirations were primarily educational. Many women who gave one of these reasons said they were too young to have children and felt they were "just starting out" in their lives. Most framed their decision in terms of the desire to have children later, when they could better provide for them. A never-married woman who had just started college and whose partner was still in high school remarked:

"You know, I'm 19 years old. I don't think I should be

TABLE 4. Percentage of women reporting interference with school or career, and unreadiness for having a child, as a reason for abortion, by selected characteristics; and odds ratios from multivariate logistic regression analysis of associations between reasons and characteristics, 2004

Characteristic	Interference with school or career		Not ready for a(nother) child	
	% (N=1,037)	Odds ratio (N=726)	% (N=983)	Odds ratio (N=693)
All	**53**	**na**	**32**	**na**
Age				
≤17 (ref)	82***	1.00	37*	1.00
18–19	71	0.46	39	0.86
20–24	58	0.26	39	1.19
25–29	47	0.20	33	1.16
≥30	35	0.12**	17	0.50
No. of children				
0 (ref)	76***	1.00	47***	1.00
1	41	0.27***	27	0.42**
2	35	0.24***	19	0.32**
≥3	31	0.31**	17	0.29**
Relationship status				
Never-married, not cohabiting (ref)	61***	1.00	38***	1.00
Cohabiting	54	1.00	37	1.06
Married	33	0.69	21	0.97
Formerly married, not cohabiting	47	1.28	14	0.62
Race/ethnicity				
White (ref)	53	1.00	34	1.00
Black	57	2.00*	31	1.05
Hispanic	46	0.78	28	0.93
Other	63	2.01	30	0.68
% of federal poverty level				
<100 (ref)	53	1.00	32	1.00
100–149	57	1.23	31	0.85
150–199	50	0.79	33	0.76
≥200	52	0.77	33	0.76
Education†				
<H.S. graduate (ref)	30**	1.00	10	1.00
H.S. graduate/GED	26	1.12	29	1.63
Some college/ associate degree	44	2.28*	20	1.57
College graduate	51	3.30	31	1.53

*p<.05. **p<.01. ***p<.001. †Percentages include only women aged 25 and older. *Notes:* Chi-square tests measured differences across the entire distribution. na=not applicable. ref=reference group.

having a child right now. I should be more focused on what I'm trying...I'm trying to do things for myself. How am I supposed to do something for another human?"—*Woman with no children, above the poverty line*

• *Financial difficulties.* Higher proportions of women who were unmarried or cohabiting, nonwhite, poorer and unemployed said they could not afford to have a child now, compared with their respective counterparts (Table 5). This reason was also more commonly given by young teenagers and women aged 20–24. Some of these social and demographic characteristics likely have overlapping influence. For example, young women are likely to be unmarried, and poor women are likely to be unemployed. In the multivariate analysis, marital status and both economic variables remained significant: Women who were married, who were in the highest income category and who were employed had reduced odds of saying they could not afford a baby (odds ratios, 0.4–0.6).

In the qualitative sample, of women who stated that they could not afford to have a child now, the majority had children already. Financial difficulties included the absence of support from the father of either the current pregnancy or the woman's other children, anticipating not being able to continue working or to find work while pregnant or caring for a newborn, not having the resources to support a child whose conception was not planned and lacking health insurance. Respondents who gave financial reasons for having an abortion frequently reported feeling stressed and strained to the limit of their current resources, as did the never-married woman who commented:

"I am on my own, and financially and mentally, I can't stand it now. That is one whole reason....It's a sin to bring the child here and not be able to provide for it....This is just in the best interest for me and the children—no, my children and this child."—*19-year-old with three children, below the poverty line*

One respondent had recently been homeless, and another's partner prevented her from working; some respondents were on government assistance:

"I have three kids already, and the guy that I was living with, he was, you know, doing good as far as helping me, but he just went to jail....I am alone with three kids, and they are all I have. It's hard....I am barely making it, you know, because it is...harder to get things,...you can't get food, you know, you cannot get food stamps....I only get 50 [dollars] in food stamps [a month]....It is just too hard."—*22-year-old, below the poverty line*

A few respondents articulated their fears that having another baby now would force them onto public assistance, an outcome they wanted to avoid. For example:

"If you think about it, OK—I get pregnant; I might not be financially stable. I got to take somebody's working money for welfare. You know what I'm saying? Why not let me get out of this situation, so I could better myself so when I do get pregnant and have another baby, I don't have to take your money, because you're working. I'm not going to be working, because I'm going to be sitting on my welfare, taking care of my baby! Why?"—*21-year-old with one child, below the poverty line*

TABLE 5. Percentage of women reporting that they could not afford another child, that they did not want to be a single mother or had relationship problems, and that they had completed childbearing or had other people depending on them, as a reason for abortion, by selected characteristics; and odds ratios from multivariate logistic regression analysis of associations between reasons and characteristics, 2004

Characteristic	Can't afford a baby now		Single mother or relationship problems		Completed childbearing or have dependents	
	% (N=1,147)	Odds ratio (N=774)	% (N=1,071)	Odds ratio (N=772)	% (N=1,147)	Odds ratio (N=828)
All	**73**	**na**	**48**	**na**	**47**	**na**
Age						
≤17 (ref)	80***	1.00	36	1.00	8***	1.00
18–19	69	0.74	39	1.40	22	4.32*
20–24	81	1.07	51	2.62	46	16.04***
25–29	70	0.80	52	3.22	58	29.05***
≥30	60	0.62	47	2.83	69	40.57***
No. of children						
0 (ref)	73	1.00	48	1.00	3***	na
1	74	1.01	46	0.73	75	na
2	68	0.89	51	1.05	81	na
≥3	73	0.93	47	0.66	90	na
Relationship status						
Never-married, not cohabiting (ref)	75***	1.00	50***	1.00	37***	1.00
Cohabiting	81	1.30	38	0.51*	48	1.49
Married	53	0.44*	25	0.29***	71	4.67***
Formerly married, not cohabiting	68	0.70	72	2.14*	72	4.39***
Race/ethnicity						
White (ref)	69**	1.00	49	1.00	41***	1.00
Black	75	1.08	45	0.85	60	2.98***
Hispanic	79	1.32	56	1.08	51	1.09
Other	77	1.51	36	0.40	44	1.06
% of federal poverty level						
<100 (ref)	81***	1.00	53	1.00	61**	1.00
100–149	79	1.04	50	0.83	48	0.51*
150–199	75	0.80	48	0.74	50	0.52
≥200	60	0.51*	43	0.64	39	0.34***
Education†						
<H.S. graduate (ref)	81	1.00	57	1.00	80***	1.00
H.S. graduate/GED	66	0.78	44	0.73	79	0.86
Some college/ associate degree	65	1.09	53	1.03	62	0.36***
College graduate	58	0.81	47	0.86	47	0.25***
Employment						
Unemployed (ref)	79**	1.00	45	1.00	48	1.00
Employed	69	0.59*	48	1.19	48	0.98

*p<.05. **p<.01. ***p<.001. †Percentages include only women aged 25 and older. *Notes:* Chi-square tests measured differences across the entire distribution. na=not applicable; parity was omitted from the third model. ref=reference group.

• *Single motherhood and relationship problems.* As might be expected, higher proportions of unmarried women who were not cohabiting (including both formerly married and never-married women) than of cohabiting or married women cited fear of single motherhood or relationship problems as a reason (Table 5). Multivariate analysis found that formerly married, noncohabiting women had elevated odds of giving this reason (odds ratio, 2.1), while cohabiting and married women had reduced odds (0.3–0.5). Furthermore, cohabiting women were more likely than married women to report this reason (not shown).

TABLE 6. Percentage of women reporting fetal or personal health concerns as a reason for abortion, by selected characteristics; and odds ratios from multivariate logistic regression analysis of associations between reasons and characteristics, 2004

Characteristic	Fetal health		Personal health	
	% (N=1,042)	Odds ratio (N=742)	% (N=1,058)	Odds ratio (N=747)
All	**13**	**na**	**12**	**na**
Age				
≤17 (ref)	7	1.00	4***	1.00
18–19	9	2.43	5	2.16
20–24	13	3.37	9	5.55
25–29	13	3.67	13	9.11
≥30	17	5.47	22	21.90*
No. of children				
0 (ref)	13	1.00	8*	1.00
1	14	1.01	12	1.03
2	13	0.68	15	0.85
≥3	10	0.71	17	1.09
Relationship status				
Never-married, not cohabiting (ref)	11	1.00	9*	1.00
Cohabiting	14	1.26	15	1.41
Married	16	1.15	17	0.82
Formerly married, not cohabiting	15	1.00	15	0.72
Race/ethnicity				
White (ref)	17*	1.00	14	1.00
Black	8	0.45*	9	0.67
Hispanic	11	0.54	13	1.03
Other	18	0.94	10	0.67
% of federal poverty level				
<100 (ref)	15	1.00	13	1.00
100–149	12	0.61	16	1.05
150–199	7	0.46	5	0.31*
≥200	14	0.70	12	0.62*
Education†				
<H.S. graduate (ref)	30	1.00	34	1.00
H.S. graduate/GED	10	0.94	18	0.70
Some college/ associate degree	16	1.09	17	0.67
College graduate	15	1.22	15	0.69
Weeks pregnant				
<7 (ref)	12	1.00	13	1.00
7–8	10	0.89	11	0.81
9–12	11	1.08	11	0.77
≥13	21	3.27*	10	0.84

*p<.05. ***p<.001. †Percentages include only women aged 25 and older. *Notes:* Chi-square tests measured differences across the entire distribution. na=not applicable. ref=reference group.

More than half of the women in the qualitative sample cited concerns about their relationship or single motherhood as a reason to end the pregnancy. Relationship problems included the partner's drinking, physical abuse, unfaithfulness, unreliability, immaturity and absence (often due to incarceration or responsibilities to his other children). Many of these women were disappointed because their partner had reacted to the pregnancy by denying paternity, breaking off communication with them or saying that they did not want a child. A small number of women stated that they were in new relationships and that it was too soon to have a child with their partner. Most who gave this reason had children already. They related how hard it was to raise children by themselves and how hard it would be to add another child to their families. Some felt depleted and alone:

"Well, I already had one son, and right now he's growing up without a father, just me and him....If you ain't got a lot of help with the family support, it's really hard. Sometimes I can't handle it, but I have to, you know, for my son's sake....I believe, right now, I'm gonna take care of myself and my son."–*19-year-old, below the poverty line*

A number of women stated that it was unfair to one's children to bring them up without a father figure.

• *Completed childbearing and responsibility to dependents.* Bivariate analysis of these reasons revealed some expected relationships: High proportions of older women, women with children and women who were currently married, as well as those formerly married and not cohabiting, cited completion of their childbearing or already having dependents as a reason for having an abortion (Table 5). The proportion citing these reasons increased with age. These reasons were more commonly given by black and Hispanic women, and by poorer and less educated women.

Combining all reasons that refer to other people or to future children,* we found that 74% of women, including at least two-thirds of women in every age, parity, relationship, racial, income and education category, identified concern for or responsibility to other individuals as a factor in their decision (not shown). Nine in 10 of these women (66% of all women) cited their inability to care for a child at this stage in their life or the quality of life they could provide for a(nother) child, and 45% of them (33% of all women) reported concern for other individuals, most commonly their children.

An initial multivariate analysis indicated that, as might be expected, women with children had sharply elevated odds of saying that they had completed their childbearing or that they had children or others depending on them; this variable overwhelmed the impact of other variables (not shown). Because of the extremely high odds ratios for this variable, we omitted nulliparous women from a second model (also not shown), and found that parity was no longer significant—that is, the important difference was between women with any number of children and those with no children. For the model shown in Table 5, we omitted parity entirely, and found that women aged 18 and older, married and formerly married women, black women, and poorer or less educated women had elevated odds of giving these reasons, findings that reflected the bivariate results.

Some interviewees said they were ending this pregnancy because they did not want any more children. Women cited financial reasons, their age and health, not wanting to "start over" and already having children of both genders. Many mentioned that having another baby would deprive the children they already had of financial, emotional and

*These reasons included financial, partner and relationship problems resulting in the inability to care for or support a(nother) child, possible problems affecting the health of the fetus, difficult family situations such as a current child's chronic illness, financial impacts on existing children and the need to care for other dependents.

time resources. One lower income, divorced mother said:

"There is just no way I could be the wonderful parent to all three of them and still have enough left over to keep the house clean and make sure the bills are paid and I'm in bed on time so I can be at work on time. It's impossible." *–30-year-old with two children, below the poverty line*

Women's concerns ranged from worries about their own health, to dealing with their children's chronic illnesses or severe disabilities, to a lack of adequate birthspacing.

• ***Fetal and personal health.*** Lower proportions of black and Hispanic women than of whites cited possible problems affecting the health of the fetus as a reason to end their pregnancies (Table 6). In the multivariate analysis, black women had reduced odds of reporting this reason (odds ratio, 0.5). In addition, women at 13 or more weeks of gestation had elevated odds of citing fetal health compared with those at fewer than seven weeks of gestation (3.3).

Concern for one's own health was a more common reason for having an abortion among older women and those with children; it was cited less often by women who were never married and not cohabiting. Women aged 30 and older had greatly elevated odds of citing their own health compared with the youngest age-group (odds ratio, 21.9), but we found no significant association with parity. In addition, women living at or above 150% of the federal poverty level were less likely to mention their own health than were women living in poverty (0.3–0.6).

A woman's concerns for her health or possible fetal health problems were cited as reasons to end her pregnancy by one-fourth of the qualitative sample. Women who felt that their fetus's health had been compromised cited concerns such as a lack of prenatal care, the risk of birth defects due to advanced maternal age, a history of miscarriages, maternal cocaine use and fetal exposure to prescription medications. Concerns about personal health included chronic and life-threatening conditions such as depression, advanced maternal age and toxemia. More commonly, however, women cited feeling too ill during the pregnancy to work or take care of their children.

• ***Opinions on adoption.*** Respondents were not specifically asked about adoption; nevertheless, it came up spontaneously in both parts of the study. While fewer than 1% of women in the quantitative survey volunteered that they would not consider or did not favor having a baby and giving it up for adoption, more than one-third of interview respondents said they had considered adoption and concluded that it was a morally unconscionable option because giving one's child away is wrong.

DISCUSSION

Women's reported reasons for ending pregnancies have been consistent over time. Furthermore, the proportion of women reporting each major reason changed relatively little between 1987 and 2004. The few larger changes appear to have been at least partially due to changes in the composition of the population, rather than entirely to changes in women's tendency to give those reasons.

The decision to have an abortion is typically motivated by diverse, interrelated reasons. Nearly three-quarters of respondents indicated that they could not afford to have a child now, and large proportions mentioned responsibilities to children, partner issues and unreadiness to parent. The in-depth interviews revealed that these reasons are multiple dimensions of complicated life situations. For example, financial difficulties are often the result of lack of support from one's partner, or lack of a partner altogether; and the financial and emotional responsibility to provide for existing children without adequate resources makes it too hard for some women to care for another child.

Yet some broad concepts emerged from the study. A crosscutting theme was women's responsibility to children and other dependents, as well as considerations about children they may have in the future. Most women in every age, parity, relationship, racial, income and education category cited concern for or responsibility to other individuals as a factor in their decision to have an abortion. In contrast to the perception (voiced by politicians and laypeople across the ideological spectrum) that women who choose abortion for reasons other than rape, incest and life endangerment do so for "convenience,"[13] our data suggest that after carefully assessing their individual situations, women base their decisions largely on their ability to maintain economic stability and to care for the children they already have.

In addition, the topic of women's limited resources, such as financial constraints and lack of partner support, regularly appeared in the survey and interview responses. A large majority of women cited financial hardship, often along with other reasons. Financial problems, exacerbated by other forms of instability, limit women's ability to provide sufficient support to additional children. The concept of responsibility is inseparable from the theme of limited resources; given their present circumstances, respondents considered their decision to have an abortion the most responsible action. The fact that many women cited financial limitations as a reason for ending a pregnancy suggests that further restrictions on public assistance to families could contribute to a continued increase in abortions among the most disadvantaged women.[14]

Although these concerns appeared among all groups, different groups of women gave diverse reasons for having abortions. Younger women who had not begun their childbearing often reported that they were unprepared for the transition to motherhood, while older women, the large majority of whom were already mothers, regularly cited their responsibility to children or other dependents as a key factor behind the decision to have an abortion.

Only a small proportion of women cited concerns about their own health. However, the qualitative results showed that these concerns encompassed not just risks to future health, but also the health burden of pregnancy itself. They further revealed how health concerns are linked to the concept of responsibility: Some women saw the physical burden of pregnancy and its associated health conditions as threatening their ability to fulfill responsibilities to de-

pendents. Others underscored the importance of appropriate birthspacing for their own health and for the health and economic security of their children.

In light of the public debate over the morality of abortion, it is notable that the women in our survey emphasized their conscious examination of the moral aspects of their decisions. Although some described abortion as sinful and wrong, many of those same women, and others, described the indiscriminate bearing of children as a sin, and their abortion as "the right thing" and "a responsible choice." Respondents often acknowledged the complexity of the decision, and described an intense and difficult process of deciding to have an abortion, which took into account the moral weight of their responsibilities to their families, themselves and children they might have in the future.

In the in-depth interviews, the language women used suggests that abortion was not something they desired; instead, these women were deciding not to have a child at this time. Facing unintended pregnancies, they clearly understood the implications of having a child (most of them firsthand) and were aware of their options. They saw not having a child as their best (and sometimes only) option.

Some advocates have used highly selective samples to claim that the majority of women having abortions are coerced into the decision.[15] Such claims suggest that women lack control over their own lives, but our findings attest that women independently make the decision to have an abortion. The proportion of women citing influence from partners or parents is small (and has declined since 1987), and fewer than 1% of respondents indicated that this influence was their most important reason.

This study is subject to some limitations. Our sample is not strictly nationally representative. Also, only 58% of the abortion patients seen by the participating facilities completed the survey, and nonresponse on some variables—notably, income—was high. However, the social and demographic characteristics of respondents were similar to those of two nationally representative surveys, which provides some reassurance that the findings are representative of abortion patients in the United States.

Although the focus of this study was women's reasons for having abortions, our findings have broader implications regarding the burden of unwanted pregnancy and the need for increased access to and use of contraceptive services. Better access to emergency contraception, for example, could lead to a reduction in unintended pregnancy, a decrease in the national abortion rate and, on the individual level, a decline in the number of women confronted with the difficult decision of how to resolve an unwanted pregnancy. The fact that an increasing proportion of women having abortions are poor[16] underscores the importance of public assistance for family planning programs as an effective means of reducing the incidence of both unintended pregnancy and abortion.

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BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

IN THE MATTER OF:)
) OAH No. 12-0236-MDS
T G) Agency No.
)

DECISION

I. Introduction

On July 11, 2012, T G's medical provider submitted a request for Medicaid travel benefits for Ms. G to travel to Seattle for evaluation regarding her acute otitis media/vertigo. On July 18, 2012, the Department of Health and Social Services, Division of Health Care Services, through Xerox State Healthcare, LLC (division), denied the travel request. Ms. G requested a Fair Hearing on July 24, 2012.

Ms. G's hearing was held on August 15, 2012. She appeared by telephone. Gerry Johnson represented the division by telephone. The hearing was recorded.

Based on the record as a whole and after due deliberation, the division's decision denying Ms. G's July 11, 2012, application for travel benefits is AFFIRMED.

II. Facts

Ms. G first began experiencing dizzy spells in 1995.[1] She was eventually diagnosed with Ménière's disease and underwent a right endolymphatic shunt procedure in 1996.[2] The surgery did not improve her symptoms; in fact, they worsened to the point that she became disabled.[3] She is currently receiving Social Security disability.[4]

Ms. G began seeing Dr. Mary C. Totten in September 2007.[5] Dr. Totten referred her to a specialist at the Virginia Mason Medical Center in Seattle.[6] He confirmed the diagnosis of Ménière's disease and chronic vestibular dysfunction.[7] She began outpatient "vestibular rehab" at a local clinic and subsequently improved considerably.[8]

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1 Exh. E, pg. 16.
2 Exh. E, pg. 16.
3 Exh. E, pg. 16.
4 Testimony of Stella G.
5 Exh. E, pgs. 14-16.
6 Exh. E, pgs. 12-13.
7 Exh. E, pg. 13. According to Ms. G, her travel to Seattle was provided by Medicaid.
8 Exh. E, pgs. 8-13.

On April 11, 2012, Ms. G saw Dr. Totten for a "sore right ear."[9] During that visit, Ms. G informed the doctor that she was trying to apply for permanent disability so that her student loans could be forgiven. In order for such an evaluation to be made, Dr. Totten would need "objective data such as an ENG, choleric, and platform testing."[10] Only one doctor in Anchorage provided that testing, but it is the same one who performed Ms. G's surgery many years ago, and who Dr. Totten believes caused the worsening in Ms. G's symptoms. Ms. G refused to submit herself to his care for the necessary testing, and Dr. Totten recommended that Ms. G's evaluation be done instead by a specialist at Virginia Mason in Seattle.[11]

On July 11, 2012, Dr. Totten submitted a request for Medicaid travel benefits for Ms. G to travel to Seattle for evaluation regarding her acute otitis media/vertigo. In the letter referring Ms. G to the Seattle specialist, Dr. Totten wrote "[s]he is up for re-evaluation of her student loan repayment and is still on medical disability."[12] On July 18, 2012, the Department of Health and Social Services, Division of Health Care Services, through Xerox State Healthcare, LLC (division), denied the travel request. The denial stated:

> Your provider requested transportation services in order for you to receive treatment in Seattle for acute otitis media/vertigo. Your provider did not provide medical justification for the travel to Seattle for treatment. The department will pay a provider for only those transportation and accommodation services that are provided to assist the recipient is (sic) receiving medically necessary services. 7AAC 120.405(a)(1).[13]

Ms. G requested a Fair Hearing on July 24, 2012.

III. Discussion

The issue in this case is whether the division correctly denied Ms. G's request for Medicaid travel benefits to Seattle for testing regarding her acute otitis media/vertigo. Ms. G[14] has the burden of proving by a preponderance of the evidence[15] that her request should have been approved.

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9 Exh. F, pg. 3.
10 Exh. F, pg. 3.
11 Testimony of Mary C. Totten, MD.
12 Exh. F, pg. 2.
13 Exh. D at pg. 1.
14 2 AAC 64.290(e).
15 Preponderance of the evidence is defined as: "Evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not. *Black's Law Dictionary* 1064 (5th Ed. 1979).

Ms. G asserts that she does not have the funds to travel to Seattle for testing regarding her Ménière's disease, and that since Medicaid paid for her first trip, it should pay for this one, as well. The division asserts that it was correct to deny Ms. G's application for Medicaid travel benefits, first because it is not "medically necessary," and second, because there is a provider in the Anchorage area who has the lab facilities and is qualified to perform the tests Ms. G's doctor needs.

Medicaid was established in 1965 to provide medical assistance to certain needy individuals and families.[16] It is a cooperative federal-state program that is jointly financed with federal and state funds.[17] In Alaska, the Department of Health and Social Services (department) administers the Medicaid program in accordance with applicable federal and state laws and regulations.

The cost for transportation and accommodations are provided by the department, so long as, among other things, the services are "provided to assist the recipient in receiving medically necessary services" and "those services are not available in the recipient's community . . . ."[18]

The federal Medicaid Act does not define "medical necessity."[19] Absent a federal definition of medical necessity, the responsibility for defining medical necessity is left to the states. Similarly, the Alaska Medicaid regulations currently do not define the term "medically necessary." Research indicates that although the term "medically necessary" is used in 42 different regulations with the Alaska Administrative Code, it is not defined except in the limited context of mental health rehabilitative services. The Alaska Statutes also do not provide an applicable definition of when a treatment is "medically necessary."

Prior to 2010, regulation 7 AAC 43.860(p) defined "medically necessary and appropriate" as follows:

> (p) In this section . . . (2) "medically necessary and appropriate" means
>
> (A) reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of medical conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a disability, or cause physical deformity or malfunction; and

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[16] 42 USC § 1396 *et. seq.*

[17] *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).

[18] 7 AAC 120.405(a)(1) & 7 AAC 120.405(b)(1).

[19] *Thie v. Davis*, 688 N.E.2d 182 (Ind.App.1997).

> (B) used because an equally effective more conservative or substantially less costly course of medical diagnosis or treatment is not available or suitable for the Medicaid recipient requesting the service; for purposes of this subparagraph, "course of treatment" includes mere observation or, if appropriate, no treatment at all.

However, this regulation was repealed in 2010, so as a result, neither the Alaska Statutes, nor the Alaska Administrative Code, contain a definition of "medically necessary."

Ms. G is requesting Medicaid travel benefits to Seattle for the purpose of being evaluated for a disability waiver for her student loan indebtedness. She has already been diagnosed with Ménière's disease, and she has been on a treatment plan for several years that has seen her condition significantly improve since she was first seen by Dr. Totten in 2007.[20] The purpose of having her evaluated in Seattle at this time is not to initiate or further any diagnosis or medical treatment for Ms. G, but solely in order to assist her in applying for student loan forgiveness. Unfortunately for Ms. G, this is not a "medically necessary" purpose, and thus does not entitle her to Medicaid travel benefits.

Because Ms. G's reason for traveling to Seattle to be evaluated by a specialist there is not "medically necessary," it is not necessary to address the secondary question of whether the services are available in the recipient's community.

IV. Conclusion

The division's determination that Ms. G is not entitled to receive Medicaid travel benefits to Seattle should be affirmed. Her purpose for being evaluated by a specialist is to further her application for disability and is thus not "medically necessary."

V. Decision

The division's decision that Ms. G is not entitled to receive Medicaid travel benefits to Seattle is AFFIRMED.

DATED this 24th day of September, 2012.

Signed
Kay L. Howard
Administrative Law Judge

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[20] Exh. E, pgs. 8-13.

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 9th day of October, 2012.

By: *Signed*
Name: Kay L. Howard
Title: Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]

11

CURRICULUM VITAE

Susan E. Rutherford, M.D.

Work Mailing Address: 12040 NE 128th St, MS #36
Kirkland, WA 98034
Work Phone: (425) 899-4719

PERSONAL:

Home Address: 13439 N. E. 115th Court
Redmond, WA 98052
Home Phone: (425) 822-7012

Date of Birth: xx/xx/1953
Place of Birth: Seattle
King County, Washington State
Citizenship: United States

LICENSURE:

State	Number	Issue date	Expiration date	
Washington	MD0019548	9/30/1981	5/21/2013	
California	GA3854	11/24/1980	5/31/2006	Expired
Iowa	35101	4/16/2003	5/1/2005 Inactive 4/9/2005	
Texas	L6612	5/14/2003	2/28/2006	Expired
Nevada	10654	9/18/2003	6/30/2005	Expired
Missouri	2005009471	3/2005	1/31/2009	Expired

DEA:

Type	Number	Issue date	Expiration date	
Federal, WA use	BR2237332	approx 1980	4/30/2014	
Federal, Texas	BR8312819	6/05/2003	4/30/2006	Expired
Texas DPS	HO128733	5/14/2003	8/31/2005	Expired
Federal, Missouri use	BR8532079	10/8/2003	4/30/2009	Expired
Missouri BNDD	559990283	10/8/2003	4/30/2009	Expired

EDUCATION:

High School: West Seattle, graduated 1970, Valedictorian

University: **Washington State University**
442 French Administration Building
Pullman, WA 99164

B. S., Zoology, summa cum laude, 06/01/1974

Extracurricular Activities:
- WSU Symphony and Chamber Orchestras
- WSU Women's Ski Team
- Associated Women Students Senator
- Spurs - Sophomore Women's Service Honorary
- Mortar Board - Senior Women's Scholastic & Service Honorary
- Scholastic Honorary Societies:
  - Alpha Lambda Delta
  - Phi Kappa Phi
  - Phi Beta Kappa

MEDICAL SCHOOL: University of Washington School of Medicine
Warren G. Magnuson Health Sciences Center
Box 356340
Seattle, WA 98195-6340
206-543-1060

M.D. 06/10/1978

INTERNSHIP: Naval Regional Medical Center
San Diego, CA 92134

07/01/1978 - 07/31/1979
Obstetrics and Gynecology

RESIDENCY: Naval Regional Medical Center
34800 Bob Wilson Drive
San Diego, CA 92134
619-532-6400

08/01/1979 – 07/31/1982
Obstetrics and Gynecology

Residency dates (including Internship): 07/01/1978 – 07/31/1982

FELLOWSHIP:

Los Angeles County/University of Southern California Medical Center
Richard Paul, M.D., Director
1200 N. State St. or 1240 N. Mission Rd.
Los Angeles, CA 90033 Los Angeles, CA 90033
323-226-3306

Certificate dates: 07/01/1985 – 06/30/1987
Maternal-Fetal Medicine
(actual dates of attendance 08/01/1985 – 07/31/1987 due to being held over at duty station in Yokosuka, Japan by U.S. Navy in 07/1985)

BOARD CERTIFICATION:

National Board of Medical Examiners 07/02/1979
Certificate No. 201118

American Board of Obstetrics and Gynecology
Certified 12/07/1984, **No expiration**
Voluntary Recertification 02/23/1998, voluntary maintenance of certification

American Board of Obstetrics and Gynecology,
Certification in Maternal-Fetal Medicine, No. 826220M
Certified 12/08/1989
Recertification 02/23/1998, ongoing maintenance of certification

ACADEMIC APPOINTMENTS:

1985 - 1987 Clinical Instructor, Maternal-Fetal Medicine,
University Of Southern California
Los Angeles, CA

1989 - 1990 Assistant Professor, Department of Obstetrics and Gynecology
Eastern Virginia Medical School
Norfolk, VA

1/1/1991 - present Clinical Assistant Professor
Department of Obstetrics and Gynecology
University of Washington
Seattle, WA

2005 –2009 Adjunct Assistant Professor,
Department of Obstetrics and Gynecology
Saint Louis University
St. Louis, MO

PROFESSIONAL SOCIETY MEMBERSHIPS:

American College of Obstetrics and Gynecology, Fellow, 1985 - present

Society for Maternal-Fetal Medicine (formerly Society of Perinatal Obstetricians), 1986 - present

American Institute of Ultrasound in Medicine, 1988 – present

Washington State Obstetrical Association, 1991 – present
Board Member and Officer 1998 – 2002, Board Member 2003 - present
President 2002
Representative to WSMA Interspecialty Advocacy Council 2004 - present

International Society of Ultrasound in Obstetrics and Gynecology, 1991- 1996, 2006-2007, 2009

King County Medical Society, 1991 – present
Delegate to Washington State Medical Association 2007, 2008, 2009

Washington State Medical Association, 1991 - 2012

American Medical Association, 1976 – 1990

Christian Medical and Dental Associations (formerly Christian Medical and Dental Society), 1986 - present

VOLUNTEER and COMMUNITY ACTIVITIES

Taproot Theatre Company Board of Directors 2003-2012
Board Chair 2005, 2006

Cascade Symphony Orchestra, violinist -- 1996 to present

CMDA Washington State representative 2005, 2006

Volunteer faculty, CMDA International Conference in Continuing Medical and Dental Education: 2006 Kenya, 2007 Thailand

WORK HISTORY:

08/1982 – 07/1985 U.S. Naval Hospital, Yokosuka, Japan
Position: Obstetrician-Gynecologist
Administrative Committees:
- Credentials
- Pharmacy and Therapeutics
- Emergency Care
- Tissue and Transfusion

Awards:
- Japanese Intern Teaching Award 1983
- Letter of Commendation

08/1987 – 01/30/1990 U.S. Naval Hospital, Portsmouth, Virginia
Director, Maternal-Fetal Medicine and Obstetrical Ultrasound
Administrative Committees and Assignments:
- Clinical Investigation
- Ethics Committee
- Medical Student Coordinator

01/31/1990 – 08/31/1990 Sabbatical
Attended CME courses
One month as volunteer at Bach Christian Hospital in Qalandarabad, Pakistan

09/01/1990 – 08/25/1996 Sole proprietor
Medical Director, Maternal-Fetal Medicine Program
Evergreen Hospital Medical Center
12040 N.E. 128th St.
Kirkland, Washington 98034
Committees:
- Family Maternity Center Care Committee
- Ob-Gyn Quality Assurance Subcommittee
- Continuing Medical Education Committee

08/26/1996 – 05/01/2001 Medical Director, Maternal-Fetal Medicine Program
Evergreen Hospital Medical Center

Owner, member: Eastside Maternal-Fetal Medicine Associates, PLLC

12040 N.E. 128th St. and	1135 116th Ave. N.E., Suite 320
Kirkland, WA 98034	Bellevue, WA 98034
425-899-2200	425-688-8111

05/02/2001 – 07/01/2002 Perinatologist

Employee, Obstetrix Medical Group of Washington Inc., PS

12040 N.E. 128th St. and 1135 116th Ave. N.E., Suite 320
Kirkland, WA 98034 Bellevue, WA 98034
425-899-2200 425-688-8111

07/01/2002 – 03/2008 Sole proprietor, Independent Contractor for Maternal-Fetal Medicine services
Contracting with:
Obstetrix Medical Group (resigned March 2008)
1301 Concord Terrace
Sunrise, FL 33323
800-243-3839

Saint Louis University, Department of Obstetrics and Gynecology
(resigned effective early 2009)
6420 Clayton Road, Suite 290
St. Louis, MO 63117
314-781-4772

11/06/2002 – 11/29/2002: Bongolo Evangelical Hospital, Gabon, Africa
volunteer work

04/01/2008 – present Evergreen Healthcare employee (changed to EvergreenHealth in 2012)
Medical Director, Women's and Children's Services 4/1/2008-12/31/2012
Ob/Gyn Hospitalist 4/1/2008 - present

MILITARY SERVICE:

U. S. Navy
Appointed Ensign, U.S. Naval Reserve 06/13/1974

Active Duty, U.S. Naval Reserve: 06/26/1978 - 01/30/1990
Rank achieved: **Commander, Medical Corps, U.S. Naval Reserve**
Date of rank 09/01/1988

Reserve not on active duty 01/31/1990 – 05/11/1994

Honorable Discharge 05/11/1994

PUBLICATIONS:

Rutherford SE, Phelan JP: Thromboembolic disease in pregnancy. Clin Perinatol 13:719-739, 1986

Artal R, Rutherford SE, Romem Y, Kammula RK, Dorey FJ, Wiswell RA: Fetal heart rate responses to maternal excercise. Am J Obstet Gynecol 155:729-33, 1986

Rutherford SE, Phelan JP, Smith CV, Jacobs N: The four quadrant assessment of amniotic fluid `volume`: An adjunct to antepartum fetal heart rate testing. Obstet Gynecol 70:353-6, 1987

Rutherford SE, Smith CV, Phelan JP, Kawakami K, Ahn MO: The four quadrant assessment of amniotic fluid volume: Interobserver and intraobserver variation. J Repro Med 32:587-9, 1987

Ahn MO, Phelan JP, Smith CV, Jacobs N, Rutherford SE: Antepartum fetal surveillance in the patient with decreased fetal movement. Am J Obstet Gynecol 157:860-4, 1987

Phelan JP, Ahn MO, Smith CV, Rutherford SE, Anderson E: Amniotic fluid index measurements during pregnancy. J Reprod Med 32:601-4, 1987

Artal R, Greenspoon JS, Rutherford SE: Transient ischemic attack: A complication of mitral valve prolapse in pregnancy. Obstet Gynecol 71, part 2:1028-30, 1988

Rutherford SE, Phelan JP: Routine postcesarean care and management of common complications. In Phelan JP and Clark SL, ed., Cesarean Delivery. Elsevier, New York, 1988

Rutherford SE, Phelan JP: Thromboembolic disorders and anticoagulant therapy in the cesarean patient. In Phelan JP and Clark SL, ed., Cesarean Delivery. Elsevier, New York, 1988

Rutherford SE: Thromboembolism in pregnancy: Diagnosis. In Mishell DR and Brenner PF, ed., Management of Common Problems in Obstetrics and Gynecology. Medical Economics, New Jersey, 1988

Rutherford SE: Thromboembolism in pregnancy: Management. In Mishell DR and Brenner PF, ed., Management of Common Problems in Obstetrics and Gynecology. Medical Economics, New Jersey, 1988

Brar HS, Rutherford SE: Classification of intrauterine growth retardation. Semin Perinatol 12:2-10, 1988

Artal R, Masaki DI, Khodiguian N, Romem Y, Rutherford SE, Wiswell RA: Excercise prescription in pregnancy: Weight-bearing versus non-weight bearing excercise. Am J Obstet Gynecol 161:1464-9, 1989

Phelan JP, Park YW, Ahn MO, Rutherford SE: Polyhydramnios and perinatal outcome. J Perinatol 10:347-50, 1990

Rutherford SE, Phelan JP: Deep venous thrombosis and pulmonary embolus. In Clark SL, Cotton DB, Hankins GDV, Phelan JP, ed., Critical Care Obstetrics. Blackwell Scientific Publications, Boston, 1991

Rutherford SE, Phelan JP: Deep venous thrombosis and pulmonary embolism in pregnancy. Obstet Gynecol Clinics N Amer 18:345-70, 1991

Rutherford SE, Phelan JP: Clinical managment of thromboembolic disorders in pregnancy. Crit Care Clinics 7:809-28, 1991

Chauhan SP, Rutherford SE, Hess LW, Morrison JC: Prophylactic intrapartum amnioinfusion for patients with oligohydramnios: A prospective randomized study. J Reprod Med 37:817-20, 1992

Chauhan SP, Rutherford SE, Sharp TW, Carnevale TA, Runzel AR: Intrapartum amniotic fluid index and neonatal acidosis: A pilot study to determine the correlation. J Reprod Med 37:868-70, 1992

McCurdy CM Jr., Rutherford SE, Coddington III CC: Toxic shock syndrome in the puerperium: Two case reports and a review of the literature. Am J Gyn Health 7:11-16, 1992

McCurdy CM Jr., Rutherford SE, Coddington III CC: Syncope and sudden arrhythmic death complicating pregnancy: A case report of Romano-Ward syndrome. J Reprod Med 38:233-4, 1993

Rutherford SE: Pulmonary embolism in pregnancy. The Female Patient 18:12-16, 1993

Rutherford SE: "Ultrasound" in Loue S and Sajatovic M, eds., Encyclopedia of Women's Health. Kluwer Academic/Plenum Publishers, New York, 2004

RESEARCH PRESENTATIONS

Spaulding L, Rutherford SE, Pruyn S: Dysmenorrhea: Ibuprofen vs. mefenamic acid, a triple-blinded, crossover study. Armed Forces District Meeting, ACOG, Las Vegas, Nevada, October, 1983 (oral by Rutherford)

Rutherford SE, Phelan JP, Smith CV, Jacobs N: The four-quadrant assessment of amniotic fluid `volume`: An adjunct to antepartum fetal heart rate testing. Society of Perinatal Obstetricians, 6th Annual Meeting, San Antonio, Texas, January 30-February 1, 1986 (poster)

Artal R, Khodiguian N, Kammula R, Rutherford SE, Wiswell RA: Cardiopulmonary adaptations to graded exercise in pregnancy. Society for Gynecologic Investigation, 33rd Annual Meeting, Toronto, Canada, March, 1986. (oral)

Rutherford SE, Smith CV, Phelan JP, Kawakami K, Ahn MO: The four quadrant assessment of amniotic fluid volume: Interobserver and intraobserver variation. Armed Forces District Meeting, ACOG, San Diego, California, October, 1986 (oral)

Rutherford SE, Artal R, Khodiguian N, Wiswell R: Fuel metabolism during exercise in pregnancy. Society for Gynecologic Investigation, 34th Annual Meeting, Atlanta, Georgia, March, 1987 (poster)

Artal R, Khodiguian N, Rutherford SE, Wiswell RA: Cardiopulmonary and metabolic responses to bicycle ergometry in pregnancy. Society for Gynecologic Investigation, 34th Annual Meeting, Atlanta, Georgia, March, 1987 (poster)

Rutherford S E, Ahn MO, Phelan JP, Diaz F: Antepartum fetal surveillance in the postdate pregnancy. Armed Forces District Meeting, ACOG, Denver, Colorado, October, 1987 (oral)

Phelan JP, Rutherford SE, Ahn MO, Broussard P: Antepartum fetal surveillance in the high risk pregnancy: The four quadrant technique for amniotic fluid volume assessment and acoustic stimulation. Armed Forces District Meeting, ACOG, Denver, Colorado, October, 1987 (oral)

Ahn MO, Phelan JP, Rutherford SE: The impact of placental grade on antepartum fetal surveillance test results. The Society of Perinatal Obstetricians, 8th Annual Meeting, Las Vegas, Nevada, February, 1988 (poster)

12

PRISCILLA K. COLEMAN

I. Academic Degrees

Date	Degree	Major	University
1998	Ph.D.	Life-Span Developmental Psychology	West Virginia University Morgantown, WV
1992	M.A.	General Psychology	James Madison University Harrisonburg, VA
1986	B.A.	Psychology	Southern Connecticut State University Minor: Studio Art New Haven, CT

II. Academic Positions

A. Teaching Positions

2010-present — Professor of Human Development and Family Studies, School of Family and Consumer Sciences, Bowling Green State University, Bowling Green, OH

2005-2010 — Associate Professor of Human Development and Family Studies, School of Family and Consumer Sciences, Bowling Green State University, Bowling Green, OH

2002-2005 — Assistant Professor of Human Development and Family Studies, School of Family and Consumer Sciences, Bowling Green State University, Bowling Green, OH

1998-2002 — Assistant Professor of Psychology, Department of Psychology, University of the South, Sewanee, TN

1995-1997 — Teaching Assistant, Department of Psychology, West Virginia University, Morgantown, WV

1993-1995 — Instructor of Psychology, Department of Psychology, James Madison University, Harrisonburg, VA

1991-1992 — Research Assistant, Department of Psychology, James Madison University, Harrisonburg, VA

B. Administrative Positions

2003-2004 — Program Coordinator, Human Development and Family Studies, School of Family and Consumer Sciences, Bowling Green State University, Bowling Green, OH

1997-1998 Research Specialist, Center for Assessment and Research Studies, James Madison University, Harrisonburg, VA

III. Non-academic Positions

1988-1989 Residential Counselor, Homestead Project Inc., Ellsworth, ME

IV. Teaching Experiences or Academic Service

A. Teaching Experiences

1. Undergraduate Courses

Bowling Green State University
Child Development (HDFS 221): 2 sections every semester Fall 2002 to present
Child Development (HDFS 221) Online Delivery, Summer 2008, 2009
Life-Span Development (HDFS 105): 1-2 sections since Spring, 2007
Research Methods (HDFS 407): 2 sections per year beginning Spring, 2010
University of the South
Child Development (with a 3 hr. lab): Spring 1999, Spring 2000, Spring 2001, Fall 2001
Introduction to Personality and Development – lecture: Fall 1998, Fall 1999, Fall 2000, Fall 2001
Introduction to Personality and Development – lab: Fall 1998, Fall 1999, Fall 2000, Fall 2001
Social Psychology: Fall, 1998, Fall 1999, Fall 2000
Social Psychology Research Seminar: Spring 2002
Educational Psychology II (Introduction to Educational Assessment and Exceptionality in the Classroom): Spring 1999, Spring 2000, Spring 2001, Spring 2002
West Virginia University
Life-Span Development: 2 sections: Fall 1995, Spring 1996
Child Behavior and Development: Spring 1997, Summer 1997
Exceptional Child: Fall 1996
Applying to Graduate School Seminar: Fall 1996
James Madison University
Psychological Statistics: Fall 1994
Experimental Psychology with lab: Spring 1993 (1 section), Fall 1994 (2 sections), Spring 1995 (3 sections)

2. Undergraduate-Graduate Courses – N/A

3. Graduate Courses
Bowling Green State University
Family Studies (HDFS 602), Spring 2003
Research Methods (FCS 626), Fall 2004, Fall 2005, Fall 2006

4. Other Teaching

Supervised an independent study pertaining to adolescent development, family dynamics, and body image for Jensine Pernell (Fall 2003, Spring 2004)

Supervised an independent study project for two students, Katie Jones and Alida Novarese, entitled "Are there Hindrances to the Development of Creativity in a Rural, Public Elementary School Setting?" (Spring 2002)

Supervised an independent Study/Tonya Internship Project for Mahvash Nazir, a sophomore Education student, entitled "Honoring Diversity and Excellence for all in the Theory of Multiple Intelligences: Studying its Applications and Implications at Harvard Project Zero" (Summer 2001)

Supervised five independent study projects (Spring 2001)

- The first was for a Political Science major at the University of the South, Matthew Guinn. His project pertained to the social behavior of orphans in Uganda.
- The second was for an international student from Germany, Veronika Schmittdiel, who conducted cross-cultural research on adult education in prisons.
- The last three (Sarah Bryan, Barbara King, and Nikel Rogers) contributed to an ongoing project pertaining to parenting self-efficacy entitled "Maternal Self-Efficacy Beliefs, Parenting Behavior, and Toddler Performance on the Bayley Scales of Infant Development". This project was funded by ACA and all three students assumed active roles in the development and/or implementation of a maternal behavior coding scheme and report writing,

Supervised independent study projects for two senior psychology majors, Caroline Byrd (Relationships among empathy, forgiveness, and peer victimization in adolescents) and Becca Waller (Psychological outcomes associated with physical therapy) (Spring 2000)

Supervised an independent study experience on experimental design and data analysis using SPSS for Kristie Alcorn and Carolin Maier, two international students attending the University of the South, Sewanee, TN (Spring 1999)

5. Thesis and Dissertation Students

a. Theses:

Carmen Ionescu: Maternal socio-demographic factors, risky health behaviors, and psychosocial stressors as predictors of low birth weight, 2003-2004, defended August, 2004.

Lauren Mackowiak: Multigenerational caregiving: correlates and predictors of applying Task Specific Theory, 2003-2004, defended March, 2004.

Janine Rosche: Correlates of perceived stress and empathy in adolescent siblings of children with special needs: A family systems perspective, 2003-2004, defended August, 2004.

b. Dissertations:

6. Membership on Dissertation Committees:

David Strukel, Communications, Fall 2011 to present

Charlotte Quinney, American Culture Studies; Completed Summer 2011

Shane Kraus, Psychology, BGSU, Fall 2009 to present.

Pamela Rogers, Leadership and Policy Studies, 2008-present

George Cave, Fielding Graduate University, Santa Barbara, CA; Completed Fall 2009

Robero Prince, American Culture Studies Program, BGSU; Completed Fall 2009

Erin Laverick, Department of English, BGSU; Completed 2008

Nicole M. Clement, Australian National University, Canberra ACT, Australia, Dissertation title: Parenting Self-Efficacy and Psychological Adjustment:: Development and Utility of the Infant Care-giving Self-Efficacy Questionnaire"; Completed Spring, 2009.

Traci Coventry, Monash University, VIC, Australia, Ph.D., Completed January 2006 Dissertation title: An examination of the relationship between mother-infant attachment and mental representations of infant feeding.

7. Membership on Thesis Committees:

Name	Degree	Year	University
Mara Lee Beebe	MFCS	2008-2009	Bowling Green State University
Kinsey Miller	MFCS	2007-2008	Bowling Green State University
Marla Murphy	MFCS	2005-present	Bowling Green State University
Becky Gardner	MFCS	2006-2007	Bowling Green State University
Caroline Kamau	MFCS	2006-2007	Bowling Green State University
Bernadette Paul	MFCS	2005-2007	Bowling Green State University
Shefali Ajmera	MFCS	2005-2006	Bowling Green State University
Sarah Kaplan	MFCS	2005-2006	Bowling Green State University
Erin Dawson	MFCS	2005-2006	Bowling Green State University
Amy Smith	MFCS	2004-2005	Bowling Green State University
Darshana Pandya	MFCS	2003-2004	Bowling Green State University
Tina Alessandria	M.A.	1997-1998	James Madison University
Tina Marie Blair	Undergrad.	1997-1998	James Madison University
Amy Greenough	Undergrad.	1997-1998	James Madison University
Kristen Finlayson	Undergrad.	1997-1998	James Madison University
Casey Martin	M.A.	1995-1996	James Madison University
Ada Boston	Undergrad.	1995-1996	West Virginia University

.Curriculum Development

A. Courses

Converted Child Development (HDFS 2210) to online delivery, Summer 2008
Converted Research Methods (HDFS 4070) to online delivery Summer, 2009

Along with Jacqueline Guzell, prepared a new undergraduate course proposal (blue sheet) for a course entitled "Parenting Processes." Spring 2003

Prepared an undergraduate course modification proposal (blue sheet) for Child Development (HDFS 221) to fit the new Early Childhood Education Curriculum. Summer 2004

B. Workshops

Invited to provide an afternoon seminar for psychology graduate students at James Madison University pertaining to the personal and academic challenges incurred across the transition from master's level programs to doctoral training. Format was a combination of lecture and informal discussion sessions, April 1998.

Assisted Dr. Katherine Karraker with a one-day concentrated training workshop on the Bayley Scales of Infant Development conducted for professionals with a variety of disciplinary affiliations. Topics covered included issues in the assessment of infant intelligence, general description of the Bayley Scales, considerations in testing infants, guidelines on learning to administer the Bayley Scales, demonstration of items, and an overview of the structure and scoring of the test, June 1996.

C. Educational Materials

Developed lab materials for an upper-level child development course at the University of the South. The materials covered 33 hours of in-class lab time. Spring 2000

VI. Professional Development

Attended a workshop offered by CFDR, using Stata with Add Health, BGSU August 2003
Attended PICT Workshop leading to revision of a syllabus to infuse Technology, BGSU January 2003
Attended HSRB training, BGSU September 2002
Attended Portfolio Workshop, Center for Teaching, BGSU September 2002

VII. Academic Advising

A. Undergraduate

Advisor for 60-90 Early Childhood Studies students, BGSU Fall 2003 - present

Freshman advisor and advisor for numerous students majoring in Psychology. Total annual advising load averaged 20-25 students per academic year, University of the South. 1999-2002

B. Graduate
Janine Rosche 2003-2004

VIII. Research Interests

1. The development, expression, and effects of individual differences in parenting
2. Socio-emotional development in early childhood
3. Parent-child interaction and family dynamics
4. Post-abortion emotional sequelae
5. Induced abortion and intimate relationship quality
6. Perinatal loss and parenting

IX. Research Projects and Grants

EDHD Research Grant, April 2004 entitled "The Choice to Abort Among Mothers Living Under Ecologically Deprived Conditions: Predictors and Consequences" to the Research Development Committee, College of Education and Human Development, Bowling Green State University, $12,058. funded.

Faculty Research Committee Research Incentive Grant for AY 2003, entitled "The Choice to Abort vs. Deliver During Adolescence: Personal and Social Predictors and Consequences", $5,976. Funded.

PICT Curriculum Grant for AY 2002-03, "A Concept-based Approach to Infusing Technology in the Early Childhood Studies Program" Nancy Stockall, Priscilla Coleman, Sally Kilmer, & Marcia Rybczynski, $15,000. Funded.

duPont Faculty-Student Research Grant from the University of the South Spring 2002 "Development of Maternal Self-Efficacy and its Relation to Early Maternal Behavior", $1,428 Funded.

Faculty Research Grant from the Appalachian College Association for AY 2000-2001, "Maternal Self-Efficacy, Parenting Behavior, and Toddler Performance on the Bayley Scales of Infant Development", $1,625. Funded.

X. Publications

A. Publications

1. Books

(a) Textbooks – N/A

(b) Scholarly books – N/A

(c) Chapters of books

Karraker, K. H., & Coleman, P. K. (2005). The effects of child characteristics on parenting. In T. Luster and L. Okagaki (Eds.), Parenting: An ecological perspective (2nd Ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Coleman, P. K., & Karraker, K. H. (2005). Parenting self-efficacy, competence in parenting, and possible links to children's social and academic outcomes. In O. N. Saracho and B. Spodek (Eds.), Contemporary perspectives on families, communities, and schools for young children. Greenwich, CT: Information Age Publishing.

Karraker, K. H., & Coleman, P. K. (2002). Infants' characteristics and behaviors help shape their environments. In H. Fitzgerald, K. H. Karraker, & T. Luster (Eds.), Infant development: Ecological perspectives. (pp. 165-191). New York: Routledge Falmer.

(e) Other

Coleman, P. K. (2001). The Education System of Iceland. In R. Marlow-Ferguson (Ed.), World Education Encyclopedia. Farmington Hills, Michigan: Gale Group. (10,000 words)

Coleman, P. K. (2000). Attachment. In L. Balter (Ed.), Parenthood in America: An Encyclopedia. Santa Barbara, CA: ABC-CLIO. (1500 words)

Coleman, P. K. (2000). Parenting Self-Confidence. In L. Balter (Ed.), Parenthood in America: An Encyclopedia. Santa Barbara, CA: ABC-CLIO. (1500 words)

Coleman, P. K. (2000). Parenting Toddlers. In L. Balter (Ed.), Parenthood in America: An Encyclopedia. Santa Barbara, CA: ABC-CLIO. (1500 words)

Coleman, P. K. (2000). Temperament. In L. Balter (Ed.), Parenthood in America: An Encyclopedia. Santa Barbara, CA: ABC-CLIO. (1500 words)

2. Journal Articles

(a) Refereed articles

Journals

Coleman, P. K., Reardon, D. C., & Calhoun, B. C. (in press) Reproductive History Patterns and Long-Term Mortality Rates: A Danish, Population Based Record Linkage Study. European Journal of Public Health.

Reardon, D. C., & Coleman, P. K. (in press) Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004. Medical Science Monitor..

Nixon, C., Linkie, C., & Coleman, P. K. (in press). Relational aggression and children's somatic complaints in early adolescence. Journal of Early Adolescence.

Coleman, P.K. (2011). Abortion and Mental Health: A Quantitative Synthesis and Analysis of Research Published from 1995-2009. British Journal of Psychiatry, 199, 180-186

Coleman, P.K., Coyle, C. T., & Rue, V.M. (2010). Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms, Journal of Pregnancy, vol. 2010, Article ID 130519.

Coyle, C., Coleman, P., & Rue, V. (2010) Inadequate Pre-abortion Counseling and Decision Conflict as Predictors of Subsequent Relationship Difficulties and Psychological Stress in Men and Women. Traumatology: An International Journal, 16, 16-30.

Coleman, P.K.. (2009) The Psychological Pain of Perinatal Loss and Subsequent Parenting Risks: Could Induced Abortion be more Problematic than Other Forms of Loss? Current Women's Health Reviews, 5, 88-99.

Coleman, P. K., Maxey, D. C., Spence, M., & Nixon, C. (2009). The choice to abort among mothers living under ecologically deprived conditions: Predictors and consequences. International Journal of Mental Health and Addiction 7, 405-422.

Coleman, P. K., Rue, V., Coyle, C. (2009). Induced abortion and quality of intimate relationships: Analysis of male and female data from the Chicago Health and Social Life Survey. Public Health 123, 331–338.

Coleman, P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009), Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. Journal of Psychiatric Research, 43, 770–776.

Coleman, P. K., Rue, V., Spence, M., & Coyle, C. (2008). Abortion and the sexual lives of men and women: Is casual sexual behavior more appealing and more common after abortion? International Journal of Clinical and Health Psychology, 8, 77-91.

Coleman, P. K., Rue, V., & Spence, M. (2007). Intrapersonal processes and post-abortion relationship difficulties: A review and consolidation of relevant literature. Internet Journal of Mental Health, V.4 (2).

Coleman, P. K., Rue, V., Coyle, C., Maxey, D. C. (2007). Induced abortion and child-directed aggressive behaviors among mothers of children who have been maltreated. Internet Journal of Pediatric Neonatology, Volume 6 Number 2.

Rue, V. M., & Coleman, P. K. (2007). The Question Too Dangerous To Ask: What If Post-Abortion Syndrome Is Real? Human Life Review.

Coleman, P. K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. The Journal of Youth and Adolescence, 35, 903-911.

Coleman, P. K., Maxey, D. C., Coyle, C., & Rue, V. (2006). Reply to

Letter to the Editor by Rachel K. Jones, Ph.D., Senior Research Associate, The Guttmacher Institute, New York, NY, USA, Acta Paediatrica,

Coleman, P. K., Reardon, D. C., & Lee, M. B. (2006). Women's preferences for information and ratings of the seriousness of complications related to elective medical procedures. Journal of Medical Ethics, 32. 435-438.

Reardon, D.C., & Coleman, P. K. (2006). Sleep disorders associated with abortion and childbirth: A prospective record-based study. Sleep, 29, 105-106.

Coleman, P. K. (2006). Induced Abortion and increased risk of substance use: A review of the evidence. Current Women's Health Reviews 1, 21-34.

Coleman, P. K., Maxey, D. C., Coyle, C., & Rue, V. (2005). Associations between voluntary and involuntary forms of perinatal loss and child maltreatment among low income, single mothers. Acta Paediatrica, 94.

Coleman, P. K., Reardon, D. C., & Cougle, J. (2005). Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. British Journal of Health Psychology, 10, 255-268.

Cougle, J., Reardon, D. C., & Coleman, P. K. (2005). Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. Journal of Anxiety Disorders, 19 (10), 137-142.

Coleman, P. K., Reardon, D. C., Strahan, T., & Cougle, J. (2005). The psychology of abortion: A review and suggestions for future research. Psychology & Health, 20, 237-271.

Reardon, D. C., & Coleman, P. K. (2004). Letter to the editor pertaining to a study published in AJOG by Gissler, Berg, Bouvier-Colle, and Buekens entitled "Pregnancy-associated mortality after birth, spontaneous abortion or induced abortion in Finland, 1987-2000." American Journal of Obstetrics and Gynecology, 191, 1506-1507.

Neilsen, A., Coleman, P. K., *Guinn, M., & *Robb, C. (2004) Length of institutionalization, contact with relatives, and previous hospitalizations as predictors of social and emotional behavior in young Ugandan Orphans. Childhood: A Global Journal of Child Research, 11, 94-116.

Reardon, D. C., Coleman, P. K., & Cougle, J. (2004). Substance Use Associated with Unintended Pregnancy Outcomes in the National Longitudinal Survey of Youth. American Journal of Drug and Alcohol Abuse, 26, 369-383.

Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). The context of elective abortion and traumatic stress: A comparison of U. S. and Russian Women. Medical Science Monitor, 10, SR5-16.

Coleman, P. K. (2003). Perceptions of parent-child attachment, social self-efficacy, and peer relationships in middle childhood. Infant and Child Development, 12, 351-368.

Coleman, P. K. (2003). Reactive Attachment Disorder in the context of the family: A review and call for further research. Emotional & Behavioral Difficulties. 8, 223-234.

Coleman, P. K., & Byrd, C. (2003). Interpersonal correlates of peer victimization in young adolescents. Journal of Youth and Adolescence, 32, 301-314.

Coleman, P. K., & Karraker, K. H. (2003). Maternal self-efficacy beliefs, competence in parenting, and toddlers' behavior and developmental status. Infant Mental Health Journal, 24, 126-148.

Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2003). Reply to letter to the editor by Darroch, Finer, Henshaw, and Jones pertaining to our article entitled "History of induced abortion in relation to substance use during subsequent pregnancies carried to term", American Journal of Obstetrics and Gynecology, 189 (2), 617.

Cougle, J., Reardon, D. C., & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. Medical Science Monitor, 9(4), CR105-112.

Reardon, D. C., Cougle, J., Rue, V. M., Shuping, M., Coleman, P. K., & Ney, P. G. (2003). Psychiatric admissions of low-income women following abortion and childbirth. Canadian Medical Association Journal. 168, 1253-1256.

Coleman, P. K., Bryan, S., King, B., Nazir, M., Rogers, N., & Trent, A. (2002). Parenting behavior, maternal self-efficacy beliefs, and toddler performance on the Bayley Scales of Infant Development. Early Child Development and Care, 172, 123-140.

Coleman, P. K., Reardon, D. C., & Cougle, J. (2002). The quality of the caregiving environment and child developmental outcomes associated with maternal history of abortion using the NLSY data. Journal of Child Psychology and Psychiatry and Allied Disciplines, 43, 743-758.

Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). History of induced abortion in relation to substance use during subsequent pregnancies carried to term. American Journal of Obstetrics and Gynecology, 187, pp. 1673-1678.

Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years. The American Journal of Orthopsychiatry, 72, 141-152.

Reardon, D. C., Cougle, J., Ney, P. G., Scheuren, F., Coleman, P. K., & Strahan, T. W. (2002). Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. Southern Medical Journal, 95, 834-841.

Blair, T. M., Nelson, E. S., & Coleman, P. K. (2001). The relationship between deception and power in college students' dating

relationships: An exploratory study. Journal of Sex and Marital Therapy, 27, 57-71.

Carlton, C. L., Nelson, E. S., & Coleman, P. K. (2000). College students' attitudes toward abortion and commitment to the issue. Social Science Journal, 37, 619-625.

Coleman, P. K., & Karraker, K. H. (2000). Parenting self-efficacy among mothers of school-age children: Conceptualization, measurement, and predictors. Family Relations, 49, 13-24.

Coleman, P. K., & Watson, A. (2000). Infant attachment as a dynamic system. Human Development, 43, 295-313.

Coleman, P. K., & Watson, A. (2000). A reply to commentaries (*by Alan Fogel, Alan Sroufe, and Megan Sampson*) on "Infant attachment as a dynamic system". Human Development, 43, 327-331.

Coleman, P. K., & Nelson, E. S. (1999). Attitudes toward abortion and interest in the issue as determinants of perceptions of the appropriate level of male involvement in abortion decisions. Journal of American College Health, 47, 164-172.

Coleman, P. K., Nelson, E. S., & Sundre, D. (1999). The relationship between prenatal expectations and postnatal attitudes among first-time mothers. Journal of Reproductive and Infant Psychology, 17, 27-39.

Coleman, P. K., & Karraker, K. H. (1998). Self-efficacy and parenting quality: Findings and future applications. Developmental Review, 18, 47-85.

Coleman, P. K., & Nelson, E. S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. Journal of Social and Clinical Psychology, 17, 425-442.

Erwin, T. D., & Coleman, P. K. (1998). The Influence of intercultural experiences and second language proficiency on college students' cross-cultural adaptability. International Education, 28, 5-25.

Nelson, E. S., Coleman, P. K., & Swager, M. (1997). Attitudes toward the level of male involvement in abortion decisions. Journal of Humanistic Education and Development, 25, 217-224.

Nelson, E. S., Karr, K., & Coleman, P. K. (1995). The relationships among daily hassles, optimism, and reported physical symptoms. Journal of College Student Psychotherapy, 10, 11-26.

(2) Proceedings

(b) Non-refereed articles

(1) Journals – NA

(2) Newsletters – N/A

(3) Miscellaneous – N/A

(c) Editorships of journals

Editorial Board Member for a new medical journal published by Bentham Science Publishers entitled "Current Women's Health Reviews." (June 04 – present)

Editorial Board Member for the Open General/Internal Medicine Journal, Feb 2007-present

Editorial Board Member for the Open Women's Health Journal, 2008-present

Editorial Board Member for the World Journal of Psychiatry, 2011-present.

Editorial Board Member, Child Development Research, 2011 – present

3. Book Reviews – N/A

4. Abstracts

Dawson, E., Haar, C., Pobocik, R., Coleman, P., Babies, K., Houston, M.S., Increased self-efficacy and dairy consumption resulting from a dairy curriculum for junior high school students. Journal of Nutrition Education and Behavior, 2007; 39: S131.

Dawson, E., Pobocik, R., Coleman, P., Haar, C., Babies, K., Houston, M.S. Development of an instrument to assess self-efficacy and behavior related to dairy foods in adolescents. FASEB J. 2007 21:528.11.

5. Reports

(a) Published – N/A

(b) Unpublished – N/A

XI. Papers Read to Professional Societies

A. Invited Papers

Coleman, P. K. (September, 2012). The Relative Safety of Abortion vs. Childbirth: A Focus on Psychological Morbidity and Mortality. International Symposium on Maternal Health, Dublin, Ireland.

Coleman, P. K. (September, 2012). Abortion and Women's Mental Health, Stormont Parliament Address, Belfast, Ireland.

Coleman, P. K. (May, 2012). Served as a keynote speaker for the 2012 Real Choices Conference: "Setting the Standards." Delivered two presentations titled: *The Psychology of Abortion: Addressing the Critical Questions to Maximize Women's Health in 2012* and *Reproductive Outcomes and Mortality: Debunking the Myth that Abortion is Safer than Childbirth Using Existing and New Data,* Melbourne, Victoria, Australia.

Coleman, P. K. (May, 2012). Abortion and Women's Mental Health: Research to Practice. Australian Family Association, Melbourne, Victoria, Australia.

Coleman, P. K. (May, 2012). Abortion and Women's Mental Health: Research to Practice. Parliament House, Sydney, New South Wales, Australia.

Coleman, P. K. (May, 2012). Abortion and Women's Mental Health: Research to Practice. Parliament House, Brisbane, Queensland, Australia.

Coleman, P. K. (May, 2012). Abortion and Women's Mental Health: Research to Practice. Emily's Voice, Toowoomba, Queensland, Australia.

Coleman, P. K. (March, 2012). Abortion and Women's Mental Health: Knowledge to Practice. Colloquium on the Psychological Effects of Abortion, UK Parliament, London, England.

Coleman, P. K. (March, 2012). Abortion and Women's Mental Health: Knowledge to Practice. The McAuley Education Center, Mater Hospital, Dublin, Ireland.

Coleman, P. K. (February, 2012). The Psychology of Abortion: Addressing the Critical Questions to Maximize Patient Care in 2012. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (February, 2012). Reproductive History and Long-Term Mortality Rates: A Progress Update on the Danish Population-Based Study. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists, Annual CME Meeting.

Coleman, P. K. (September, 2011). Abortion and Women's Mental Health: Helping through Knowledge. Care Net Annual Conference, Orland FL.

Coleman, P. K. (October, 2011). Abortion and Women's Mental Health: Knowledge to Practice. Healing Vision International Conference, Milwaukee, WI.

Coleman, P. K. (October, 2011). Abortion and Mental Health: Knowledge to Practice. Women in Medicine and Dentistry Annual Conference, Scottsdale, AZ.

Coleman, P. K. (October, 2011). Abortion and Mental Health: Knowledge to Practice. University of Chile, Santiago, Chile.

Coleman, P. K. (May, 2011). Abortion and Mental Health: Research to Practice. Keynote Address for the First National Convention of Real Choices Australia, Collaroy, NSW, Australia.

Coleman, P. K. (May, 2011). Medical Abortion: An update on Psychological Risks to Women. First National Convention, Real Choices Australia, Collaroy, NSW, Australia.

Coleman, P. K. (March, 2011). Abortion and Mental Health: Research to Practice. Commission on the Status of Women, 55th Session United Nations.

Coleman, P. K. (March, 2011). Medical Abortion and Women's Mental Health. Commission on the Status of Women, 55th Session United Nations.

Coleman, P. K. (January, 2011). Abortion and Women's Mental Health: Research to Practice: Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (January, 2011). Abortion and Women's Mental Health: Model Research: Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (January, 2010). Evidence-Based Practice in Informed Consent for Abortion: Toward More Systematic Qualitative and Quantitative Reviews of the Literature

Presentation for the American Association of Pro-Life Obstetricians and Gynecologists Annual CME meeting.

Coleman, P. K. (January, 2009). Abortion and Mental Health: The APA Task Force Report of the Literature and the Reality. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (March, 2009). Abortion and Mental Health: The APA Task Force Report of the Literature and the Reality. Commission on the Status of Women, 53rd Session United Nations, March 2009.

Coleman, P. K. (October, 2008). APA Task Force Report on Abortion and Mental Health: A Violation of the Ethics of Science and a Breech of Public Responsibility. Panel Presentation, Family Research Council, Washington, DC.

Coleman, P. K. (October, 2008). Abortion and Mental Health Research Panel Presentation, Family Research Council, Washington, DC.

Coleman, P. K. (January, 2008). Does abortion hurt intimate relationships? Review of the evidence. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists, Annual CME meeting.

Coleman, P. K. (January, 2008). Post-abortion mental health research: update and quality of Evidence. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P.K. (November, 2007). Abortion and Mental Health. First Meeting of the Lisbon Medical Studies About Life: The impact of abortion on women's health, Lisbon, Portugal.

Coleman, P. K. (March, 2007). Maternal-Fetal Attachment. 51st Session on the Status of Women, United Nations.

Coleman, P. K. (March, 2007). Post-abortion mental health research: update and quality of evidence. 51st Session on the Status of Women, United Nations.

Coleman, P. K. (Feb, 2007) Post-abortion mental health research: update and quality of evidence. Furman University.

Coleman, P. K. (Nov, 2006) Post-abortion mental health research: update and quality of evidence. Princeton University.

Coleman, P. K. (Nov, 2006). Nature and Experiences of Pregnancy Losses. Diocese of Orlando.

Coleman, P. K. (Nov, 2006). What Does The Latest Post-Abortion Research Show? Diocese of Orlando.

Rue, V. M. & Coleman, P. K. (Nov, 2006). Men and Abortion. Diocese of Orlando.

Rue, V. M. & Coleman, P. K. (July, 2006). Men and Abortion. International Life Services, Advanced Training Institute, Los Angeles California.

Coleman, P.K. (July, 2006). Post-Abortion Research: Update and Quality of Evidence. International Life Services, Advanced Training Institute, Los Angeles California.

Coleman, P. K. (Sept, 2005). Research on the Psychological Complications Associated with Abortion: Past, Present, and Future. Pro-Life Science & Technology Symposium. Dayton, OH.

Coleman, P. K. (Jan, 2005). On Abortion and Psychological Fallout/Substance Abuse Problems. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (Dec, 2004). The uniquely destructive psychological experience of elective abortion: Comparisons with other forms of perinatal loss and delivery of an unintended pregnancy. Association for Research in Values and Social Change Research Bulletin, 17, 1-8.

Coleman, P. K. (Jan, 2004). Research on the psychological complications associated with abortion: Past, present, and future. Presentation for the American Association of Pro-Life Obstetricians and Gynecologists (a special interest group of the American College of Obstetricians and Gynecologists), Annual CME meeting.

Coleman, P. K. (June, 2004). "Psychological causes of abortion." Presentation for an international conference entitled "Abortion: Causes, Ramifications, Therapy" sponsored by the Demographic Committee of the Polish Academy of Science, the Ombudsman for Children in Poland, and the Institute of Psychiatry and Neurology.

Coleman, P. K. (June, 2004). Research on the psychological complications associated with abortion: Past, present, and future. Presentation for the XLI Convention of the Polish Psychiatric Association.

Coleman, P. K. (June, 2004). Co-Chairman with Professor Bogdan Chazan of the Opening Session of an international conference entitled "Abortion: Causes, Ramifications, Therapy" sponsored by the Demographic Committee of the Polish Academy of Science, the Ombudsman for Children in Poland, and the Institute of Psychiatry and Neurology.

Self-Efficacy beliefs, parenting quality, and child outcomes. (Feb, 2002) Invited presentation for the School of Family and Consumer Sciences, BGSU.

Self-Efficacy beliefs, parenting quality, and child outcomes. (Feb, 2002) Invited presentation for the Department of Human Development and Family Studies, University of Alabama.

Self-Efficacy beliefs, parenting quality, and child outcomes. (Feb, 2002) Invited presentation for the Department of Psychology, Murray State University.

Self-Efficacy beliefs, parenting quality, and child outcomes. (Jan, 2002) Invited presentation for the Department of Psychology, Grand Valley State University.

Self-Efficacy beliefs, parenting quality, and child outcomes. (Jan, 2001) Invited presentation for the Department of Psychology, St. Mary's College of Maryland.

B. Refereed Papers

Dawson, E., Haar, C., Pobocik, R., Coleman, P., Babies, K., Houston, M.S. (July, 2007). Increased self-efficacy and dairy consumption resulting from a dairy curriculum or junior high school students. Society for Nutrition Education, Chicago, Il.

Dawson, E., Haar, C., Pobocik, R., Coleman, P., Babies, K., Houston, M.S. (April 2007). Development of an instrument to assess self-efficacy and behavior related to dairy foods in adolescents. Experimental Biology, Washington, DC.

Coleman, P. K. (March, 2007). Development of Parenting Self-Efficacy during the First Six Months (Troutman, B.R.. Chair). Serving as Discussant for symposium accepted for presentation at the Biennial Meeting of SRCD.

Coleman, P. K. (April, 2005). Resolution of Unwanted Pregnancy during Adolescence: Predictors and Consequences. Poster presented at the Biennial Meeting of the Society for Research in Child Development, Atlanta, GA.

Coleman, P. K. (July, 2004). Partner violence, induced abortion, and women's mental health. Paper presented at the Annual American Psychological Association Convention, Honolulu, HI.

Coleman, P. K., & *Maxey, C. D. (May, 2004). Pregnancy resolution and substance use in the Fragile Families and Well-being Study. Poster presented at the 16th annual meeting of the American Psychological Society, Chicago, IL.

Karraker, K. H., Wiedman, C., & Coleman, P. K. (May, 2004). Infancy in life-span perspective: Relationships between infants and family members. In K. Karraker (Chair), The role of infants in family relationships across the life-span. Symposium paper presented at the 14th Biennial International Conference on Infant Studies, Chicago, IL.

Coleman, P. K., & Karraker, K. H. (April, 2004). Parenting self-efficacy, competence in Parenting, and possible links to children's social and academic outcomes. 12th International Roundtable on School, Family, and Community Partnerships.

Coleman, P. K., Reardon, D. C., & Cougle, J. (June, 2003). Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. Presented at the 15th annual meeting of the American Psychological Society, Atlanta, GA.

Coleman, P. K., Karraker, K. H., *Lowe, M., *Murden, R., *Reid, C.,& *Merchant, M. (April, 2003). Prenatal and postnatal correlates of parenting self-efficacy. Poster presented at the meeting of the Society for Research in Child Development, Tampa, FL.

Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (June, 2002). Prior history of induced abortion and substance use during pregnancy. Poster presented at the American Psychological Society, 14th Annual Convention, New Orleans, LA.

Reardon, D. C., Ney, P. G., Scheuren, F. J., Cougle, J. R., Coleman, P. K., & Strahan, T. W. (May, 2002). Suicide associated with pregnancy outcome: A record linkage study of low income American women. Poster presented at the American Psychiatric Association Meeting, Philadelphia, PA.

Coleman, P. K. (April, 2002). Self-efficacy beliefs, parenting, and toddler behavior and development. In M. Stern (Chair), Maternal expectations, caregiving and infant outcomes. Symposium paper presented at the 13th Biennial International Conference on Infant Studies, Toronto, Canada.

Coleman, P. K., & Neilsen, A. (April, 2002). Length of institutionalization, contact with relatives, and previous hospitalizations as predictors of social and emotional behavior in young Ugandan Orphans. Poster presented at the 13th Biennial International Conference on Infant Studies, Toronto, Canada.

Karraker, K. H., Atkins, M., Coleman, P. K., & Cottrell, L. E. (April, 2002). Mothers' expectations for their infants' performance on the Bayley Scales of Infant Development. In M. Stern (Chair), Maternal expectations, caregiving and infant outcomes. Symposium paper presented at the 13th Biennial International Conference on Infant Studies, Toronto, Canada.

Coleman, P. K., *Bryan, S., *King, B., *Trent, A., *Anderson, J., *Cavender, N., *Nalley, I., *Nazir, M., *Novarese, A., & *Rogers, N. (June, 2001). Mothers' self-efficacy beliefs, parenting behavior, and toddler performance on the Bayley Scales of Infant Development. Poster presented at the American Psychological Society, 13th Annual Convention, Toronto, Canada.

Coleman, P. K., Reardon, D. C., & Cougle, J. (June, 2001). Child developmental outcomes associated with maternal history of abortion using the NLSY data. Poster presented at the American Psychological Society, 13th Annual Convention, Toronto, Canada.

Coleman, P. K. (April, 2001). Interpersonal correlates of peer victimization in young adolescents. Poster presented at the meeting of the Society for Research in Child Development, Minneapolis, MN.

Coleman, P. K., *Bryan, S. *King, B., & *Trent, A. (March, 2001). Mechanisms linking parenting self-efficacy beliefs to parenting competence and toddler development. Poster presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Coleman, P. K., Reardon, D. C., & Cougle, J. (March, 2001). Child developmental outcomes associated with maternal history of abortion using the NLSY data. Poster presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Coleman, P. K., Reardon, D. C., Rue, V. & Cougle, J. (March, 2001). State-funded abortions vs. deliveries: A Comparison of outpatient mental health claims over six years. Poster presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Cougle, J., Reardon, D. C., & Coleman, P. K. (March, 2001). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. Poster presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Cougle, J., Reardon, D. C., Rue, V., Shuping, M., Coleman, P. K., & Ney, P. (March, 2001). Psychiatric admissions following abortion and childbirth: A record-based study of low-income women. Poster presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Reardon, D. C., Ney, P., Schueren, F., Cougle, J., & Coleman, P. K. (March, 2001). Suicide deaths associated with abortion: A record linkage study. Symposium paper presented at the 1st World Congress on Women's Mental Health, Berlin, Germany.

Karraker, K. H., Coleman, P. K., & Cottrell, L. (July, 2000). Prenatal and postnatal maternal self-efficacy. Poster presented at the 12th Biennial International Conference on Infant Studies. Brighton, UK.

Coleman, P. K., & Reardon, D. C. (June, 2000). State-Funded Abortions vs. Deliveries: A Comparison of Subsequent Mental Health Claims Over Six Years. Poster presented at the American Psychological Society, 12th Annual Convention, Miami, FL.

Coleman, P. K., *Anderson, J., *Bryan, S., *Byrd, C., *King, B., *Lacy, A., *Novarese, A., & *Trent, (April, 2000). Potential process mechanisms linking parenting self-efficacy beliefs to parenting competence and toddler development. Poster presented at the 16th biennial meeting of the Conference on Human Development, Memphis, TN.

Coleman, P. K., *Anderson, J., *Bryan, S., *Byrd, C., *King, B., *Lacy, A., *Novarese, A., & *Trent, A. (April, 2000). Potential process mechanisms linking parenting self-efficacy beliefs to parenting competence and toddler development. Poster presented at Scientific Sewanee.

Coleman. P. K., Karraker, K. H, & Cottrell, L. (April, 2000). Prenatal and postnatal maternal cognitions as predictors of infant behavior and parenting competence in mothers of 3-6 month old infants. Poster presented at the 16th biennial meeting of the Conference on Human Development, Memphis, TN.

Coleman, P. K., & Erwin, T. D. (June, 1999). Novelty-seeking and persistence among college students: Preliminary study of the Curiosity Index. Poster presented at the American Psychological Society, 11th Annual Convention, Denver, CO.

Coleman, P. K., & Karraker, K. H. (April, 1999). Maternal self-efficacy beliefs as predictors of parenting competence and toddlers' behavior and development. Poster presented at the meeting of the Society for Research in Child Development, Albuquerque, NM.

Karraker, K. H., & Coleman, P. K. (April, 1999). Mothers' predictions of their toddlers' performances on the Bayley Scales of Infant Development. Poster presented at the meeting of the Society for Research in Child Development, Albuquerque, NM.

Karraker, K. H., & Coleman, P. K. (May, 1998). Parenting self-efficacy beliefs among

mothers of school age children. Poster presented at the American Psychological Society, 10th Annual Convention, Washington, DC.

Coleman, P. K. (April, 1997). Toward a dynamic system of child development: The importance of changing environments and person-context relations. In A. W. O'Reilly (Chair), Dynamic systems theory: Taking seriously the complexity of organism-behavior-environment relations. Paper symposium conducted at the meeting of the Society for Research in Child Development, Washington, DC.

Coleman, P. K., & Nelson, E. S. (April, 1997). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. Poster presented at the meeting of the Society for Research in Child Development, Washington, DC.

*student collaborator

C. Non-refereed Papers

Coleman, P. K., & Maxey, C. D. (November, 2005). Resolution of unwanted pregnancy during adolescence: predictors and consequences. Poster presented at the 3rd Annual BGSU Research Conference.

Coleman, P. K., Reardon, D. C., & Cougle, J. (November 2003). Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. Poster presented at the 2nd Annual BGSU Research Conference.

Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (November 2002). Prior history of induced abortion and substance use during pregnancy. Poster presented at the 1st Annual BGSU Research Conference.

Coleman, P. K. (December 2002). Is induced abortion associated with mental health risks for women? Research presentation for FCS 692/693 class.

Stockall, N., Coleman, P., Kilmer, S., & Rybczynski, M. (April 2003). A concept-based approach to infusing technology in the Early Childhood Studies Program." Poster presented at the PICT Technology Showcase, Bowling Green State University.

Coleman, P. K. (April 2003) Is induced abortion associated with mental health risks for women? Research presentation for Falcons for Life.

Coleman, P. K. (November 2000). Abortion vs. delivery: Implications for women's mental health. Lecture sponsored by the Psychology Club, University of the South.

XII. Service

A. Department/School

School of Family and Consumer Sciences, Bowling Green State University

Member, Assessment Committee, March 2009 - 2010; elected Chair 2009-2010
Member, Scholarship Committee, August 2008 - present
Faculty Development and Evaluation Committee, August 2005-2007
Co-coordinator of Human Development and Family Studies, with duties including scheduling, development and dissemination of meeting agendas, email correspondence with faculty, attending Program Area Coordinators meetings, development of the

program review self-study document for HDFS, and sharing moderation of meetings with the other coordinator, Sally Kilmer. February 2003-August 2004

Member, Program Review Committee, served as the editor along with Jean Hines for the full School document, March – October 2003.

Member, Child Development Center Scholarship Review Committee, September 2002-Present.

Psychology Department, University of the South

Served as a faculty mentor to a minority student, 1999-2002

Maintained a research lab group designed to actively involve 5-9 undergraduate students in a wide variety of research-related activities relevant to all phases of the research process, October 1998-May, 2002

Psychology Department liaison to the library for ordering new books, 1998-2002

Co-Advisor of the Psychology Club, 1998-2002

Department of Psychology, James Madison University

Member of the Advising Committee, 1993-1994

Member of the General Psychology Program Committee, 1993-1994

Department of Psychology, West Virginia University

Elected Student Representative to the Developmental Training Committee, 1997

Member of the Diversity Committee, 1995-1997

Member of the Alumni Fund Committee, 1995-1996

B. College

College of Education and Human Development, Bowling Green State University

Tenure and Promotion Review Committee, 2010 - present

Scholarship Committee, August 2006-2010

Program Council, elected member, August 2004 - 2006

Research Development Committee, elected member, August 2004 - 2006

Early Childhood Studies Coordinating Committee, elected member, August 2003 - 2006

FCS Director Search Committee, appointed member, January 2004 - May 2004

Portfolio Committee, appointed member, February 2003 - September 2003

Program Council, elected member (alternate), September 2002 - May 2004

Advanced Program Council, appointed member, September 2002 - May 2004

C. University

Bowling Green State University

Climate Commitment Committee, Spring 2012-present

Faculty Advisor, Phi Sigma Theta, Fall 2009-present

Faculty Advisor, Falcons for Life, Fall 2005-2010

Faculty Senate, Alternate, Spring 2008 -present

Distinguished Thesis Award Committee, Fall 2006

Guest lecture for Molly Laflin's Human Sexuality class. Abortion and Mental Health: Consolidating and Solidifying the Evidence with Results of a Meta-Analysis. Spring, 2010.

Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Relationships. Fall, 2009.
Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Relationships. Spring, 2009.
Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Mental Health. Spring, 2008.
Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Mental Health. Fall, 2007.
Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Mental Health. Spring, 2007.
Guest Lecture for Creed (Catholic student organization). Topic: Abortion and Mental Health. Spring, 2006.
Guest lecture for Molly Laflin's Human Sexuality class. Topic: Abortion and Mental Health. Spring, 2006.
Guest Lecture for Jeanie Ludlow's Women's Studies 400 class, Reproduction Health & Politics class. Topic: Abortion and Mental Health. Spring, 2006.
Served on a panel entitled "Setting Research Priorities for New Faculty" during the 2005 BGSU Research Conference.
Guest lecture for Chadwick Robert's Women's Studies 200 class Topic: Is Abortion Associated with mental health risks for women? Fall 2004
Assessed a student portfolio for Continuing and Extended Education, Spring 2004
Served as a judge for the Shanklin Award Competition, Spring 2004
Guest lecture for Dr. Maria Spence's Social Work 322 class (Social Policy and Social Services), Topic: National and International Abortion Laws, February 2004
Chair of Honors and Awards Committee, 2002-2003

<u>University of the South</u>
Member of the Education Certification Committee, 1999-2002
Member of the University Bookstore Committee, 1999-2002
Member of the University Pre-Medicine Committee, 1999-2002
Served as an essay judge for the Daniel Prize through the Department of English at the University of the South, May 2001
Together with the other members of my family, served as a host family to an international student from Bulgaria, 1999-2000.

D. <u>Professional</u>

Served as an external reviewer for M. Angela Nievar's application for tenure. Development and Family Studies Program, Educational Psychology Department, University of North Texas. (Fall, 2009)

Reviewer for the *Journal of the American Board of Family Practice.* (May 05 – present)

Served as a reviewer for a report produced by the American Psychological Association Task Force on Abortion and Mental Health; submitted a 10 single-spaced page evaluation of their 80 page document reviewing the published literature between 1990 and 2007. November, 2007.

Participated in a Child Development teaching symposium sponsored by McGraw-Hill Publishing, Boca Raton, FL, September 21-24th, 2006

Reviewed a child development textbook: Magnificent in the Mundane by Charlotte Patterson for McGraw-Hill Publishing (August, 2006).

Served on the Scientific Committee for an international conference entitled "Abortion: Causes, Ramifications, Therapy" sponsored by the Demographic Committee of the Polish Academy of Science, The Ombudsman for Children in Poland, and the Institute of Psychiatry and Neurology (June, 2004).

Serving on the Council of Healthcare Advisors, Gerson Lehrman Group. The Council of Healthcare Advisors provides investment analysts access to a highly structured network of industry and academic experts to conduct surveys, phone consultations, and arrange in-person events (Fall, 2003-present)

Served as a reviewer for a manuscript submitted to *Psychology, Health, and Mediine,*

Served as a reviewer for a manuscript submitted to the *British Journal of Psychiatry* (June 2011)

Served as a reviewer for a manuscript submitted to the *Journal of Psychiatric Research* (June 2011)

Served as a reviewer for a manuscript submitted to the Obstetrics and Gynecology International (January, 2011)

Served as a reviewer for a manuscript submitted to the *Open Family Studies Journal* (December, 2010)

Served as a reviewer for a manuscript submitted to *Journal of clinical and Social Psychology* (September, 2010)

Served as a reviewer for a manuscript submitted to *Depression and Anxiety* (February, 2010).

Served as a reviewer for a manuscript submitted to *Developmental Psychology* (November, 2008)

Served as a reviewer for a manuscript submitted to *Open Women's Health Reviews* (November, 2008)

Served as a reviewer for a manuscript submitted to *General Hospital Psychiatry.* (September, 2008)

Served as a reviewer for a manuscript submitted to *Open Women's Health Reviews* (January, 2008)

Served as a reviewer for a manuscript submitted to *Research to Practice Journal for the Intervention Field* (December, 2007)

Served as a reviewer for a manuscript submitted to *Addiction* (October, 2007)

Served as a reviewer for a manuscript submitted to *Infant Behavior and Development* (September, 2007)

Served as a reviewer for a manuscript submitted to *Current Women's Health Reviews* (September, 2007)

Served as a reviewer for a manuscript submitted to (September, 2007) *Journal of Developmental Processes.*

Served as reviewer for a manuscript submitted to *Current Women's Health Reviews* (November 2006)

Served as reviewer for a manuscript submitted to *International Internet Journal of Mental Health* (October 2006)

Served as reviewer for a manuscript submitted to *Social Sciences and Medicine* (August 2006)

Served as reviewer for a manuscript submitted to *The Lancet* (July 2006)
Served as reviewer for a manuscript submitted to *Infant and Child Development* (May 2006)
Served as reviewer for a manuscript submitted to *Parenting: Research and Practice* (May 2006)
Served as reviewer for a manuscript submitted to *Medical Science Monitor* (March 2006)
Served as reviewer for a manuscript submitted to *Journal of Medical Ethics* (February 2006)
Served as reviewer for a manuscript submitted to *European Journal of Psychology of Educations* (February 2006)
Served as reviewer for a manuscript submitted to *Annales Academiae Medicae Bialostocensis* (February 2006)
Served as a reviewer for a manuscript submitted to the *European Journal of Clinical Nutrition* (October, 2005)
Served as a reviewer for a manuscript submitted to *Family Relations* (October, 2005)
Served as a reviewer for a manuscript submitted to *Social Development* (October, 2005)
Served as a reviewer for a manuscript submitted to *Journal of Youth and Adolescence* (September, 2005)
Served as a reviewer for a manuscript submitted to *BMC Pregnancy and Childbirth* (June, 2005)
Served as a reviewer for a manuscript submitted to *Psychology in the Public Interest* (May, 2005)
Served as a reviewer for 2 manuscripts submitted for publication in *Family Relations* (March – April 2005)
Served as a reviewer for 2 manuscripts submitted for publication in the *Journal of Family Psychology* (March – April 2005)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Adolescence* (March 2005)
Served as a reviewer for a manuscript submitted for publication *in Current Women's Health Reviews* (November, 2004)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Pediatrics* (August, 2004)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Pediatrics* (May, 2004)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Adolescence* (February, 2004)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Child Psychology and Psychiatry and Allied Disciplines* (January, 2004)
Served as a reviewer for a manuscript submitted for publication in *Social Problems* (August 2003)
Served as a reviewer for a manuscript submitted for publication in the *Journal of Women's Health and Gender-Based Medicine* (May, 2003)
Served as a reviewer for a manuscript submitted for publication in *Journal of Applied Developmental Psychology* (March, 2003)
Served as a reviewer for a manuscript submitted for publication in *Parenting: Science and Practice* (March, 2002)
Served as a reviewer for a manuscript submitted for publication in *Family Relations* (March, 2002)
Served as a reviewer for a manuscript submitted for publication to the *Journal of Personality and Social Psychology* (July, 2000)
Served as a reviewer for a manuscript submitted for publication to the *Journal of Reproductive and Infant Psychology* (September, 1999)

Participated in a focus group sponsored by Worth Publishers with 5 other faculty members currently teaching child development across the U.S. for the purpose of generating ideas for the development of the 5th edition of Kathleen Berger's *The Developing Person through Childhood and Adolescence* (June, 2001)

E. Community

Expert testimony

Serving as an expert witness in Planned Parenthood Minnesota, North, Dakota, South Dakota, and Carol E. Ball, MD, Plaintiffs, vs. Dennis Daugaard, Governor SD, Marty J. Jackley, Attorney General SD, ALPHA CENTER, Sioux Falls, SD, Intervenors. — Aug 2011-present

Provided expert testimony for Ohio House Bill 78, Post-Viability Ban — March, 2011

Affidavit submitted in the case of PLANNED PARENTHOOD OF THE HEARTLAND vs. DAVE HEINEMAN, Governor of Nebraska: JON BRUNING, Attorney General of Nebraska; KERRY WINTERER, Chief Executive Officer, and DR. JOANN SCHAEFER, Director of the Division of Public Health, Nebraska Department of Health and Services; and CRYSTAL HIGGINS, President, Nebraska Board of Nursing, and BRENDA BERGMAN-EVANS, President, Nebraska Board of Advanced Practice Registered Nurses. — July 1010

Affidavit submitted to the Supreme Court of the United States in support of Amicus Brief of Sandra Cano, the former "Mary Doe" of Doe v. Bolton and the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) in Rosa Acuna v. Sheldon C. Turkish, M.D. — May, 2008

Provided Expert Testimony, Health Sub-committee, Committee on Energy and Commerce, U.S. House of Representatives. H.R. 20, the Melanie Blocker-Stokes Postpartum Depression and Care Act, Washington, DC — May 1, 2007

Expert witness for the Plaintiffs, Zallie v. Brigham, Camden, NJ — August, 2007-2011

Expert witness for the Plaintiffs, ROE ET AL. v. PLANNED PARENTHOOD, Cincinnati, OH — September, 2006-2010

Expert witness for the defense in PLANNED PARENTHOOD MINNESOTA, NORTH DAKOTA, SOUTH DAKOTA, and CAROL E. BALL, M.D., Plaintiffs, v. MIKE ROUNDS, Governor, and LARRY LONG, Attorney General, Defendants Civil Case No.: 05-4077. — December 2005-present

Assisted legislation consultant, Vincent Rue, Ph.D. hired by Attorney General Phil Kline of Kansas in the defense of a mandatory underage sexual activity reporting statute (S.A. 38-1522), AID FOR WOMEN v FOULSON, Federal District Court — October, 2005-February 2006

Provided expert testimony for Ohio House Bill 239 pertaining to our studies comparing the psychological effects of abortion versus childbirth. — October 12, 2005

Provided expert testimony to the South Dakota Task Force to Study Abortion on post-abortion mental health literature accumulated since 1973. The task force consists of eight legislators and nine medical and legal professionals and interested lay persons charged with studying the application of medical, psychological, technological, societal, economic, and sociological developments and research to legislative and public policy formulations on abortion issues. The testimony was presented during hearings at the State Capitol in Pierre, South Dakota — September 21, 2005

Non-Profit

Founder and Director of the World Expert Consortium for Abortion Research and Education (WECARE). The website for this 501 c(s) is www.wecareexperts.org — June, 2011-present

Co-founder and Co-director with Dr. Catherine Coyle & Dr. Vincent Rue, of a non-profit Corporation, *Alliance for Post-Abortion Research and Training. Website: www.standaprt.org.* — June, 2006 – 2010

Media interviews

Radio interview with Teresa Tomeo, the "Catholic Connection" regarding post-abortion research *in general and recent publications.* — April 7, 2009

Radio interview with Teresa Tomeo, the "Catholic Connection" regarding post-abortion research *in general and recent publications.* — December 21, 2008

Interviewed by Andrea Mrozek, Manager of Research and Communications Institute of Marriage and Family Canada regarding APA Task Force and Research on mental health and abortion. — November, 2008

Interviewed by Melanie McDonagh, London Times — August, 2008

Interviewed by Stephanie Simon, Wall Street Journal for an article related to the APA Task Force on Abortion and Mental Health. She also asked about my research on the topic. — August, 2008

Interviewed by Bruce Isaacson for a documentary film to be produced by Lion Heart Films related to abortion and women's lives. The film Titles "South Dakota" is due out in 2009 — November, 2007

Interviewed by Father Frank Pavone, Life on the Line Radio Show — June, 2007

Interviewed by James Penice, for an article in Our Sunday Visitor, Titled "Awareness seen as Growing that Abortion Opponents are Pro-Women" — June 14, 2007

Interviewed by Kathy Hughes, Producer, NOW on the News for an Upcoming Public Television Broadcast on Abortion and Women's Health — May 24, 2007

Interviewed by Susan E. Wills, U.S. Conference of Catholic Bishops, For an article titled "The New York Times Won't See Their Pain" — February, 2007

Interviewed by Emily Bazelon, NYT Magazine reported. The article was the Cover story on the New York Times Magazine, — January 21, 2007

Radio interview with Family News in Focus (Josh Montez) regarding post-abortion research, a paper published in the *Journal of Medical Ethics* — August 30, 2006

Radio Interview on New Zealand's Rhema regarding post-abortion research, a paper published in the *Journal of Youth and Adolescence.* — August 29, 2006

Radio interview with reporter Mary Rettig from American Family Radio and Agape Press regarding post-abortion research, a paper published in the *Journal of Youth and Adolescence.* — August 24, 2006

Radio interview with Teresa Tomeo, the "Catholic Connection" regarding post-abortion research, a paper published in the *Journal of Youth and Adolescence* — August 21, 2006

Radio interview with Family News in Focus (Kimberly Trombee) regarding post-abortion research, a paper published in the *Journal of Youth and Adolescence* — August 14, 2006

Presentation on abortion and mental health, St. Aloysius Catholic Church — February 15, 2006

Interview with reporter, Alison Motluk, *New Scientist Magazine* regarding Scientific evidence provided for the South Dakota Task Force on Abortion — March 6, 2006

Taped interview with CDR Radio, affiliated with Cedarville University (post-abortion research). — January 26, 2006

Interviewed by a reporter, Shepherd Pittman, with the Washington Times. He was interested in a paper recently published paper in *Acta Paediatrica.* — October 27, 2005

Interviewed by a reporter, Josh Montez, with Focus on the Family. He was interested in a paper recently published paper in *Acta Paediatrica.* — October 18, 2005

Interviewed by a reporter, Josh Montez, with Focus on the Family. He was interested in a recently published paper entitled "Generalized anxiety following unintended pregnancies resolved though childbirth — November 8, 2004

and abortion: A cohort study of the 1995 National Survey of Family Growth" recently published in the Journal of Anxiety Disorders.

Serving on a committee to assist the Bowling Green Schools Board of Education in determining future directions for the system. — April 2004-present

Interviewed for 2 hrs. by s science reporter, Jenni Laidman with the Toledo Blade. The 1500 word front-page story ran on January 22, 2004 — December 11, 2003

Interviewed by U.S. Assistant Attorney, Sheila Gowan from New York and another U.S. Assistant Attorney from Nebraska (post-abortion research). These two individuals assumed primary responsibility for defending the Partial-Birth Abortion ban against objections raised by cases in New York, Nebraska, and California. — November 25, 2003

Interviewed by s science reporter, Jenni Laidman with the Toledo Blade. She was interested in a recently published paper on attachment to parents and peer relationships in middle childhood. The story ran on November 17, 2003. — November 6, 2003

Interviewed by a reporter with the Sentinel-Tribune, Bowling Green, for a story to appear in the lifestyles section (post-abortion research). Article appeared one year later on January 22, 2004 — January 28, 2003

Interviewed by a reporter with Reuter's Health (post-abortion research), story appeared on their website the same day. — January 9, 2003

Taped interview with CDR Radio, affiliated with Cedarville University (post-abortion research). — October 1, 2002

Taped interviews with reporters, Bob Kellogg and Stewart Shepard, Family News in Focus (post-abortion research). — August 15, 2002 & September 18, 2002

Interviewed by a reporter with CNSNews, story appeared on their website (post-abortion research). — August 16, 2002

Live guest of radio talk show host Jason Lewis, KSTP, 1500 am Minneapolis, MN (post-abortion research). — September 9, 2002

Other

Met with 6 crisis pregnancy center directors from Northwest Ohio for a 2.5 hour session to discuss recent research on post-abortion adjustment — June 17, 2003

Entered and analyzed data from parent, teacher, an community surveys for Sewanee Elementary School to meet one requirement for their 5-year accreditation. Sewanee, TN. — March, 2002

[II. Membership in Professional Organizations

American Psychological Society
American Psychological Association
Society for Research in Child Development

XIV. Honors and Awards

A. Membership in Honor Societies
Phi Kappa Phi, West Virginia University, 1997 - present

B. Awards
Recipient of College of Education and Human Development Faculty Scholarship Award, $1,000, August, 2004
Recipient of Eberly College of Arts and Sciences WVU $450 Doctoral Research Award, 1998
Doctoral Qualifying Exams "Pass with Distinction," 1997
Recipient of Eberly College of Arts and Sciences WVU $200 Student Travel Award, 1997
Recipient of SRCD $300 Student Travel Award, 1997
Recipient of $2,000 HERF Fellowship, 1995

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CURRICULUM VITAE
JOHN M. THORP, JR., M.D.

Personal Information

Name	John M. Thorp, Jr., M.D.
	Department of Obstetrics and Gynecology 3027 Old Clinic Building CB # 7570 Chapel Hill, NC 27599-7570
Telephone	(919) 843 7852
Fax	(919) 966-6001
E-mail	thorp@med.unc.edu

Education

Master's	Duke University School of Medicine Master of Health Sciences in Clinical Leadership	2009
Fellowship	University of North Carolina School of Medicine Chapel Hill, North Carolina Fellowship in Maternal-Fetal Medicine Fellowship Director: J.W. Seeds	1987 – 1989
Residency	University of North Carolina School of Medicine Chapel Hill, North Carolina Residency in Obstetrics & Gynecology Program Director: W.C. Fowler	1983 – 1987
Medical School	East Carolina University Medical School, M.D. Greenville, North Carolina	1979-1983
College	University of North Carolina at Chapel Hill B.A. Zoology	1975-1979

Certification:

Board Certification	Obstetrics and Gynecology	1991-annually to present
Sub-Specialty	Maternal-Fetal Medicine	1992-annually to present

Professional Experience

Division Director	Women's Primary Healthcare	2006-present
Program Director	Women's Reproductive Health Research Scholars Program	2006 - present
Research Core Co-Director	Women's Reproductive Health Research Scholars Program	2006 - present
Interim Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	2006 – present
Professor	Department of Maternal and Child Health School of Public Health University of North Carolina, Chapel Hill, NC	2005 - present
Adjunct Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	2004- present
Director	Biomedical Core Carolina Population Center University of North Carolina, Chapel Hill, NC	2004-present
Deputy Director	Center for Women's Health Research Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	2004-present
Adjunct Professor	Department of Epidemiology School of Public Health and Tropical Medicine Tulane University	2003-present
Fellow	Carolina Population Center University of North Carolina, Chapel Hill, NC	2003-present
Hugh McAllister Distinguished	Department of Obstetrics and Gynecology School of Medicine	2001-present

Professor Ob & Gyn	University of North Carolina, Chapel Hill, NC	
Professor	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	2000-present
Co-Director	North Carolina Program for Women's Health Research, Cecil G. Sheps Center For Health Services Research Department of Epidemiology School of Public Health Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1999-2004
Senior Research Fellow	Cecil G. Sheps Center for Health Services Research University of North Carolina, Chapel Hill, NC	1999-present
Co-Director	Institute Generalist Physician School of Medicine University North Carolina-Chapel Hill	1999-2000
Adjunct Associate Professor	Department of Epidemiology School of Public Health University of North Carolina, Chapel Hill, NC	1999 - 2004
Associate Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1995-2000
Associate Chair	Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1995-1999
Medical Director	HORIZONS Perinatal Substance Abuse Program School of Medicine University North Carolina-Chapel Hill	1993-present
Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1990-1995
Clinical Assistant Professor	Division of Maternal-Fetal Medicine Department of Obstetrics and Gynecology School of Medicine University of North Carolina, Chapel Hill, NC	1989-1990

Honors

University of Rochester School of Medicine Teaching Fellow	2010
Golden Tar Heel Medical Student Teaching Award	2005, 2006
Robert C. Cefalo Excellence in Teaching Professors Award	2004-2005
Hugh McAllister Distinguished Professorship in Obstetrics and Gynecology	2002
Professor Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1993, 2000
Perinatal Health Model of Excellence North Carolina Department of Health and Human Services in Conjunction with the March of Dimes	1999
North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services Recognition Award for Outstanding Service to Women and Children	1999
APGO/CREOG Departmental Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1992, 1995
Junior Faculty Teaching Award Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1990, 1992, 1995
Family Medicine Teaching Award Department of Family Practice School of Medicine University North Carolina-Chapel Hill	1989
American Journal of Obstetrics & Gynecology One of the top 100 reviewers for the academic year	2006-2007

Memberships

Fellow, American Gynecological and Obstetrical Society	2004 - present

Vice President, Southern OBG Seminar	2003-present
Southern Obstetrics & Gynecologic Seminar	1994-present
South Atlantic Association of Obstetrics and Gynecology	1994-present
Society for Gynecologic Investigation	1993-present
Association of Professors of Gynecology and Obstetrics	1993-present
Society for Maternal-Fetal Medicine	1984- present
American College of Obstetricians Gynecologists	1983-present

Administrative Accomplishments

Four of six clinicians in Women's Primary Care Division were cited for excellence in graduate and postgraduate medical education	2005
Four of seven clinicians in Women's Primary Care Division were cited for excellence in resident Medical education	

Bibliography

Book Chapters

1. **Thorp, JM** , Cefalo RC. Role of perinatal factors in brain disorders. In *Precis IV.* Visscher HC (ed), ACOG, 79-166, 1990.

2. **Thorp JM** Listeriosis: a treatable cause of intrapartum fever. In *Clinical Decisions in Obstetrics and Gynecology.* Cefalo RC (ed). Rockville, MD: Aspen Publishers, 48-9, 1990.

3. **Thorp JM** , Herbert WNP. Pancreatitis in pregnancy. In *Clinical Decisions in Obstetrics and Gynecology.* Cefalo RC (ed). Rockville, MD: Aspen Publishers, 60-2, 1990.

4. **Thorp JM** Maternal-fetal physiologic interactions in the critically ill pregnant patient. *Critical Care Obstetrics* 2/E:102-11, May 1990.

5. **Thorp JM** Third trimester bleeding. In *Gynecology and Obstetrics*: an integrated approach. Moore T, Reiter RC, Rebar RW, Baker VV (eds). New York: Churchill Livingstone, 479-85, 1993.

6. **Thorp JM** Pasteur, Charles. In *Dictionary of North Carolina biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

7. **Thorp JM** Pasteur, Thomas. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

8. **Thorp JM** Pasteur, William. In *Dictionary of North Carolina Biography.* Powell WS (ed). U of North Carolina P. Vol 5: p28, 1994.

9. **Thorp, JM** Management of Drug Dependency, Overdose, and Withdrawal in the Obstetrical Patient. *Obstetrics and Gynecology Clinics of North America,* Accepted 7/94, 14 pages.

10. **Thorp JM**, Episiotomy, Clinical Management of Labor, *Churchill Livingstone*, Accepted, 11/94, 20 pages.

11. **Thorp JM** Episiotomy. in Intrapartum Obstetrics, John T. Repke, MD (ed). Churchill Livingstone: New York, 1995.

12. **Thorp, JM**, Prenatal Diagnosis and Therapy. in New Issues in Medical Ethics, Jay Hollman, MD (ed). Christian Medical and Dental Society, Bristol, TN, 1995.

13. Feilder M, **Thorp JM** Radiologic Examinations During Pregnancy. In Drug Therapy in Pregnancy, Third Edition. Jerome Yankowitz & Jennifer R. Niebyl (eds.). Lippincott Williams & Wilkins: Philadelphia PA, 2001.

14. Gwyther RE, **Thorp JM.** Substance Abuse. Netter's Internal Medicine. Marschall Runge & M. Andrew Greganti (eds.). Icon Learning Systems: Teterboro, NJ, 2003.

15. Wilson JK, **Thorp JM.** Substance Abuse in Pregnancy. Clinical Obstetrics, Volume 2, Chapter 33.

16. **Thorp JM.** Clinical Aspects of Normal and Abnormal Labor. Maternal-Fetal Medicine; Principles and Practice, sixth edition, Chapter 36. Robert Creasy and Robert Resnik (eds.): The Curtis Center, Philadelphia, PA, 2007.

17. Garbutt JE, Gwyther RE, **Thorp JM.** Alcohol and Substance Dependence and Abuse. Netter's Internal Medicine 2nd Edition. Marschall S. Runge & M. Andrew Greganti (eds.). Saunders Elsevier, Philadelphia PA, 2009.

18. **Thorp JM Jr.** Chapter 36: Clinical Aspects of Normal and Abnormal Labor. In: Creasy & Resnick's Maternal-Fetal Medicine: Principles and Practice. Sixth Edition. (Robert K. Creasy, Robert Resnik, Jan D. Iams, Charles J. Lockwood, Thomas R. Moore Eds.) Saunders Elsevier, Philadelphia PA, 2009, pp.691-725.

Journal Refereeing

Reviewer	*Journal of Developmental Origins of Health and Disease*
Reviewer	*The Journal of Obstetrics and Gynaecology Research*
Reviewer	*Obstetrics and Gynecology International*
Reviewer	*Human Reproduction*

Reviewer	*British Journal of Obstetrics and Gynaecology*
Reviewer	*American Family Physician*
Reviewer	*Mayo Clinic Proceedings*
Reviewer	*Journal of the American Women's Association*
Reviewer	*International Journal of Psychophysiology*
Reviewer	*Journal of the American Medical Association*
Reviewer	*New England Journal of Medicine*
Reviewer	*Clinical Anesthesia*
Reviewer	*Preventive Medicine*
Reviewer	*Journal of Maternal-Fetal Medicine*
Reviewer	*Primary Care Field Reviewer's Guide to Substance Abuse Service for Primary Care Clinicians*
Reviewer	*Paediatric and Perinatal Epidemiology*
Reviewer	*American Journal of Perinatology*
Reviewer	*Obstetrics and Gynecology*
Reviewer	*American Journal of Obstetrics and Gynecology*
Reviewer	*Journal of Pediatrics*
Reviewer	*Journal of Perinatal Medicine*
Reviewer	*Journal of Perinatology*
Reviewer	*Reproductive Toxicology*
Reviewer	*Southern Medical Journal*
Reviewer	*International Urogynecology Journal*
Reviewer	*Medscape Women's Health*
Reviewer	*Evidence-Based Preventive Medicine*
Reviewer	*JAMA- Archives of General Psychiatry*
Reviewer	*OB/GYN Management*
Reviewer	*American Family Physician*
Reviewer	*Nature Clinical Practice Endocrinology & Metabolism*
Reviewer	*The Lancet*
Reviewer	*Journal of Psychiatric Research*
Reviewer	*Early Human Development*
Reviewer	*Canadian Medical Association Journal*
Reviewer	*Scientific proposals for AHA*
Reviewer	*Women's Health*

Editorial Board

Obstetric and Gynecological Survey	1995-present
British Journal of Obstetrics and Gynaecology	2006-present

Abstracts and presentations:

1. Siega-Riz AM, Savitz DA, **Thorp J**, Bodnar LM. Supplementation use preconceptionally and during pregnancy: does it decrease the risk of preterm births? Poster presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.
2. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Herrmann T. Meal patterning during pregnancy and its association with preterm births. Oral presentation at the Annual Meeting of the American Public Health Association, Washington, DC, 1998.

3. West S, Yawn B, **Thorp JM**, Korhonen M, Savitz D, Guess H. The efficacy of tocolytic therapy for preterm labor. Presented at the Society for Gynecologic Investigation Annual meeting, Atlanta GA, March, 1999.

4. Saacks C, Wells E, **Thorp JM**. The effects of parturition on immediate puerperal bladder function. To be presented at the Society for Gynecologic Investigation Annual Meeting, Atlanta GA, March, 1999.

5. Pastore LM, Hulka B, **Thorp JM**, Wells E, Kuller J. Postmenopausal vaginal symptoms in relation to douching and smoking. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999.

6. Sayle AE, Savitz DA, **Thorp JM**, Hertz-Picciotto I, Wilcox AJ. Sexual activity during late pregnancy and preterm delivery. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

7. Savitz D, Dole N, Henderson L, **Thorp JM**. Socioeconomic status, race, and pregnancy outcome. Presented at the Society for Epidemiologic Research Annual Meeting, Baltimore MD, June, 1999. Am J Epidemiol 1999;149:S28 (Abstract #111).

8. Forna F, Hartmann KE, Savitz D, **Thorp J**, Buekens P. Early pregnancy bleeding and risk to preterm birth. Poster presentation at the Student National Medical Associatio9n Annual Conference (Second place Clinical Research Award), April, 1999.

9. Herrmann TS, Seiga-Riz AM, Savitz DA, **Thorp JM**. Association between prolonged periods of time without food during pregnancy and preterm birth. Poster presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

10. Pastore LM, Hartmann KE, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. Bacterial vaginosis and cervical dilation and effacement at 24-29 weeks' gestation. Poster presentation at The Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June 1999.

11. Dole N, Savitz D, Hertz-Picciotto I, **Thorp JM**. Stress, social support and pregnancy outcome. Oral presentation at the Society for Pediatric and Perinatal Epidemiologic Research 12th Annual Meeting, Baltimore MD, June, 1999.

12. Pastore LM, **Thorp JM**, Royce RA, Savitz DA, Jackson TP. BV PIN Points: Clinical risk scoring system for antenatal bacterial vaginosis. Annual Meeting of the Society for Maternal-Fetal Medicine, San Francisco, CA, January 1999, and oral presentation at The Society of Perinatal Epidemiologic Research, Baltimore MD, June, 1999.

13. Savitz DA, Runkle ND, **Thorp JM**. Smoking and preterm birth: Evaluation of timing, dose, and etiologic pathway. Poster presentation at the International Scientific Meeting of the International Epidemiological Association, Florence, Italy, August, 1999.

14. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Antibiotics for treatment of preterm labor—review and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

15. **Thorp JM**, Berkman ND, Gavin NI, Hasselblad V, Lohr KN, Hartmann KE. Maintenance tocolysis for treatment of preterm labor—review of the evidence and meta-analysis. Presented at ACOG Annual Meeting, October, 1999.

16. **Thorp JM**, Hartmann KE, Berkman ND, Lohr KN. Fetal fibronectin and endovaginal ultrasound in the management of preterm labor—a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

17. McPheeters M, **Thorp JM**, Gavin NI, Hasselblad V, Berkman ND, Lohr KN, Hartmann KE. Hone uterine activity monitoring in the care of preterm labor – a review of the evidence. Presented at ACOG Annual Meeting, October, 1999.

18. **Thorp JM**, Berkman ND, Gavin NI, Lohr KN, Hartmann KE. Acute tocolysis for treatment of preterm labor – review of the evidence and meta-analysis. Submitted to ACOG, October, 1999.

19. McMahon MJ, **Thorp JM**, Savitz DA, Bagchee R. Risk factors for preterm birth. Presented at the Society for Maternal-Fetal Medicine, January, 2000.

20. Strauss RA, Royce RA, Sanasuttipun W, Eucker B, **Thorp JM**. Diagnosis of bacterial vaginosis from self-obtained vaginal swabs. Poster presentation. Poster presentation at the Annual meeting of the Society for Gynecologic Investigation. Chicago IL, March 25, 2000. *J Soc Gynecol Invest* 2000; 7(1) suppl (abstract #840).

21. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Presented at 21st Annual Meeting of the Southern Gerontological Society, Raleigh NC, April, 2000.

22. Savitz D, Wilkins D, Rollins D, **Thorp JM**, Henderson L, Dole N. Hair as an indicator of cocaine use during pregnancy and risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, June 2000, Seattle WA. Am J Epidemiol 2000;151:S7 (abstract #25).

23. Gavin NI, **Thorp JM**. Medical care costs associated with postmenopausal hormone replacement therapy. Accepted for poster presentation at the World Congress on Osteoporosis 2000. Chicago, IL, June 15-18, 2000.

24. Pastore LM, Wells E, **Thorp JM**, Kuller J, Hulka BS. Bacterial vaginosis in postmenopausal women: prevalence, symptoms and diagnostic implications. Poster presentation at the Southern Gerontological Society, April, 2000.

25. Pastore LM, **Thorp JM**, Dawson IJ. Public health clinic use of antenatal bacterial vaginosis risk score. Accepted for poster presentation to International Federation of Gynecology and Obstetrics XVI World Congress Conference, Washington DC, September, 2000.

26. Saldana TM, Seiga-Riz AM, Adair LS, Savitz DA, **Thorp JM**. Women with impaired glucose status during pregnancy have heavier babies. Poster presentation at the

Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June 2001.

27. Saldana TM, Siega-Riz AM, Adair LS, Savitz DA, **Thorp JM**. The association between impaired glucose tolerance and birth weight among black and white women in central North Carolina. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2001.

28. Siega-Riz AM, Savitz DA, **Thorp JM Jr**, Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth? Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research. Toronto, CA, June 2001

29. Connolly AM, **Thorp JM**, Pahel-Short L, Copeland K. Effects of pregnancy and childbirth on postpartum sexual function. Poster presentation. American Urogynecology Society Annual Meeting, October, 2001, Chicago, IL.

30. Connolly AM, **Thorp JM**, McMahon M, Pahel-Short L, Wells E. Pregnancy, Childbirth, and Postpartum Bladder Function. Poster presentation at the American Urogynecologic Society Annual Meeting, Hilton Head Island, SC. Oct 26-28, 2000.

31. Whitecar PW, Boggess KA, McMahon MJ, **Thorp JM**, Taylor DD. Comparison of asymmetric, non-precipitating antibodies in preeclampsia to normotensive pregnant controls. Poster presentation at the Twenty-first Annual Meeting of the Society for Maternal-Fetal Medicine, February, 2001, Reno NV.

32. Savitz DA, Terry J, Dole N, **Thorp JM,** Siega-Riz AM, Herring A. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, June, 2001, Toronto ONT CAN

33. Seiga-Riz AM, Savitz DA, **Thorp JM,** Zeisel S. Is there an association between maternal folate status in the second trimester and preterm birth: Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Toronto, CAN, June, 2001.

34. **Thorp JM**, Gavin NI, Ohsfeldt RL. Hormone replacement therapy in postmenopausal women: Utilization of Health Care Resources by New Users. Presented at the South Atlantic Association of Obstetricians & Gynecologists Annual Meeting, Hot Springs VA, January, 2001.

35. Yang J, Savitz DA, **Thorp JM**, Hartmann KE, Dole N. Predictors of vaginal bleeding in the first two trimesters of pregnancy. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June, 2001.

36. Berkman ND, **Thorp JM**, Lohr KN, Carey TS, Hartmann KE, Gavin NI, Hasselblad V, Idicula AE. Tocolytic Treatment for the Management of Preterm Labor: A Review of the Evidence. To be presented at the South Atlantic Association of Obstetricians and Gynecologists 64th Annual Meeting, January, 2002.

37. Siega-Riz AM, Hartzema AG, Turnbull C, **Thorp JM**, McDonald T, Cogswell M. A trial of selective versus routine iron supplementation to prevent third trimester anemia during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

38. Balu R, **Thorp JM**, Savitz D, Heine P. Association between cervical length and markers of immune status of the cervico-genital tract during pregnancy. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

39. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis and vaginal fluid defensins during pregnancy. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

40. Balu R, Savitz D, Ananth C, **Thorp JM**, Heine P, Eucker B. Bacterial vaginosis, vaginal fluid defensins and preterm birth in a cohort of North Carolina women. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

41. Balu R, **Thorp JM**, Savitz D, McMahon M, Hartmann K, Eucker B. Cervical length and the etiologic heterogeneity of preterm birth. Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

42. Savitz D, Terry JW, Dole N, **Thorp JM**, Siega-Riz AM, Herring AH. Comparison of pregnancy dating by last menstrual period, ultrasound, or their combination. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

43. Malizia B, **Thorp JM**, Siega-Riz AM, Savitz D, Hartmann K, Eucker B. Identification of perinatal substance use in clinical care. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

44. Siega-Riz AM, Savitz D, **Thorp JM**, Zeisel S, Hartmann K, Eucker B. Is there an association between maternal folate status in the second trimester and preterm birth? Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

45. Dole N, Savitz D, Siega-Riz AM, McMahon M, **Thorp JM**, Eucker B. Psychosocial factors and preterm birth among African-American and white women in central North Carolina. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA, January 17, 2002.

46. Siega-Riz AM, Promislow J, Savitz D, **Thorp JM**, Hartmann K, Eucker B. Vitamin C intake and the risk of preterm birth. Poster Presentation: Society for Maternal Fetal Medicine 2002 Annual Meeting, New Orleans, LA. January 17, 2002.

47. Evenson KR, Siega-Riz AM, Savitz DA, Leiferman JA, and **Thorp JM**. Vigorous leisure activity and pregnancy outcome: The Pregnancy, Infection, and Nutrition Study. Poster at the American College of Sports Medicine meeting in St. Louis, MO, May 31, 2002. Abstract in Med Sci Sport Exercise. 2002;34(5) Supplement.

48. Pompeii LA, Savitz DA, Evenson KR, Loomis D, Rogers B, **Thorp JM**. Cessation of employment and the risk of preterm delivery and small-for-gestational age birth. Third International Congress of Women, Work, and Health. Stockholm Sweden, June, 2002.

49. Savitz DA, Dole N, Herring AH, Kaczor DA, Murphy J, Siega-Riz AM, **Thorp JM Jr**. Risk factor profile of spontaneous and medically indicated preterm births. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

50. Vahratian A, Siega-Riz AM, Savitz DA, **Thorp JM Jr**. Multivitamin use and the risk of preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Palm Desert CA, June, 2002.

51. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Siega-Riz AM, **Thorp JM**. Perinatal factors associated with both intermediate and positive bacterial vaginosis in pregnancy. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

52. Murphy J, Dole N, Savitz DA, Herring A, Kaczor D, Benson A, Siega-Riz AM, **Thorp JM**. Decision to delivery in preterm preeclampsia: Maternal or fetal indications. Poster presentation at the 23rd Annual Meeting of the Society of Maternal-Fetal Medicine, San Francisco CA, February, 2003.

53. Savitz DA, Kaufman JS, Dole N, Siega-Riz AM, **Thorp JM Jr**, Kaczor DT. Poverty, education, race, and pregnancy outcome. Poster presentation at the Annual Population Association of America Meeting, Minneapolis MN, May, 2003.

54. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Early Analgesia and Labor. Poster Presentation: Society for Pediatric and Perinatal Epidemiologic Research, Atlanta, Ga, June 10-11, 2003.

55. Yang J, Savitz DA, Dole N, Hartmann KE, Herring AH, Olshan AF, Thorp JM Jr. Predictors of vaginal bleeding during pregnancy/ poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Atlanta GA, June, 2003.

56. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Umbilical cord insertion and timing of delivery: 3 measures of relative umbilical cord insertion account for 29% of gestational age variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

57. Salafia C, **Thorp JM**, Maas E, Eucker B, Smith F, Savitz D. Measures of Relative Umbilical Cord Insertion Account for 26% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

58. Salafia C, Maas E, **Thorp JM**, Eucker B, Smith F, Savitz D. Chorionic Plate Measures Account for 39% of Birthweight Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans LA, February 4, 2004.

59. Salafia C, Mass E, **Thorp JM**, Eucker B, Smith F, Savitz D. Measures of Chorionic Plate area Account for 45% of Gestational Age Variance. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

60. Vahratian A, Zhang J, Hasling J, Troendle J, Klebanoff M, **Thorp JM**. Effects of Early Epidural Analgesia vs IV Analgesia on Labor Progression: A Natural Experiment. Presentation: Society for Maternal-Fetal Medicine 2004 Annual Meeting, New Orleans, LA, February 4, 2004.

61. Vahratian A, Zhang J, Troendle J, Siega-Riz AM, Savitz D, **Thorp JM**. Maternal obesity and labor progression in nulliparous Women. Poster presentation at the Annual Meeting of the Society for Maternal-Fetal Medicine. New Orleans, LA, February 4, 2004. Am J Obstet Gynecol 2003;189(6 Suppl1):S202.

62. Savitz DA, Dole N, Siega-Riz AM, Kaczor DA, Kaufman J, Herring AH, **Thorp JM**. Probability samples or clinic populations to study pregnancy and children's health? Contrasting approaches of demography and epidemiology. Oral presentation at the Annual population Association of America Meeting, Boston, MA, April, 2004.

63. Fogleman K, Herring A, Jo H, Pusek S, **Thorp JM.** Factors that influence the timing of spontaneous labor at term. Annual Clinical Meeting, Philadelphia PA, May, 2004.

64. Dole N, Herring AH, Savitz DA, **Thorp JM.** Corticotropin-releasing hormone (CRH) perceived stress, and preterm birth. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

65. Herring Ah, Liao X, Savitz DA, Dole N, Evenson K, Thorp JM. Time-varying coefficient models for preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Salt Lake City UT, June, 2004.

66. Harville E, Savitz Da, Dole N, **Thorp JM**, Predictors of placenta resistance. Oral presentation at the Annual Meeting of the Society for Epidemiologic Research. Salt Lake City UT, June, 2004.

67. Harville E, Dole N, **Thorp JM**, Savitz DA. Diurnal patterns of cortisol. Poster presentation at the Annual Meeting of the Society for Epidemiologic Research, Toronto CAN, June 2005.

68. Siega-Riz AM, Savitz DA, Kaczor D, Herring A, **Thorp J.** Serum transferring receptor and preterm birth. Oral presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiological Research, Toronto, CAN, June, 2005.

69. Harville E, Dole N. **Thorp JM,** Savitz DA. Stress and uterine dopplers. Poster presentation at the Annual Meeting of the Society for Pediatric and Perinatal Epidemiology, Toronto CAN, June, 2005.

70. Harville E, Dole N, Savitz DA, Herring AH, **Thorp J.** Stress questionnaires and stress biomarkers during pregnancy: Do they measure the same thing? Poster presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

71. Salafia CM, Pezzullo JC, **Thorp JM,** Eucker B. Pijnenborg R, Savitz DA. Basal plate uteroplacental vasculature in a birth cohort: measurement methods and analyses. Poster presented at 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle WA, June, 2006.

72. Siega-Riz AM, Howard DL, Savitz DA, **Thorp J.** The association between dyslipidemia and preterm delivery. Oral presentation at the 19th Annual Meeting of the Society for Pediatric and Perinatal Epidemiologic Research, Seattle, WA, June, 2006.

73. Rouse, Dwight and the MFMU Network: A randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Abstract #1. Plenary Session 1 at the 28th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 28, 2008.

74. Chireau M, Crosslin D, Hauser E, Olshan A, Zheng S, Salafia C, Thorp J. Endothelial function gene polymorphisms are associated with pregnancy outcomes, indepent of placental vascular disease. (Abstract #668). Poster presentation at the 29th Annual Meeting of the Society for Maternal Fetal Medicine, Dallas TX, January 29, 2008.

75. Rouse, D for the NICHD MFMU Network. A Randomized controlled trial of magnesium sulfate for the prevention of cerebral palsy. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

76. Tita, A for the NICHD MFMU Network. The MFMU Cesarean Registry: Impact of gestational age at elective repeat cesarean on neonatal outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

77. Harper, M for the NICHD MFMU Network. A Randomized controlled trial of Omega-3 fatty acid supplementation for recurrent preterm birth prevention. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

78. Mertz, H for the NICHD MFMU Network. Placental eNOS in multiple and single dose bethamethasone exposed pregnancies. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

79. Bakhshi, T for the NICHD MFMU Network. Maternal and neonatal outcomes of repeat cesarean delivery in women with a prior classical versus low transverse uterine incision. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

80. Rouse, D for the NICHD MFMU Network. When should labor induction be discontinued in the latent phase? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

81. Varner, M for the NICHD MFMU Network. Can fetal oxygen saturation identify chorioamnionitis? Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

82. Contag, S for the NICHD MFMU Network. Operative vaginal delivery versus cesarean delivery in the second stage of labor. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

83. Rogers, B for the NICHD MFMU Network. Placental pathology associated with the factor V leiden mutation. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

84. Aagard-Tillery, K for the NICHD MFMU Network. Hazardous air pollutants and risk of adverse pregnancy outcomes. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

85. Joy, S for the NICHD MFMU Network. Latency and infectious complications following preterm premature rupture of the membranes: Impact of body mass index. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

86. Sciscione, A for the NICHD MFMU Network. Perinatal outcomes in women with twin gestations who conceived spontaneously versus by assisted reproductive techniques. Presented at the 28th Annual Meeting of the Society for Maternal-Fetal Medicine, Dallas, TX, February 2008.

87. Caritis, S for the NICHD MFMU Network. Relationship of 17? Hydroxyprogesterone Caproate (17-OHPC) Concentrations and Gestational Age at Delivery in Twins. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

88. Caritis, S for the NICHD MFMU Network. Impact of Body Mass Index (BMI) on Plasma Concentrations of 17 ? Hydroxyprogesterone Caproate (17-OHPC). Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

89. Simhan, H for the NICHD MFMU Network. The Effect of 17-alpha Hydroxyprogesterone Caproate (17-OHPC) on Maternal Plasma CRP Levels in Twin Pregnancies. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

90. Cormier, C for the NICHD MFMU Network. Relationship between Severity of Maternal Diabetes and VBAC Success in Women Undergoing Trial of Labor. Presented at the 55th Annual Scientific Meeting for Society of Gynecologic Investigation, San Diego, CA, March 2008.

91. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Magnesium sulfate (MgSO4) dose and timing, and umbilical cord Mg++ concentration: Relationship to cerebral palsy (CP) Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

92. Mercer B, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Fetal thyroid function and neuro-

developmental outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

93. Roberts JM, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A randomized controlled trial of antioxidant vitamins to prevent serious preeclampsia-associated morbidity. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

94. Rouse D, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Second stage labor duration: Relationship to maternal and perinatal outcomes. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

95. Silver R, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Prothrombin gene G20210a mutation and obstetric complications: A propsective cohort. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

96. Manuck T, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Do antiphospholipid antibodies affect pregnancy outcomes in women heterozygous for factor v leiden? Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

97. Landon MB, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. A prospective multicenter randomized treatment trial of mild gestational diabetes (GDM). Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

98. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, MD. Effect of omega-3 supplementation on plasma fatty acid levels. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

99. Harper M, for the Eunice Kennedy Shriver National Institute of Child Health and Human Development MFMU Network, Bethesda, Maryland. Cytokine gene single nucleotide polymorphisms (SNPS) and length of gestation. Presented at the 29th Annual Meeting of the Society for Maternal-Fetal Medicine, San Diego, CA, January 2009.

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117. Hauth JC, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal insulin resistance and preeclampsia. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

118. Figueroa D, et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Relationship between the 1-hur glucose loading test results and perinatal outcomes. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

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120. Constantine MM, Clark EAS et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Oxidative stress, neuroprotection candidate gene polymorphisms and adverse neruodevelopmental outcomes. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

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122. Harper M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Tumor necrosis factor α -308 genetic polymorphism and cytokine production. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

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126. Stuebe A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal BMI, glucose tolerance, and adverse pregnancy outcomes. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

127. Stuebe A. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Is there a threshold OGTT value for predicting adverse neonatal outcome? Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

128. Johnson J. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network.

Outcomes associated with failure to achieve the 2009 Institute of Medicine (IOM) guidelines for weight gain in pregnancy. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 11, 2011.

129. Varner M. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Influenza-like illness in hospitalized pregnancy and immediately postpartum women during the 2009-2010 H1N1 influenza pandemic. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 12, 2011.

130. Graves SW, Esplin MS et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Validation of predictive preterm birth biomarkers obtained by maternal serum proteomics. Oral presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

131. Carreno C. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Excessive early gestational weight gain and risks of gestational diabetes and large for gestational age infants in nulliparous women. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

132. Hauth JC. et al (Thorp JM) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Insulin resistance in pregnancy and maternal body mass. Poster presentation at the 31st Annual Meeting Society for Maternal-Fetal Medicine, San Francisco, CA, Feb 10, 2011.

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Publications

Peer Reviewed Articles

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Non-Peer Reviewed Articles

1. **Thorp JM.** Should episiotomy be routine? *Current Practices* 8:3, December 1988.

2. **Thorp JM.** Should we routinely screen for toxoplasmosis? *Current Practices* 10:6, September 1990.

3. **Thorp JM.** Endovaginal sonography. *Current Practices* 12(4):1-2, December 1991.

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5. Hansen WF, **Thorp JM**. Postterm pregnancy. *Current Practices* 13 (1):1-2, March 1992.

6. **Thorp JM,** Stanford D. The Horizons program: a perinatal substance abuse project. *Current Practices* 13(2):6, June, 1993.

7. Kurtzman JL, **Thorp JM**, Spielman FJ, Mueller RC, and Cefalo RC. Do Nifedipine and Verapamil Potentiate the Cardiac Toxicity of Magnesium Sulfate? *Obstetric Anesthesia Digest*, 14(2) 45-92, 1994.

8. **Thorp, JM.** Patient Autonomy, Informed Consent, and Routine Episiotomy. *Contemporary OB/GYN*, September, 1995.

9. **Thorp, JM.** Point/Counterpoint: Should physicians with strong pro-life views avoid specializing in perinatology? No. *Physicians Weekly*, 12 (23); April 19, 1995.
10. **Thorp, JM.** Challenging Cases as a preceptor. *The Front Line* 1; 3-4, Summer, 1995.
11. **Thorp, JM.** Is episiotomy necessary? *Health Confidential*, 1995.
12. **Thorp JM**, Pisano EA. Why you should read the blue handbook about breast cancer mailed to you by the NC comprehensive breast and cervical center control coalition. *Current Practices* 4;1,1995.
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14. **Thorp, JM.** Should I Incorporate Fetal Fibronectin Testing into my Practice; and if so, How? *Current Practices* 16;2, 1996.
15. **Thorp JM.** New Services Offered by the Department and the End of an Era. *Current Practices* 16;1, 1996.
16. Guise J-M, **Thorp JM.** Antibiotics in the Management of Preterm Premature Rupture of Membranes. *Current Practices* 16;4, 1996.
17. **Thorp, JM.** Should I Incorporate Fetal Fibronectin into my Practice; and if so, How? *OBG Management*. Accepted, Sept, 1996.
18. **Thorp JM**, Cefalo RC, Bowes WA Jr. Court-ordered obstetrical intervention. *Contemporary OB/GYN*. June, 1997.
19. **Thorp JM**, Cefalo RC, Bowes WA Jr. Court-ordered obstetrical intervention. *Current Practices*, June, 1997
20. **Thorp JM.** Editorial Comment: Preterm Birth: The Role of Infection and Inflammation. *Medscape Women's Health*, 2(8), 1997.
21. Dorman K, **Thorp JM**. Improving Access to UNC Clinicians. *Current Practices*, September, 1998.
22. Cefalo RC, **Thorp JM.** Videotaping in Labor and Delivery. *Current Practices*, September, 1998.
23. **Thorp JM.** I Want To Be Like Watt. *Current Practices*, March, 1999.
24. **Thorp JM**. Literature Review and Study Design: Resource use associated with hormone replacement therapy. Research Triangle Institute project report funded by Eli Lilley, January 1999.
25. Gavin N, Wilson A, Greene AI, West, S, **Thorp JM**. Health Care Resource Use Associated with Hormone Replacement Therapy. Research Triangle Institute Report Project No 7203, funded by Eli Lilley, November, 1999.

26. **Thorp JM**. No role for maintenance tocolysis in preterm labour: study. Obstet & Gynaecol Canada. November, 2000, Vol 4, No. 7, p 13.

27. Ansbacher R, Creinin MD, **Thorp JM**, Nolan TE, Darney PD, Thorneycrost IH. Consensus statement: Public health considerations with therapeutic substitution of low-dose oral contraceptives. *Am J Obstet Gynecol (Clinical Opinion)*, September, 2000.

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30. Sayle A, Savitz D, **Thorp JM**. Sexual intercourse and orgasm during late pregnancy may have a protective effect against preterm delivery. Family Planning Perspective 2001;33(4):185.

31. **Thorp JM**. Integrity, Abortion, and the Pro-Life Perinatologists. Proceedings of World Federal of Catholic Medical Associations, "The Future of Obstetrics and Gynaecology: The Fundamental Human Right to be Trained and to Practice According to Conscience". Marie S.S. Bambina Institute, Rome, Italy, 2001.

32. Ansbacher R, Creinin MD, **Thorp JM**, Nolan TE, Thorneycroft IH. Therapeutic substitution of low-dose OCs. *The Female Patient* 2002;27:11-12.

33. **Thorp JM**. Predicting and preventing preterm birth. *OBG Management* 2005;17 (6):49-53.

34. **Thorp JM Jr**, Rowland Hogue CJ, Does elective abortion increase the risk of preterm delivery? *Contemporary OB/GYN: Controversies in OB/GYN* 2006(September)51(9):88-92.

35. **Thorp JM Jr**. Does cervical dysplasia raise the risk of preterm birth? Examining the Evidence (commentary). *OBG Management* 2007:19(40:20-23.

36. **Thorp JM Jr**. Can intrauterine growth restriction be present in the first trimester: Expert Commentary. *OBG Management* 2008;20(6):28.

<u>Teaching Activities</u>

Faculty Committees	1. Tenured Medicine Council 2. Faculty Executive Committee(alternate)	2007
Liaison	Area Health Education Center Liaison School of Medicine University North Carolina-Chapel Hill	2000-2003
Member	Doctoral Dissertation Committees Department of Epidemiology School of Public Health	1997-present

University North Carolina-Chapel Hill

Oral Examiner	American Board Obstetrics and Gynecology MFM Subspecialty	2005 - present
Oral Examiner	American Board Obstetrics and Gynecology	1996-present
Fellowship Director	Division of Maternal-Fetal Medicine Department of Obstetrics & Gynecology School of Medicine University North Carolina-Chapel Hill	1997-2000

Grants

Cooperative agreement in community child — 1/2002 - 1/2006
Study proposes to do community based participatory research in Eastern NC. (Thorp 5%)
Principal Investigator: John M. Thorp
Source: NICHD
Funding: $600,000

Epidemiology of Leptin Production and Fetal Growth. This study's goal is to understand the Determinants of fetal growth in human pregnancy, With the focus on growth potential to the growth that Is attained with respect to leptin production. (Thorp 13% yr 1) — 9/2004 – 9/2009
Principal investigator: John M. Thorp
Source: NIH
Funding Period: 9/2004-9/2009
Funding: 5,500,000 – Awaiting resubmission

Pregnancy-Related Weight Gain: A Link to Obesity. This study's goal is to identify modifiable behaviors for pregnant women that are associated with weight gain above the recommended ranges and that result in high postpartum weight retention. (Thorp 5%) — 8/01/02 –7/31/07
Principal Investigator: Anna Maria Siega-Riz, PhD
Source: NIH/NIDDK
Funding Period: 08/01/02 – 07/31/07
Funding: Total Direct: $1,749,033

Placental Vascular Compromise and Preterm Delivery: This study will look at the association between placental vascular compromise and preterm delivery rates. (Thorp 20% in year 1) — 9/01/01-8/31/06
Principal Investigator John Thorp MD
Source: NICHD/NIH 1 RO1 HD39373-0A1.

Funding Period: 9/01/01-8/31/06
Funding: Total Direct: $2,350,497
Current Year Funding $510,996

Cooperative Multicenter Maternal Fetal Units Network: This study proposes to conduct clinical trials in perinatal medicine (Thorp 10%) — 4/1/01 – 3/ 31/06
Principal Investigator: John Thorp Jr. M.D.
Source: NIH: Grant No. 1 U10 HD40560-01
Funding Period: 4/1/01 – 3/ 31/06
Funding: $ 1,459,785
Current Year Funding $ 272,087

Gates Global Network to Improve Maternal Health. This is a collaborative, multicenter, global network that will investigate clinician behavior regarding episiotomy and oxytocin use in Uruguay and Argentina in conjunction with the Center for Latin American Perinatology. (Thorp 7.5%) — 1/01/01-1/01/06
Principal Investigator: Pierre Buekens, MD, PhD
Source: NICHD
Project Period: 1/01/01-1/01/06
Total Funding: $2,800,000
Type: Research

Epidemiologic Study of Vaginal Bleeding during Pregnancy and Preterm Birth. The proposed study extends an NIH-funded study of epidemiology of exertion, stress, and pre term birth. Detailed information regarding vaginal bleeding will be added to the interviews for all enrolled women administered after recruitment and at 27-30 weeks' gestation. (Thorp 0%) — 6/01/01-5/31/04
Principal Investigator: David Savitz PhD
Source: March of Dimes
Funding Period: 6/01/01-5/31/04
Total Direct Costs: $163,258 Total Indirect Costs: $16,326 Total Funding: $179,584
Current Year Funding: $61,405

Epidemiology of Exertion, Stress and Preterm Delivery. In this study, it is proposed that the role of external stressors, perceived stress, enhancers and buffers of perceived stress, and physiologic markers of response to stress be examined in relation to pregnancy outcome. A detailed evaluation of domestic, occupational and recreational physical activity patterns before and during pregnancy will be conducted. (Thorp 5%) — 12/1/99-11/30/04
Principal Investigator: David A. Savitz, PhD.
Source: NICHD/NIH RO1-HD3758

Total Project Period: 12/1/99-11/30/04
Total Funding: $3,735,28 Direct: $2,586,817
Indirect: $1,148,464
Current Year Funding: $385,179

Drinking Water Disinfection By-Products and Spontaneous Abortion – this prospective cohort study will test the hypothesis that water disinfection by-products, particularly trihalomethanes and haloacetic acids are associated with increased rise of early spontaneous pregnancy loss. Approximately 3,000 women, in three distinct water supplier regions will be enrolled in early pregnancy or prior to conception. First trimester ultrasound data, as well as supplementary studies of time to conception, and the grief counseling needs of women with poor pregnancy outcomes will be based at the Sheps Center. (Supported by a grant to the Department of Epidemiology. (Thorp 5% in-kind) — 11/15/99-06/15/02
Principal Investigator: David A. Savitz, PhD
Source: American Water Works Association Research Foundation AWWARF Grant No. 2579
Total Project Period: 11/15/99-06/15/02
Total Funding:$3,000,000
Direct: $1,668,000 Indirect: $1,332,000
Current Year Funding: Direct: $1,287,677.00
(30 month budget – Year 1 budget)
Type: Research

Psychosocial Risks and Preterm Birth in African-American Women. It is proposed that this study evaluates the role of external stressors perceived stress, enhancers and buffers of perceived stress in relation to pregnancy outcome. Building on an ongoing study of preterm delivery, an additional 550 women will be enrolled who obtain prenatal care at the University of North Carolina Hospitals' clinics between the 24th and 29th weeks of gestation. External stressors (life events, physical and emotional abuse, job stress, socioeconomic stress), perceived stress (impact of life events, discrimination, and safety), enhancers (anxiety, depression) and buffers social support, coping, religion) will be evaluated during pregnancy. (Thorp 3%) — 9/09/99-9/08/02
Principal Investigator: David Savitz PhD
Source: ASPH S0807-18/20
Total Project Period: 9/09/99-9/08/02
Total Direct Costs: $179,892. Total Indirect Costs: $76,949 Total Funding: $256,841
Current Year Funding: $53,652

Model Program for Perinatal Substance Abuse 1/01/94 – Present
HORIZONS.
This is a demonstration projectof a novel paradigm
to treat perinatal substance use problems by combining
perinatal and mental health care. It combines an array of
treatment resources including a residential program in which
families can receive substance abuse treatment.
(Thorp 10%)
Principal Investigator: John M. Thorp, Jr., MD
Source: NC Department of Health
and Human Services
Project Period: 1/01/94 – Present
Funding to Date: $4,500,000

Past Support

Influence of iron, zinc, and folate on 1999-2001
preterm delivery
Funding Agency: NICHD/NIH
Co-Investigator
$570,000

Addiction Studies, Center for Welfare 1998-2001
reform and perinatal substance abuse
Funding Agency: RW Johnson
Medical Director
$800,000

Evidence based management of Preterm Labor 1998-1999
Funding Agency: AHRQ
Scientific Director
$200,000

Perinatal iron metabolism 1996-1999
Funding Agency: CDC
Co-Principal Investigator
$386,000

Epidemiology of cocaine use 1996-1999
Funding Agency: NICHD
Co-Principal Investigator
$78,000

Perinatal HIV Prevention 1996-1997
Funding Agency: CDC
Co-Principal Investigator
$120,000

Perinatal smoking cessation 1993-1995
Funding Agency: Kate B. Reynolds

Charitable Trust
Medical Director
$109,000

Smoking cessation — 1995-1997
Funding Agency: R.W. Johnson
Principal Investigator
$205,000

Professional Service

Specialty and Sub-Specialty Certification

	Sub-Specialty certification, Gynecology American Board of Obstetrics and Gynecology	1992-present
Diplomate	American Board of Obstetrics and Gynecology Maternal-Fetal Medicine	1991-present

Committee Assignment

	University of North Carolina in Chapel Hill Appointment to promotion with tenure Chapel Hill, NC	2003 - 2005

Proposal Reviewer

Member	Study Section – Maternal & Child Health NICHD, Bethesda, MD	2002 - present
Member	Steering Committee, MFMU Network CHD, Bethesda, MD	2001 - present
Member	Expert Review Panel – Evidence report on post-term pregnancy Duke University, Durham, NC	2001 - 2002
Proposal Reviewer	Family Health International RTP, NC	2000 - present
Member	Special emphasis group on regional anesthesia NICHD, Bethesda, MD	1999